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DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES	(00	-K		9 01/29:	722 2042
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		0	FOR	VI APPRO	VED
STATEMEN	VT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	·0225 8413	H TID	OMB NO	<u>). 0938-0</u>	391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILT	DING	Ilian St	TE SURVE	Υ
				D111C	·		·
		056039	B. WING	3		C	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	/09/2017	
WELLS	PRINGS POST ACUTE	CENTER			14445 NO.15TH ST. WEST		l
					ANCASTER, CA 93534		
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES	מו		PROVIDER'S PLAN OF CORRECTION	T	
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD BE	COMPLET	ПОИ
		•	, no		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
		·				 	
F 000	INITIAL COMMENT	· ·	FC	000		~	-
		r			This Plan of Correction serves as the	2017	젊
	The following reflec	ts the findings of the	,		Facility's credible of allegation of	-11	1
	Department of Publi	c Health during a Complaint			compliance.	833	013
	investigation.					1	Y.
	Complaint Number	CA00506863 - Substantlated				7	
	demplant Harring.	CAUCOUCOS - Substantiated				PH	=1-
. •	Representing the Da	partment of Public Health				1	1115
				1	• • •	5	70
	Surveyor ID Number	: 04945, HFEN			F 309	12	.
	The inspection upo t	imited to the specific		-	1. Resident #1 is no longer in the facility.		1
	complaint and does	not represent the findings of			Upon learning of the alleged deficient		
	a full inspection of th	e facility		1	practice, the DON and the MRD reviewed		
					the bowel elimination records of all		
	Highest S/S: G				residents; no similar deficient practice was	1	
F 309	483.25 PROVIDE CA	ARE/SERVICES FOR	F 3	09	identified.		
SS=G	HIGHEST WELL BE	ING			2. All residents have the potential to be		
	Each recident must -	manken mind the Country			affected by the same alleged deficient		ŀ
	provide the percent	eceive and the facility must y care and services to attain			practice. The DON and the Unit Manager	\$	
	or maintain the higher	st practicable physical,		- 1	reviewed the medical records of residents		
	mental, and psychose	ocial well-being, in			that have a potential likelihood for		
	accordance with the	comprehensive assessment			constipation and bowel impaction derived		
	and plan of care.				from the use of opiates, and other factors	•	·
				1	(post-surgery, lack of mobility, etc.). Residents that were identified were		
[,			İ	initiated on a bowel management program		
.1	This REQUIREMENT	is not met as evidenced			that includes monitoring bowel sounds,		
l	by:	- not met da calhellen			bowel discomfort, bowel distention,		l
	Based on interview a	and record review, the facility			frequency and consistency of bowel		
	failed to implement a	resident's (Resident 1) care			movement every shift.		
	plan for being at risk	for constination/fecal			3. The bowel management program now		
j	impaction (a mass of	dry, hard stool that will not			includes among others documentation in		- 1
1	hase out of the colon	or rectum) by failing to:			the eMAR for monitoring bowel sounds,		- 1
ŀ	1. Monitor the howel r	movements (BM) every shift			bowel distention, bowel frequency and		
					<u>/</u>		1.
BORATORY	DIRECTOR'S OR PROVIDER	USUPPLIER REPRESENTATIVE'S SIGNA	URE /	<i>X</i>	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 svallable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

The

FORM CMS-2557(02-89) Previous Versions Obsolete

Event ID: MU0411

Administrator

(X8) DATE

02-07-1

PRINTED: 01/29/2017 FORM APPROVED

		& MEDICAID SERVICES			· Ot	MR NO	0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION .		(X3) DATE SURVEY COMPLETED		
		056039	B. WING			04/0	; 9/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	01/0	312017	
WELLSF	PRINGS POST ACUTE	CENTER		44445 NO.15TH ST. WEST LANCASTER, CA 93534				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF	TION SHOULD I THE APPROPR	RF	(X5) COMPLETION DATE	
F 309	Continued From pa and record in the fix 2. Observe closely in	ow sheet.	F3	charge nurse. The DON and DSD	ding MD by to in-serviced	he		
	nausea, and vomitir3. Administer stool sorder.	h as distended abdomen, ng. softener per the physician's cations for possible cause of	•	licensed nurses on 2017 regarding bow constipation and fed identifying potential This in-service inclu implementation of n	vel managen cal impactior high risk res uded the nonitoring bo	nent, n and sidents.	•	
	constipation. 5. Encourage fluid in more in 24 hours. This failed practice is transfer to the gener (GACH) where she final diagnoses that severe dehydration (mostly water, exceein), and early small to fithe intestines which digestion to pass throbstruction (intestines)	resulted in Resident 1's ral acute care hospital died the following day with the included nausea, vomiting, (when the loss of body fluids, ds the amount that is taken bowel obstruction (blockage ch prevents the products of ough) versus possible ileus all obstruction) versus severe or complete constipation).	•	sounds, bowel patter consistency and free in the eMAR and tal measures to notify a attending physician. On February 2 & 3, service was provided DSD in identifying the bowel movements to caring for assigned Notification of lack of will be recorded in CADL. Flow records a communication and licensed nurses.	equency ever king appropriabnormalities for intervent 2017 a similar de for CNA's he absence beyond 3 day residents. of bowel mov CNA tasks of and effective	riate s to tions. lar in- by the of ys when wement n their		
	Investigate an allega have a bowel moven nursing facility (SNF) transferred to the GA on February 16, 201 A review of Resident	i6, an unannounced nade to the facility to tion that Resident 1 did not nent (BM) while in the skilled of four days. She was ACH for abdominal distention 5, and died the following day.		4. The effectiveness of monitored by the Unit Note of CNA's management records a flow records. This revision identify residents that revaried combination of lessofteners and diet modification. Admission Nurses was admits with predisposition.	Managers by bowel and daily ADI will effect may benefit in axative, stoo ification will ensure the	daily care lively from a		

05:41:07 p.m.

01-29-2017

11/22

PRINTED: 01/29/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVE	D
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	1
		056039	B. WING	3		•	C	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2017	╛
WELLSP	PRINGS POST ACUTE	CENTER		. 4	4445 NO.15TH ST. WEST			
(X4) ID	SIIMMARY STA	TEMENT OF DEFICIENCIES			ANCASTER, CA 93534			1
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE	(XS) COMPLETION DATE	
	tollowing a fall at ho compression fracture vertebra of the lumb therapy and pain conintervention. Her ad fracture of the lumb disorder [persistent schizophrenia (breal and fatigued)], hypot production resulting diabetes type II (a chearbohydrate metablohyperlipidemia (an in anemia (a reduction red blood cells), dem disturbances (intelled and major depression. The Nurses' Admission 11, 2015, indicated in was continent of bow verbally responsive. Assessment dated Fix Resident 1's care platidentified the problem constipation/fecal impression medication). The have a bowel movem days. The intervention Resident 1's bowel movem days.	at 4:30 pm, from the GACH me which resulted in an L1 e (collapse of the upper ar spine) requiring physical introl with no surgical mission diagnoses included a revertebra, schizoaffective symptoms resembling with reality and feeling sad thyroidism (lack of thyroid in fatigue and weight gain), included a lack of insulin), in the number of circulating tentia without behavioral citual function impairment), in disorder (altered mood). On Record dated February in the notes that Resident 1 rel and bladder, alert and The Bowel and Bladder ebruary 11, 2015, in of at risk for paction resulting from it mobility, poor fluid intake, edications and narcotics in goal was for Resident 1 to ent at least every three on plan was to monitor overments every shift and set, review medication for estipation, give stool softener der, encourage fluid intake	F:	309	to constipation, fecal impaction opiates, post-surgery, lack of metc.) will be identified upon admediate physician orders are transcribe appropriate bowel managemen Admission nurses will also transmonitoring bowel sounds, bower consistency, bowel frequency eshift in the eMAR. In addition, the DON and MRD review daily all admission recort the new admissions. The MRD/designee will further condically qualitative audits to identify residents who had no bowel moder 3 days to ensure that the EMANAGEMENT MANAGEMENT MA	obility, ission. d for t. scribe el very will ds with uct a y ovement Bowel nented hitted to shall mittee lysis, tion and	02/13/201	7
11	per the physician's or	stipation, give stool softener der, encourage fluid intake 24 hours, and give laxative			•			

FORM CMS-2587(02-89) Previous Versions Obsolete

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If continuation sheet Page 4 of 14

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

1	·.			101 (1100 a	and the second second	. 1
		ŀ		20 mgs. PO daily for	Ast I alossidamo.	-
				Drug handbook, 2015,	2965 148-150)],	
				side effects included	suppassion suggested its	2
				ns si villida) .2102, St Vis	unded beteb emitbec	
				grams (mgs) by mouth at		
				9 Drug handbook, 2015,	53862 704-705)].	
				babulari staeffects included	analgesic medication	: [
				ITY 12, 2015. [Norco is an	surded bateb enituo	
				PO every eight hours	5. Norce tablet 5/325	
				er oral (PO - mouth) twice a 12, 2015.	day dated February '	
				r use for treatment of	4. Lactulose (solution	
				3102 ,11 yieunds	suppository dated Fe	
				lon if no result from Dulcolax	needed for constipat	
				sative that promotes bowel as yellostion rectally as	3. Fleet Enema (a la L'heani - (hemevom	
	,			ted February 11, 2015.	sb MOM gnivig 1971s	
				nsert 1 suppository rectally pation if no results 8 hours	as needed for consti	
				estomorg that evidence in yrotes	2. Dulcolax Supposit	
					February 11, 2015.	
				if no BM in three days dated	(cc) sa useqeq qsily	
				Concentrate suspension etc.) - give 30 cubic centimeter	nefros loots - MOM)	
				•	•	
				sician orders as follows:	Resident 1 had phys	
				19, and notify the physician.	abdomen, or vomitin	
	•			serve closely for any signs cal impaction, distended	and symptoms of fe	
				er the physician's order. The	dality of tatesibut gala	,
		60	E 30		Continued From page	E 309
21140	DEFICIENCY)			_		
COMPLETION DATE	ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIETE	ว นวษส) 🦠 🤫	XITERY DAT	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	(בעכע מבעכובעכג	XITƏRT ĐAT
	IDER'S PLAN OF CORRECTION		Q)	TEMENT OF DEFICIENCIES	ATS YAAMMUS	Ol (AX)
		HT4466 NO.18TH S		СЕИТЕЯ	STUDA TEON SENIS	MELLSP
1189755	S, CITY, STATE, ZIP CODE				PROVIDER OR SUPPLIER	
09/2012 C			B. WING	086039		STANK
03T3J9I	voo ———	ÐN	A BUILDI	NEGWAN NOUNCE		
. 0938-0391 E SURVEY	110	прте соматкисти		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OF DEFICIENCIES OF CORRECTION	STATEMENT
APPROVED				& MEDICAID SERVICES	32 FOR MEDICARE	CENTE

Facility ID: CA920000048

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it continuation sheet Page 5 of 14

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

FORM CMS-2567(02-89) Previous Versions Obsolete Assessment" data dated February 11 to 15, 2015, A review of Resident 1's "Elimination Pattern match the previous MAR documentation. cc twice daily. "MOM also given," which did not note indicated the resident receives Lactulose 30 for five days; charge nurse notified. An added 2015, (no time) indicated Resident 1 had no BM On the back of the flow sheet, dated February 15, indicated Resident 1 had no bowel movement. three shifts dated February 11 to 15, 2015, The Nursing Assistant Daily Flow sheet for the by the physician and as indicated in the care plan. when Resident 1 did not have a BM, as ordered administered MOM, Dulcolax or a Fleet Enema, documented evidence that Resident 1 was daily on February 14 and 15, 2015. There was no 13, 2015, as ordered by the physician, and twice dose was circled), rather than twice on February Lactulose was only administered once (morning (MAM) for the month of February 2015, indicated A review of the Medication Administration Record was left blank. management. The fluid requirement assessment and that she was on medication for bowel indicated Resident 1 was at risk of constipation the Registered Dietitian on February 16, 2015, sheet dated February 11, 2015, and reviewed by The Nutritional Assessment Screening Data February 15, 2015 (no time). 8. Zofran 4 mgs PO for nausealvomiting dated handbook, 2015, Pages 1046-1047)]. effects included constipation. (Nursing Drug Omeprazole is an antiulcer drug and its side stomach upset dated February 13, 2015. F 309 Continued From page 4 60E 4 DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIETE (XS) COMPLETION BTAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **DAT** XFIBRY DAT XITERIX РЯОУЮЕЯЗ РІАИ ОГ СОВВЕСТІОИ SUMMARY STATEMENT OF DEFICIENCIES GI (PX) LANCASTER, CA 93534 WELLSPRINGS POST ACUTE CENTER TEBW .TE HTEI.ON SAPPA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7109/2017 B. MING 660330 (x3) DATE SURVEY COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA 1660-8660 ON 8MO STATEMENT OF DEFICIENCIES FORM APPROVED

Facility ID: CA92000048

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05:42:44 p.m.

01-29-2017

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DEPAR' CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 01/29/2017	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED	
	·	056039	B. WING	3		,	C 01/09/2017	
NAME OF	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		110312017	
WELLSP	RINGS POST ACUTE	CENTER			14445 NO.15TH ST. WEST LANCASTER, CA 93534			
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILO RE	(X5) COMPLETION DATE	
F 309	Continued From paindicated Resident	ge 5 I had no bowel movements.	F:	309				
	12, 13, 14, and 15, 2 shift, under General movement, was left 2015, (no time indic Resident 1 vomited	Nurses Notes dated February 2015, on the 3 pm to 11 pm Description for last bowel blank. On February 15, ated), it was noted that twice, and Zofran for nausea ven. (The adverse reaction to pn.)						
	Record from Februa indicated the fluid in	t 1's Intake and Output (I&O) ny 11 to February 16, 2015, take given ranged from 1080 ommended fluid intake was						
	interview with the As stated that the I&O r Certified Nursing As	016, at 9:30 am, during an sistant Director of Nurses, he ecords were completed by a sistant (CNA). He stated the apposed to be tallied by a e end of the shift.				• •	•	
	telephone interview of the stated Residual constipation, but did was given, or if she of She stated she reme	on the licensed nurse (LN ent 1 received medication for not know what medication documented on the MAR. embered Resident 1 did not eing sent to the hospital).						
	Nurses on January 9 stated Resident 1's cencourage 1800 ml cencourage	iew with the Director of b, 2017, at 3:40 pm, she care plan indicated to pr more of fluids per day.				,		

have been implemented.

05:43:16 p.m. 01-29-2017

15/22

01/29/2017 APPROVED

JEPARIMENT OF HEALTH	AND HUMAN SERVICES		PRINTED:
	& MEDICAID SERVICES		FORMA
	(Va) SSS) CRESCO	(X2) MULTIPLE CONSTRUCTION	OMB NO. (

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MU A. BUIL		E CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		056039	B. WING	3		4	C	
,	PROVIDER OR SUPPLIER PRINGS POST ACUTE	CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 4445 NO.15TH ST. WEST ANCASTER, CA 93534	_ [/09/2017	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE		
	A review of Resider Weekly Progress N indicated the following of the follo	at 1's Licensed Personnel otes for February 2015 ng: 2015, on the 11 pm to 7 am implained of pain at a level of 6 or pain and 10 being the worst was given Norco. 2015, (no time documented, dent 1 complained of pain, and with therapeutic effect. 2015, (no time indicated) episode of vomiting (10 cc of a in color). Resident 1 refused nausea. 2015 at 5:30 am, Resident 1 obtal for further evaluation miting with brown colored distention, and no bowel promiting, or growling noises aused by the muscular ves the contents of the nes downward) heard over all with a stethascope to the four nen and lower stomach mentation in the Licensed rogress Notes from February Resident 1 was administered Fleet Enema as ordered by	F	309				

FORM CMS-2587(02-89) Previous Versions Obsolete

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If continuation sheet Page 8 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

					Resident 1 had no BM; and final distention and for the owel sounds, until February	documentation when assessing for abdom		
,					nt 1's care plan on monitoring for BM every	medical record that t implemented Reside		
,					5, LM 1 requested her to secause of the resident's rospital. Resident 1 had no our quadrants and was sent	on February 16, 201; assess Resident 1 to bowel sounds in all fi to the hospital		
					wei sounds. The physician ma m. 116 at 9:15 am, during an stated that that betated that	was notified at 4:49 ; On December 29, 20		
	•			-	nal) form dated February 16, icated Resident 1 was iting, constipation, abdominal	(Situation, backgrour request-gastrointesti 2015 at 4:49 am, ind having nausea, vom		
	•				the resident was getting bed to go to the hospital. ot have a bowel movement ysician ordered to transfer	am, the note indicate anxlous and request Resident 1 still did n		
					bowel movement, miort, and her abdomen was swel sounds in four quadrants e supervisor. Fleet Enema nentation of results). At 4:00	resident still had no complained of disco distended with no bodistened Nurs		
	٠			£ 308	ye 7 Spisodes of brown emesis sovement Dulcolax en and a digital check was fool present At 3:20 am, the	m lawod on ban bins vip 25w Ynolieoqqua	euc 1	
	(X5) COMPLETION DATE	38	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR (YOUR DEFICIENCY)	GI XITƏRT DAT	TEMENT OF DEFICIENCIES IC IDENTIFYING INFORMATION)	REGULATORY OR LE	GI (FX) XI33R4 DAT	
	•		HEET ADDRESS, CITY, STATE, ZIP CODE 446 NO.18TH ST. WEST ANCASTER, CA 93534	9 0	•	ETUDA TEOS EDNIR	METT26	
	0 0)5011 C	10		B. WING	026039	PROVIDER OR SUPPLIER	NAME OF	
Ĺ	NPLETED	FAG (EX)	ионтинствиот =	(X2) MULTIPL(A BUILDING A	THE PROPERTY OF THE PROPERTY O			
C	19VOA99A 1 0938-039	FORM.			& MEDICAID SERVICES	RS FOR MEDICARE	CENTE	

Facility ID: CA920000048

Event ID: MUO411

17/22

indicated Resident 1 arrived at the emergency A review of the Emergency Physician Record initiating the preliminary Care Plan. addressing perlinent resident problems and complete documentation every shift for 72 hours, Requirements" indicated for new admissions, section titled "Licensed Nurse Documentation toward the goals of the written Care Plan. The response, and progress or lack of progress all communications made, the resident's assessments of residents, all interventions taken, a.m. or p.m.; and documentation includes all charting includes the date and time, indicating Procedure, titled "Documentation" indicated all A review of the facility's undated Policy and pharmacist medications had not been reviewed by the resident was only in the facility for four days, the the physician orders. The DON stated since the February 14, 2015, the third day of no BM, as per no f Inables A of nevigion sew MOM tent a resident's bowel movements. The DON stated they stated the CNAs are supposed to document and Assistant DOV, regarding Resident 1's death, at 3:40 pm, with the Director of Nurses (DON) Dufing a telephone Interview on January 9, 2017, constipation/fecal impaction. constipation according to the care plan to prevent medications were reviewed for possible cause of documentation to indicate Resident 1's 16, 2015, at 3:20 am. There was no F 309 Confinued From page 8 F 309 DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIETE COMPLETION (XS) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **DAT** XITERY DAT XITERIX PROVIDER'S PLAN OF CORRECTION QI (PX) LANCASTER, CA 93534 WELLSPRINGS POST ACUTE CENTER AAAAB NO.15TH ST. WEST STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7105/60/10 B' MINE 660330 (x3) DATE SURVEY COMPLETED A BUILDING. (rx) PROVIDER/SUPPLIER/CLIA (PROVIDER/SUPPLIER/CLIA **АИ**В РLАИ ОF СОЯ**КЕСТІ**ОИ (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES 16E0-8E60 ON 8MO CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/29/2017

At to e ages seats notauntinoo it

Facility ID: CA92000048

Event ID: MUD411

bruote estication of the same of the ground 16, 2015, indicated Resident 1 had mild level of The GACH Emergency Record dated February nausea, vomiting, and the last BM was four days. room on February 16, 2015, at 5:50 am, for

05:44:52 p.m. 01-29-2017

18/22

PRINTED: 01/29/2017 FORM APPROVED

		& MEDICAID SERVICES				O	FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		CONSTRUCTION		(X3) DAT	E SURVEY IPLETED
-		056039	B. WING		•			C
NAME OF	PROVIDER OR SUPPLIER		1	STI	REET ADDRESS, CITY, STATE,	ZIP CODE	<u> </u>	09/2017
WELLSP	RINGS POST ACUTE	CENTER			45 NO.16TH ST. WEST NCASTER, CA 93534		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	ID PREFII TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD THE APPROPE	BE	(XS) COMPLETION DATE
F 514 SS=D	through the nares d inserted with an initial fluid. The CT (compliance of the body Resident 1's abdom diffusely distended stomach suggesting bowel obstruction via A review of the GAC indicated Resident 1 emergency departm vomiting on Februar initiated. Resident 1 at 116, and was give saline fluid resuscite overnight and died a 2015. The final diagnomiting, severe deleanly small bowel on infect of the complete of the severe of the se	stric tube (a tube pass own to the stomach) was all output of 400 ml of brown puted tomograpy - takes using x-rays) scan report of the and pelvis, indicated small bowel loops and petither partial/early small ersus severe ileus. CH Discharge Summary I was admitted to the tent with severe nausea and by 16, 2015. Critical care was also sodium was profoundly lower a bolus (rapid) with normal attom. Resident 1 deteriorated at 1:18 am on February 17, proses included nausea, mydration, acute kidney injury, instruction versus possible obstipation, and sepsis as caused by the body's ection). ETE/ACCURATE/ACCESSIB intain clinical records on each tice with accepted professional idea that are complete; ted; readily accessible; and	F 5		F514 1) Resident #1 is no lor Upon learning of the all practice, the DON, QA MRD/designee did a re	nger in the fa eged deficie and view of MAR	nt 's of	
	resident's assessme services provided; th	ints; the plan of care and			consistency in the eMA alleged deficient practic			

05:45:24 p.m.

01-29-2017 PRINTED 19/22

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			PI	RINTEL	D: 01/29/2017 MAPPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU A. BUILI		IPLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		056039	B. WING				C
NAME OF	PROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE	01	/09/2017
WELLSPRINGS POST ACUTE CENTER				l	44446 NO.15TH ST. WEST LANCASTER, CA 93534		
(X4) ID	SUMMARY STAT	FEMENT OF DEFICIENCIES	ID	L_			· .
PREFIX TAG	EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE	COMPLETION DATE.
F. 514	Lagrange Light bot	ning conducted by the State:	F	514	2) All residents are at risk to be affe by the noted alleged deficient practi On February 02, 2017 the Medical Records Designees conducted an a	ce.	·
	by:	T is not met as evidenced view and interview, the facility			sweep of the medication administrative records to identify similar deficient practice. No similar alleged deficien	tion	
	failed to maintain res were complete and a follow its policy and p Administration or title	sidents medical records that accurately documented, and procedure for Medication and "Documentation" when			practice was identified. 3) The facility established a 3 way medication administration records d check and audit that coincides with	the	
	documenting medical medications were no Resident 1's medical	ation administration. The t charted as given on tion administration record practice had the potential for			weekly summary schedule. On Febr 02, 2017 DON and QA conducted a service to licensed nurses regarding consistency, accuracy and complete	n in- the	
	a resident not receivi Findings:	ng medications as ordered.			of documentation in the medication administration records to reflect medication administration in the care		
•	1 was admitted to the 2015, at 4:30 pm, fro hospital (GACH) follows:	cal record revealed Resident e facility on February 11, m the general acute care wing a fall at home which			all residents. This is to ensure and eliminate medication errors and adversaction related to lack of concise documentation. On February 02, 20		
	of the upper vertebra requiring physical the no surgical intervention	mpression fracture (collapse of the lumbar spine)			similar in-service was given by Medi Records Director and QA coordinate the Medical Record Designees. This service addressed the audit aspect a	r to in- and	
- [vertebra, schizoaffect symptoms resembling reality and feeling sac hypothyroidism (lack	live disorder [persistent g schizophrenia (break with d and fatigued)], of thyroid production			timeliness in identifying the consiste accuracy and completeness of licent documentation in the eMAR's. 4) The implementation of the plan of	sed	
•	resulling in fatigue an type II (a chronic diso metabolism due to a I hyperlipidemia (an inc	d weight gain), diabetes rder of carbohydrate ack of insulin), crease of fat in the blood).			correction will be monitored by the U Managers, RN Supervisors and the licensed nurses on daily basis by conducting a 3-way audit of the eMA	ıR's	
	anemia (a reduction in red blood cells), demo	n the number of circulating entia without behavioral tual function impairment),			of residents that are schedule for we summary documentation each shift.		

05:45:57 p.m.

01-29-2017 20 /22 PRINTED: 01/29/2017

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			03.43.33 p.iii, 01-	PRINTE	20/22 D: 01/29/2017 M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	OMB N	O. 0938-0391 ATE SURVEY OMPLETED
		056039	B. WING	·			С
NAME OF	PROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE	. 0	1/09/2017
WELLS	PRINGS POST ACUTE	CENTER		444	445 NO.15TH ST. WEST NCASTER, CA 93534		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	HILD DE	(X5) COMPLETION DATE
F 514	The resident had ph 1. Milk of Magnesia (MOM - stool softend (CC) as needed dail February 11, 2015. 2. Dulcolax Supposit bowel movement) - i as needed for constituting MOM da 3. Fleet Enema (a later piving MOM da later giving giving MOM da later giving giv	on disorder (altered mood). ysician orders as follows: Concentrate suspension er) - give 30 cubic centimeter y if no BM in three days dated tory (a laxative that promotes insert 1 suppository rectally pation if no results 8 hours ted February 11, 2016.	F	514	DON, QA Coordinator, Medical Director will ensure effectivenes plan of correction thru biweekly review. In addition, the Pharmac Consultant and Medical Record Consultant will monitor complian their schedule visit. Significant findings will be submithe administrator and will be for the QA & A Committee for trend analysis., corrective action and 5) Corrective action will be in plate before February 28, 2017.	es of the eMAR cy s nce during itted to warded to ing for CQI.	
	movement) - insert 1 needed for constipat suppository dated Fe	application rectally as ion if no result from Dulcolax			•		02/282017
	constipation) 30 cc p day dated February 1 A review of the Medic (MAR) for the month Resident 1 was not a or Fleet Enema. Lact once (morning dose) on February 13, 2015 February 14 and 15, 2	er oral (PO - mouth) twice a 12, 2015. cation Administration Record of February 2015, indicated dministered MOM, Dulcolax ulose was administered was circled) instead of twice 5, and twice daily on					
	interview with a licens that Resident 1 received the constipation but did not medication was given the documented on the constitution of the constitution was given the constitution of the constitution with the constitution of	sed nurse (LN 1), she stated ved medication for ot remember what she did not remember if					

05:46:28 p.m. 01-29-2017

21/22

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/29/2017 I APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		E CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY
		056039	B. WING	·	. •	1	С
NAME OF	PROVIDER OR SUPPLIER			Si	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> 01/</u>	09/2017
WELLSF	PRINGS POST ACUTE	CENTER		44	1445 NO.16TH ST. WEST ANCASTER, CA 93534		
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F 514	General Description	2015 on the 3 to 11 shift under for last BM was left blank. 15 (no time), it was noted that	F	514			
	Nursing Assistant Di February 15, 2015 (in no BM for 5 days an notified. The residen	ntation on the back of the aily Flow sheet dated no time), that Resident 1 had d the charge nurse was at was receiving Lactulose 30 OM also given (no time when					
,	dated February 14, 2 Resident 1 complain ordered with therape 2015, (no time) the r	nnel Weekly Progress Notes 2015, (no time) indicated ed of pain, medicated as autic effect. On February 15, esident had an episode of ttery emesis white in color).					
ľ	Resident 1's Nurses dated February 16, 2 Enema was given, b documented.	Progress Note & Care Plan 1015, indicated that a Fleet ut the time was not					
	1's medical records t monitoring the reside activity, checking the presence of abdomin	nented evidence in Resident hat the licensed nurses were ent's bowel movement resident's abdomen for the hal distention and bowel y 16, 2015 at 3:20 am.					
	Procedure, titled "Do charling includes the a.m. or p.m.; and do assessments of resid all communications n	y's undated Policy and cumentation" indicated all date and time, indicating cumentation includes all lents, all interventions taken, hade, the resident's					

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22/22 01-29-2017

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

PRINTED: 01/29/2017
FORM APPROVED

If continuation sheet Page 14 of 14

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					,		medication given.			
					to waiver A .r. bettit, t	it resident prot nary Care Plar Ind Procedure	complete document addressing perlimit initiating the prelimit the facility's Policy a medication Adminis			
	, .	• •		F 214	noitetnemus, snoissimbe	the written Ca sed Nurse Dos sated for new s	toward the goals of section filled "Licen Requirements" indic	∳ra न		
(XS) COMPLETION DATE	PROVIDER'S PLAN OF CORRECTION. (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		di Xi7389 Əat	DED BY FULL	TEMENT OF DEFICE MUST BE PRECE CO IDENTIFYING II	ДІ (ÞX) ХІТЭЯЧ ӘАТ				
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09/2017 C	Tros/60/10 ———			B. WING	6039	PROVIDER OR SUPPLIER				
CIVIS INC. 1938-1397 (X3) DATE SURVEY COMPLETED		• .•	ROITOURTEMOD E.	(X2) MULTIPL A. BUILDING	I SABAMUN NOT	TOF DEFICIENCIES (X1) PROVIDENCIFICATION NI				

Facility ID: CA92000048

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PRINTED: 03/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 056039 A WING 03/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 44445 NO.15TH ST. WEST WELLSPRINGS POST ACUTE CENTER LANCASTER, CA 93534 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 000} INITIAL COMMENTS {F 000} The following reflects the findings of the This Plan of Correction serves as the Department of Public Health during an Facility's credible allegation of compliance: Abbreviated Survey Revisit: Complaint Number: CA00506863 - Not in Compliance F 309 Representing the Department of Public Health: 1. Resident 1 remains at the facility in stable condition. Licensed Nurses are now Surveyor Federal I.D. Number: 36500, RN. following the Physician's orders to hold **HFEN** stool softeners and laxatives when the resident has an episode of loose stools. The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility. 2. All residents who require the use of laxative or stool softeners have the Highest S/S: D F309 - Repeat Deficiency potential to be affected by same alleged (F 309), 483.25 PROVIDE CARE/SERVICES FOR {F 309}; SS=D HIGHEST WELL BEING deficient practice. On 03/24/2017, the DON and QA nurse reviewed the medication Each resident must receive and the facility must administration record and Physician Orders provide the necessary care and services to attain for those residents who are receiving stool or maintain the highest practicable physical. mental, and psychosocial well-being, in softeners and laxatives. The attending accordance with the comprehensive assessment physician for identified residents was and plan of care. notified and an order was received to monitor the residents for episodes of loose stools prior to administering the stool This REQUIREMENT is not met as evidenced softener or laxatives every shift. The order by: for monitoring for loose stools was placed Based on observation, interview, and record on the resident's medications review, the nursing staff failed to follow the physician's order to hold medications [Docusate administration record. Sodium-stool softener and Senna-laxative that

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 projection 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.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10:14:40 a.m. 03-20-2017

10/13

PRINTED: 03/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 056039 B. WING 03/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 44445 NO.15TH ST. WEST **WELLSPRINGS POST ACUTE CENTER** LANCASTER, CA 93534 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION m (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG DEFICIENCY) (F 309) Continued From page 1 {F 309} 3. On 03/21/2017 to 03/24/2017 the DON promotes bowel movement] for bowel DSD and QA nurse provided in-service management when the resident was having loose stools for one out of two sample residents (1). training to licensed nurses and nursing assistants on the importance of reporting This deficient practice placed the resident at risk episodes of loose stools immediately to the for having excessive loose stools due to the charge nurse. It was explained to the failure of the nursing staff to hold the laxative medications. CNAs that some residents take laxatives daily and it is important for the charge Findings: nurse to be informed in a timely manner so that the laxative can be held for that shift. A review of the admission record indicated Resident 1 was originally admitted to the skilled The CNAs were directed to contact the nursing facility (SNF) on November 15, 2016, and 1 Charge nurses immediately after a resident readmitted on January 13, 2017, with diagnoses has a bowel movement. The Charge that included fracture of the left pubis, dementia Nurses were directed to contact the RN (decline in mental ability that interferes with daily life), anemia (lack of healthy red blood cells in the Supervisors anytime there is a change of blood), age-related osteoporosis (a condition in condition for a resident. The RN which bones become weak and fragile), and Supervisors were directed to assess all stress incontinence (inability to control the urge to urinate). residents when a change of condition occurs, and contact the physician as The Minimum Data Set [MDS-a comprehensive required. The DON informed the licensed assessment and care screening tool] dated nurses that there is now a physician's December 19, 2016, indicated Resident 1 had moderately impaired cognitive skills (the act or order to monitor residents for loose stools process of knowing, perceiving), required prior to administering stool softeners or extensive assistance with two-person physical assist with bed mobility, transfer, and toilet use. laxative and that the order will be placed The MDS also indicated Resident 1 was on the resident's medication administration frequently incontinent of bowel. record for those residents receiving stool softeners and laxatives. 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.

10:15:09 a.m. 03-20-2017 11/13

PRINTED: 03/18/2017

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C 056039 03/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 44445 NO.15TH ST. WEST **WELLSPRINGS POST ACUTE CENTER** LANCASTER, CA 93534 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) 4. The RN supervisors will monitor {F 309} Continued From page 2 (F 309) compliance on every shift daily by When Resident 1 was asked how she was doing, Resident 1 stated, "I need help, I'm constipated," directly observing all residents with while clutching her stomach. The Licensed changes in condition. The RN supervisor Vocational Nurse (LVN 1), who was outside the will maintain close communication with resident's room was made aware of the resident's the licensed nurses and CNAs with complaint. LVN 1 stated Resident 1 is always complaining she is constipated, and is currently regards to change of condition and do having a bowel movement. record review to ensure that residents are properly assessed when they Resident 1 had physician orders as follows: experience episodes of loose stools, that 1. Docusate Sodium (stool softener) Tablet 100 the physician's orders to hold laxative milligram (mg) by mouth two times a day for and stool softeners are followed, and bowel management. Give 100 mg/2 tablets. Hold that resident's physician are notified for loose stool. when he or she has changes in 2. Senna (Sennosides) tablet 8.6 mg. Give 17.2 condition. Findings will be addressed mg, by mouth at bedtime for bowel management. with staff involved for immediate Give 8.6 mg/2 tablets. Hold for loose stool. corrective action. The Certified Nursing Assistant (CNA) Point of Significant findings will be submitted to Care Flow sheet on bowel and bladder the administrator and will be forwarded elimination dated February 23, 2017 to 24, 2017. to the QA & A Committee for trending indicated Resident 1 had five successive analysis, corrective action and for CQI. loose/diarrhea stools. The date, time, and size of the loose stools were as follows: 5. Corrective action will be in placed on 1. February 23, 2017 at 10:23 p.m. (large loose or before 03/28/2017 03/28/2017 2. February 24, 2017 at 12:44 a.m. (medium loose stool). 3. February 24, 2017 at 5:04 a.m. (small loose 4. February 24, 2017 at 10:46 a.m. (medium loose stool).

10: 15: 37 a.m. 03-20-2017

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DEPARTMENT OF HEALTH AND HUMAN SERVICES								03/18/2017	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES						APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED		
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/E 3001	Continued From pa	ao 3	(E-2)	oos İ	•				
1. 0001	•	-	{F 3	09}					
	stool).	17 at 1:18 p.m. (small loose							
	aloui).		: 	•			•	! .	
	A review of the Med	lication Administration Record		ĺ					
	(MAR) for the mont	h of February 2017, indicated	: !					!	
į		ninistered Docusate Sodium	;	i					
i		a.m. and 5 p.m. and Senna	,	•					
	tablet 17. 2 mg at b	edtime on February 24, 2017.	•	;					
	presence of License February 27, 2017 indicated there was Resident 1's episod	rsing Progress Notes in the ed Vocational 2 (LVN 2) on at approximately 2:00 p.m., no documentation of less of loose stools nor did the							
		esident's physician was ent's change in condition.		!				: : :	
	review of Resident stated the physician and the laxative me	with LVN 2 at the time of the 1's clinical records, LVN 2 n should have been notified dications held (Docusate) due to Resident 1 having			· •				
	day at approximate nursing staff should documentation on I administering the n physician's order in hold the medication	rview with LVN 3 on the same ly 3:00 p.m., LVN 3 stated if have checked the CNA's powel and bladder before nedications because the dicated for licensed nurses to as (Docusate Sodium and ent was having loose stools.							
	procedure titled "Cl report to the MD/NI (Physician Assistan	lity's undated policy and nange in Condition: When to P (Nurse Practitioner)/PA at) indicated acute onset of odes of loose stools should be lety.							

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13/13 03-20-2017

It continuation sheet Page 5 of 5

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DEFICIENCY COMPLETION (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIETE GI XITƏRQ ƏAT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) () () () XI국글R역 DAT LANCASTER, CA 93534 WELLSPRINGS POST ACUTE CENTER teby. Te htel.on 24444 STREET ADDRESS, CITY, STATE, ZIP CODE MAME OF PROVIDER OR SUPPLIER 03/01/2017 B. WING 650930 **D-8** (X3) DATE SURVEY COMPLETED A BUILDING :ЯЗЕМПИ ИОПАСІНІТИВЕВ: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) МИГЛРЬЕ СОЙЗТВИСТЮИ (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/18/2017

Facility ID: CA920000048

Event ID: MU0412

FORM CMS-2567(02-99) Previous Versions Obsolete

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04-07-2017

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		AND HUMAN SERVICES			•			APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X2) MULTIPLE CONSTRUCTION				OMB NO. 0938-0391		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING				(X3) DATE SURVEY COMPLETED			
056039		B. WING				R-C 03/31/2017				
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE					
WELLSPRINGS POST ACUTE CENTER			44445 NO.15TH ST. WEST LANCASTER, CA 93534							
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{F 000}	INITIAL COMMENTS		{F 0	00}						
•	The following refle Department of Publi Abbreviated second			***************************************						
	Complaint Number: CA00506863		!	· ;				*		
	Representing the D	epartment of Public Health:								
	Surveyor Federal I.	D. Number: 36500, RN, HFEN			:					
	complaint investiga	limited to the specific ted and does not represent inspection of the facility.			•		•			
	No deficiencies wer	e issued.								
			:	:	· ·		1			

LABORATORY DIRECTOR'S ORPROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

Administration

(X8) DATE 'ーガフー/フ

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.