

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2013
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NAME OF PROVIDER OR SUPPLIER KNOLLS WEST CONVALESCENT HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 16890 GREEN TREE BLVD VICTORVILLE, CA 92395
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(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
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F 000 INITIAL COMMENTS

F 000

The following reflects the findings of the California Department of Public Health during an abbreviated survey to investigate a complaint.

Complaint number: CA00346484

Representing the California Department of Public Health:
26774

The investigation was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.

One deficiency were issued for complaint number: CA00346484

Acronyms

COC- change of condition
DON- director of nursing
LVN- licensed vocational nurse
P&P- policies and procedures
PMD- primary medical doctor

F 514 483.75(1)(1) RES
SS=D RECORDS-COMplete/ACCURATE/ACCESSIBLE

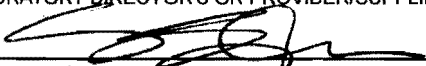
F 514

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

13 JUN -3 AM 10:06
LIC 6088
-AN DEFENDING COURT

RF
6/3/13

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 05/23/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's 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: 05/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2013
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F 514 Continued From page 1
resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to document an assessment of Resident status prior to notifying the physician as per their facility policy and procedures (P&P). This had the potential to result in the physician having inadequate information on which to base orders.

Findings

During an unannounced visit to the facility to investigate a complaint regarding the care provided to Resident on 03/27/13, a tour of the building was taken with the administrator. It was observed that Resident was no longer at the facility.

During a review of the clinical record for Resident, it reflected that was an admitted to the facility from out of state on 03/27/13, with diagnoses to include (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) 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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2013
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NAME OF PROVIDER OR SUPPLIER KNOLLS WEST CONVALESCENT HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 16890 GREEN TREE BLVD VICTORVILLE, CA 92395
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(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
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F 514 Continued From page 2

a¹ indicated "Call out (C/O) to MD re:
(regarding) (new order) "

Resident is awake up in
doctor's appointment. No signs and symptoms
of ac. s. No complaint of " "
a second entry was made by the
same nurse that indicated " [Name of , made
aware o " n."

During a review of the clinical record for Resident
A with the DON at 3,
was asked to show where there had been
any documentation of Resident. 1,
and where any assessment had been charted of
the resident's

prior to
notification of the e was unable to locate
any documentation.

During an interview with the DON at
stated, . The
is the one who told the nurse . The
The nurses didn't notice any .
or . was . The
nurse [used LVN 1's name] got an order for a
and should have
written assessment.

During a review of the facility P&P titled, "Acute
Condition Changes" , indicated
under "Assessment and Recognition" , "Before
contacting the physician about someone with an
acute change of condition, the nursing staff will
make pertinent observations and collect

D.

F 514

1. DNS will monitor medical records
audits for compliance and timely
completion every day (M-F). Effective
04/01/13. Continued in-servicing will
be based on audit reviews by DNS or
medical records consultant as
needed. Effective 04/01/2013. 04.01.13

2. Administrator will review second
and third request audits to assure
medical records, DNS and nurses are
complying with above system
changes. Effective 04/01/13. 04.01.13

3. Effectiveness of system in place
will be incorporated into the Quality
Assurance meeting 04/09/2013 with
further review as needed based on
compliance and completion.

E. Corrective action completion date 04.09.13
effective 04/09/2013.

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NAME OF PROVIDER OR SUPPLIER KNOLLS WEST CONVALESCENT HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 16890 GREEN TREE BLVD VICTORVILLE, CA 92395
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F 514 Continued From page 3 F 514

appropriate information to report to the Physician..."

During an interview with the DON at " " 1, was asked why the " " would order " " medication and ar " of Resident ") if there was no evidence of a or other signs of " " and without an assessment of Resident: " " said " " would discuss it with the staff who called and spoke to the physician.

During review of the facility's policy with the DON titled, "Charting and Documentation", undated, the purpose for documentation is listed as "Guidance to the physician in prescribing appropriate medications and treatments." confirmed that LVN 1 should have documented " " conversation with the " " as " " described " " and written an assessment of what s " " had observed.