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 06/14/2023

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 California Department of Public Health during the investigation of three complaints. Complaint Number: CA00845228, CA00843430, and CA00844790 Representing the Department: Health Facilities Evaluator Nurse: 45958 Health Facilities Evaluator Nurse: 46445 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for complaint number: CA00843430 (F609).	F 000	F 000 INITIAL COMMENTS **This Plan of Correction (POC) serves as our Credible Allegations of Compliance. The Facility will be in substantial compliance on or before 06/23/23.This plan of Correction does not admit guilt to any of the alleged violations nor does this interfere with the right to contest or appeal the alleged violations.** **CA00843430** **F 609- Reporting of Alleged Violations**	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609	***How corrective action(s) will be accomplished for those residents Found to be affected by the deficient practice;** ➢ Resident 2 is no longer a resident in the facility. ➢ Upon notification of the allegation on 06-07-23, Resident 2 was interviewed by the ADON, RN Incident Coordinator and SSD regarding the allegation. ➢ Preliminary findings were reported to the Abuse Coordinator for mandated reporting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stan Dall, RN, DON — TITLE — (X6) DATE: 6/27/23

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.

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 06/14/2023

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 609	Continued From page 1 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report the allegation of staff to resident abuse to the State Survey Agency (SSA) for one of nine sampled residents (Resident 2). This deficient practice had the potential to result in unidentified abuse and failure to protect other residents from abuse. Findings: A review of Resident 2 ' s Admission Record indicated the facility admitted the resident on 5/15/2023 with diagnoses including peritoneal adhesions (an irritation of a membrane that lines the inside of the abdomen and pelvis by infection or surgical trauma), type two diabetes mellitus (a disease that occurs when the blood sugar levels were too high), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread , and uneasiness). A review of Resident 2 ' s Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 5/21/2023, indicated the resident was cognitively (conscious mental	F 609	➢ Resident's roommate and caregivers were interviewed, obtained statements regarding the allegation. (1.1) sitter was interviewed by ADON/RN found the sitter was not the alleged staff as claimed by resident 2. ➢ Resident 2 agreed and was willing to be care for by the same 1.1 sitter assigned on 7-3 shift 06/07/23. ➢ Skin Assessment was conducted by Wound Coordinator, revealed no Evidence of any recent skin trauma. ➢ Nursing/SSD provided psychosocial reassurance to resident in regard to her sense of security and safety in the facility as well as to her emotional & psychosocial wellbeing. ➢ Both Attending Physician and the responsible party were informed that initial investigation was conducted regarding the resident allegation. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	

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 06/14/2023

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 609	Continued From page 2 activities including thinking, reasoning, understanding, learning, and remembering) intact. The MDS indicated Resident 2 did not have behavior symptoms. Resident 2 required extensive assistance (resident involved in activity and staff provide weight bearing support) on bed mobility. A review of Resident 2 ' s Situation, Background, Assessment, and Recommendation (SBAR) Communication Form and Progress Note, dated 6/7/2023, indicated that CNA 2 allegedly pushed the resident on the wall. Resident 2 ' s family was notified on 6/7/2023 at 9:52 a.m. and the primary care clinician was notified on 6/7/2023 at 10 a.m. On 6/14/2023 at 6:15 a.m. and 7:55 a.m., attempted to contact CNA 2 but she did not answer and did not return the call. On 6/14/2023 at 6:48 a.m., during an interview, LVN 4 stated that on 6/7/2023 at 3:30 a.m., the family member called the facility and stated he received a text message from the resident indicating CNA 2 hit the resident. LVN 4 went to check on Resident 2 while the family member was on the phone and found the resident sitting in bed and holding the cellphone. LVN 4 stated that CNA 2 was sitting on a chair, close to bed B ' s foot part of the bed, facing Resident 2 with a safety mattress in between the resident and the CNA. LVN 4 stated she reported the incident to RN 4. On 6/14/2023 at 12:24 p.m., during an interview, the Administrator (ADM) stated he is the facility ' s abuse coordinator. The ADM stated that the allegation of abuse happened on 6/7/2023 at 3:30 a.m. and he was informed immediately, and an	F 609	**what corrective action will be in place.** ➢ All Residents have the potential to be affected by the same deficient practice. ➢ On 06/19/23, The Director of Staff Development Started an In-Service with the Goal that All Staff received retraining regarding different type of Abuse with Emphasis on timely reporting, Completed by 06/23/23. • **What measures will be put into place or what systemic changes the Facility will make to ensure that the deficient practice does not recur.** ➢ Any Identified reported type of Abuse must report right away to the Abuse coordinator for timely reporting with the Department, Local Law Enforcer, And to the Office of the Ombudsman according to the Facility's Abuse protocol and procedure. • **How the facility plans to monitor its performance to make sure that solutions are sustained.**	

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 06/14/2023

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 609	Continued From page 3 investigation was initiated. The ADM stated that he did not report the incident to SSA because Resident 2 ' s statements were constantly changing and later retracted the allegation. The ADM stated he was aware allegations of abuse must be reported within two hours to the SSA, Ombudsman, and to the law enforcement. A review of the facility ' s policy and procedure titled, "Elder Justice Act," revised on 7/28/2023, indicated the ADM, Director of Nursing (DON), or any other designated individual will report within the required time frames, any reasonable suspicion of a crime against a resident to the SSA and local law enforcement agency. The policy also indicated the timing of reporting if the event involves abuse or results in serious bodily injury, the suspicion will be reported immediately but no later than 2 hours after forming the suspicion.	F 609	**This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the Quality Assurance System.** ➢ The Abuse coordinator/and or his Designee will monitor daily for any type of reported of suspected allegation of abuse is investigated and as needed report timely to the Department and other Agency within (2) hours according to the Facility's Abuse Policy and Procedure. ➢ Any Findings will be corrected immediately and reported to the Abuse Coordinator and or Designee. ➢ The administrator will review monthly with the QA committee and as needed (3) months for analysis and recommendations. • Completion Date: 06/23/23	