

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  The Springs Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  10625 Leffingwell Road Norwalk, CA 90650	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45269</p> <p>Based on observation, interview, and record review the facility failed to report an injury of unknown origin (the cause of injury was not observed by any person or could not be explained by the resident) to California Department of Public Health (CDPH) for one of three sampled residents (Resident1) when Resident 1 had swelling on the right knee on with a right femur fracture (break in the thigh bone) on 5/29/2024.</p> <p>This failure had the potential to result into a delayed investigation to rule out abuse and neglect.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage( irreversible damage to the brain caused by lack of oxygen) cardiac arrest ( abrupt loss of heart function), tracheostomy(opening surgically created in the neck into the windpipe to allow air to fill the lungs) and gastrostomy tube ( G-tube inserted through the wall of the abdomen into the stomach used to give medicines and liquid nutrition).</p> <p>During a review of Resident 1's History and Physical (H&amp;P) dated 6/8/2024, the H&amp;P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool) dated 6/14/2024, the MDS indicated the Resident 1 was dependent on staff with bathing, toileting hygiene, dressing, personal hygiene, bed mobility, and transfer to and from a bed to chair.</p> <p>During a review of Resident 1's Situation, Background, Assessment, and Recommendation ([SBAR] used as a communication tool to share information about a patient condition that needs to be addressed) dated 5/29/2024 timed at 10:50 a.m., the SBAR indicated Resident 1 had right knee swelling and the physician ordered right knee and femur x-ray.</p> <p>During a review of Resident 1's SBAR Documentation dated 5/30/2024, timed at 3:50 p.m., the SBAR indicated x-ray results (displaced at the distal femoral diaphysis (break at the thigh bone just above the knee) related to the knee swelling was relayed to the physician.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's right knee x-ray performed on 5/29/2024 at 7:54 p.m., the result indicated the resident had a displaced at the distal femoral diaphysis.</p> <p>During an interview on 7/31/2024, at 10:04 a.m. with Certified Nursing Assistant (CNA1), CNA1 stated Resident 1 required two people assist when providing care because of the right leg fracture. CNA1 stated Resident 1 used to require one person assist when providing care like repositioning and incontinence (inability to control flow of urine from the bladder and escape of stool from the rectum) care.</p> <p>During an interview on 7/31/2024, at 10:39 a.m. with Treatment Nurse (TN 1), TN 1 stated Resident 1 had no incidence of fall. TN 1 stated a physician order for right knee and right femur x-ray was done on 5/19/2024 due to an observed swelling of the right knee during resident care on 5/29/2024.</p> <p>During a concurrent observation and interview on 7/31 /2024, at 9:41 a.m., with Registered Nurse Supervisor (RNS 1) TN1 and Licensed Vocational Nurses (LVN 1), observed Resident 1 in bed, unable to follow commands and nonverbal (unable to speak). Resident 1 had a knee immobilizer on the right leg. Right knee and thigh were observed more swollen than the left thigh and knee when the knee immobilizer was removed by TN1 and LVN 1. RNS 1 stated Resident 1 had more swelling on the right knee. RNS 1 stated Resident 1 had right femur fracture based on the x-ray result.</p> <p>During an interview on 7/31/2024, at 2:03 p.m. with RNS 1, RNS 1 stated Resident 1 had no incident of fall. RNS 1 stated she instructed the Certified Nursing Assistants to team up when providing care to Resident 1. RNS 1 stated Resident 1 only get out of bed during shower with two people assist for transfer. RNS 1 stated they did not know how Resident 1 sustained right femur fracture and it an injury of unknown origin was. RNS 1 stated it should have been reported to CDPH to rule out possibilities of abuse or neglect.</p> <p>During an interview on 7/31/2024, at 4:27 p.m. with Assistant Director of Nursing (ADON), ADON stated Resident 1 did not have a fall in the facility. ADON stated Resident 1's femur fracture was an unusual occurrence because the facility did not know the cause of the fracture. ADON stated Resident 1's femur fracture was considered an unusual occurrence because resident suddenly had a swollen knee and fracture on the femur. ADON agreed it should have been reported to CDPH because of the possibility of abuse or neglect and needed to be investigated.</p> <p>During a concurrent interview and record review on 7/31/2024, at 10:57 a.m. with the Director of Nursing (DON), the DON stated he did not report Resident 1's injury to CDPH because he never thought Resident 1's femur fracture was trauma. Reviewed facility's policy and procedure for Unusual Occurrence, the DON agreed the Resident 1's injury should be reported to CDPH within 24 hours because it was an unusual occurrence for compliance to state and federal regulations and for investigation of possible abuse or neglect.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 9/2022, the P&amp;P indicated all reports of resident abuse including injuries of unknown origin are reported to local, state, and federal agencies and thoroughly investigated by facility management. The P&amp;P indicated findings of all investigations are documented and reported and resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion should be reported immediately to the administrator and to other officials according to state law.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility's P&amp;P titled Unusual Occurrence Reporting dated 12/2022, the P&amp;P indicated facility will report unusual occurrences or other reportable events which will affect the health, safety, or welfare of residents, employees, or visitors. The P&amp;P indicated the facility will report events like allegations of abuse, neglect and misappropriation of resident property and other occurrences that interfere and affect the welfare, safety, or health of the residents. The P&amp;P indicated Unusual Occurrences should be reported to appropriate agencies as required by current law and regulations within 24 hours of such incident or as required by federal and state regulations.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269</b></p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was prescribed with Percocet (medication used to help relieve moderate to severe pain that contains combination of acetaminophen and oxycodone) were reassessed and monitored for its continued used.</p> <p>This failure had the potential for Resident 1 to receive unnecessary medication and at risk for adverse drug effects (unwanted undesirable effects that are possibly related to a drug) of Percocet.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage( irreversible damage to the brain caused by lack of oxygen) cardiac arrest ( abrupt loss of heart function), tracheostomy(opening surgically created in the neck into the windpipe to allow air to fill the lungs) and gastrostomy tube ( G-tube inserted through the wall of the abdomen into the stomach used to give medicines and liquid nutrition).</p> <p>During a review of Resident 1's History and Physical (H&amp;P) dated 6/8/2024, the H&amp;P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool) dated 6/14/2024, the MDS indicated the Resident 1 was dependent on staff with bathing, toileting hygiene, dressing, personal hygiene, bed mobility, and transfer to and from a bed to chair.</p> <p>During a review of Resident 1's Physician Order Summary Report, dated 6/7/2024, the Physician Order Summary Report indicated to monitor pain level during and after treatment daily by using the non-verbal scale:</p> <p>A.no signs of pain, relaxed, calm expression,</p> <p>B. Least pain stressed, tense expressions,</p> <p>C. Mild pain -guarded movement, grimacing,</p> <p>D. Moderate pain moaning and restlessness,</p> <p>E. Excruciating pain increased intensity of above behavior, perspiration on upper lip and body.</p> <p>During a review of Resident 1's Physician Order Summary Report dated 6/7/2024, indicated to assess pain level every shift (pain scale rating from zero to ten (pain screening tool using numerical value to assess the level of pain ranging from 0 no pain, 1 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 10-severe pain).</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Physician Order Summary Report dated 6/15/2024 with a start date of 6/16/2024 indicated a physician order of Percocet tablet 5-325 milligrams (mgs unit of measurement) give one tablet via G-tube every 6 hours for pain management.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) dated June and July 2024, the MAR indicated Resident 1 had been receiving Percocet every six hours since 6/16/2024 up to 7/31/2024. The MAR indicated Resident 1 received the Percocet even the pain level assessment was zero (indicating resident was not in pain) on the following dates and times for the month of June and July 2024.</p> <ol style="list-style-type: none"> <li>1. On 6/16/2024, at 12:00 a.m., 6/16/2024, at 6:00 a.m.</li> <li>2. On 6/17/2024, at 12:00 a.m., at 6:00 a.m., at 12:00 p.m., and at 6:00 p.m.</li> <li>3. On 6/18/2024, at 12:00 a.m., 6/18/2024 6:00 a.m., at 12:00 p.m. and 6:00 p.m.</li> <li>4. On 6/19/2024, at 12:00 a.m., 6:00 p.m.</li> <li>5. On 6/20/2024, at 6:00 a.m., 12:00 p.m.</li> <li>6. On 6/21/2024, at 6:00 a.m., 12:00 p.m., at 6:00 p.m.</li> <li>7. On 6/22/2024, at 12:00 a.m., at 6:00 a.m., and at 12:00 p.m.</li> <li>8. On 6/23/2024, 12:00 a.m., at 6:00 a.m., at 12:00 p.m. and 6:00 p.m.</li> <li>9. On 6/24/2024, at 12:00 a.m., at 6:00 .am, at 12:00 p.m., and at 6:00 p.m.</li> <li>10. On 6/25/2024, at 12:00 a.m., 6:00 a.m., at 12:00 p.m. and at 6:00 p.m.</li> <li>11. On 6/26/2024, at 6:00 pm.</li> <li>12. On 6/27/2024, at 12:00 p.m. and 6:00 p.m.</li> <li>13. On 6/28/2024, 12:00 a.m., at 12:00 p.m. and at 6:00 p.m.</li> <li>14. On 6/29/2024, at 12:00 a.m., at 6:00 a.m. and at 12:00 p.m.</li> <li>15. On 7/1/2024, 12:00 p.m.,</li> <li>16. On 7/3/2024, at 12:00 p.m. and at 6:00 p.m.</li> <li>17. On 7/4/2024, at 12:00 a.m. and at 6:00 p.m., 7/5/2024, at 6:00 p.m., 18. On 7/6/2024, at 12:00 p.m., 7/7/2024, at 6:00 a.m., at 6:00 p.m.,</li> <li>19. On 7/10/2024, at 12:00 p.m. 7/10/2024 at 12:00 p.m.,</li> <li>20. On 7/13/2024 at 6:00 p.m. ,7/14/2024, at 12:00 p.m., 7/15/2024, at 12:00 p.m.,</li> </ol> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 7/31/2024, at 4:27 p.m. with Assistant Director of Nursing (ADON), reviewed of Resident 1's MAR. ADON stated the licensed nurses continue to administer Percocet to Resident 1 because it was a regularly scheduled medicine. ADON confirmed per record review Resident 1 was on Percocet one tablet every 6 hours for pain management related to right femur fracture and the licensed nurses were still administering the medicine despite pain level assessment of zero (no pain) prior to administration. ADON stated the medication nurse should have called the physician to change the order or either changed the frequency or switch to a milder pain medicine. ADON stated no medication regimen review (MRR, thorough evaluation of medication regimen of a resident by a pharmacist to promote positive outcome and minimize adverse consequences associated with the medication) was done for Percocet by the pharmacist. ADON stated she had told the licensed nurses to call the physician to change the order of Percocet by changing the frequency to every 12 hours or change Percocet order to a milder pain medicine because there are times the resident was not exhibiting pain. ADON stated Resident 1's use of Percocet since 6/16/2024 could place him at risk for adverse side effects like respiratory depression and constipation.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled Preventing and Detecting Adverse Consequences and medication Errors revised January/2018, the P&amp;P indicated the facility's Interdisciplinary team reviews the resident 's medication regimen for efficacy, actual, and potential medication related problems on ongoing basis in accordance with the policy on medication management.</p> <p>During a review of facility's P&amp;P titled Pain Assessment and Management revised October 2022, the P&amp;P indicated when opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. The P&amp;P indicated ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medication.</p>		