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 09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 The following reflects the findings of the Department of Public Health during an Abbreviated Survey. Complaint No. CA00488639- Substantiated-F274 Representing the Department of Public Health: Surveyor ID No. 35671- RN. HFEN This inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.	F 000	2016 NOV 10 PM 4:30 LOS ANGELES COUNTY HEALTH FACILITIES DIVISION	
F 274 SS=D	Highest S/S = D 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 274	F274 1. Resident #1 is no longer in the facility 2. All residents with a diagnosis of subdural hematoma can be affected by the same alleged deficient practice. On 11/09/16 DON, RN supervisor performed a record review and assessment of all residents with diagnosis of subdural hematoma (bleeding in the brain and is considered as high risk for stroke) for signs and symptoms of neurological impairments that deferred from established baseline comparison for those residents. No similar findings were noted. 3. On 11/10/16 facility updated policy and procedure assessing and reporting change of condition which now include assessment of neurological status for resident's with diagnosis of Subdural Hematoma (bleeding in the brain and is considered as high risk for stroke). All residents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leonard Dayao	QA/AIT	11/10/16

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.

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F 274	Continued From page 1 Based on interview and record review the facility failed to ensure that a resident was assessed and monitored for signs and symptoms of a stroke (bleeding in the brain) for one out of one sample resident (1). Resident 1 experienced an increase in generalized weakness, slurred speech and facial drooping and had to be transferred to a general acute care facility (GACH) for further evaluation. Findings: On May 18, 2016, the Department received a complaint (CA 00488639) that alleged, on May 9, 2016, May 10, 2016, and May 11, 2016, Family Member (FM) 1 informed nursing staff that Resident 1 was not doing well, but nothing was done to assess the resident for a stroke. Investigation of the complaint was initiated on June 02, 2016. A review of the GACH discharge summary dated May 4, 2015, indicated Resident 1 was admitted on May 1, 2014 following a fall at home resulting in right periorbital bruising, a subdural hematoma (blood clot in the brain) and was considered high risk for a stroke. A review of the admission record, indicated Resident 1 was originally admitted to the skilled nursing facility (SNF) on May 5, 2016, with diagnoses that included, non-traumatic subdural hemorrhage (bleeding in the brain), history of falling, hypertension (high blood pressure) and atrial fibrillation (irregular heartbeat). A review of the Minimum Data Set [MDS- a comprehensive assessment and screening tool]	F 274	identified upon admission with diagnosis of Subdural Hematoma (bleeding in the brain and is considered as high risk for stroke) will be monitored for signs and symptoms of acute neurological fluctuations every shift x 1 month then reevaluate. Licensed nurses were in serviced by the DON on November 10, 2016 regarding observation and assessment of signs and symptoms of neurological fluctuations of patient with diagnosis of Subdural Hematoma (bleeding in the brain and is considered as high risk for stroke). This in serviced included training on establishing individualized care plans that are patient specific problems and goal related to Subdural Hematoma (bleeding in the brain and was considered as high risk for stroke). This will be done quarterly X 1 year and annually thereafter. 4. The plan of correction will be implemented by the licensed nurses every shift in addressing the care of residents with diagnosis of Subdural Hematoma (bleeding in the brain and is considered as high risk for stroke). The effectiveness of the plan of correction will be evaluated by the DON, and RN supervisors by record review of documentation and care plans specific to diagnosis of Subdural Hematoma (bleeding in the brain and is considered as high risk for stroke). The clinical nursing consultant will also monitor compliance by performing a clinical record review during their scheduled monthly visits. Any significant findings shall be submitted to the QA & A committee for trending and root cause analysis, recommendation, corrective action and for CQI. 5. Corrective action will be in place on or before 11/11/2016.	11/11/16

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F 274	Continued From page 2 dated May 12, 2016; indicated Resident 1's cognitive status was moderately impaired. A review of physician order's dated May 5, 2016, did not indicated for resident to be monitored for signs and symptoms of a stroke. A review of Resident 1's care plans dated May 5, 2016, on admission do not indicate a care plan was initiated for risk for stroke. A review of care plan care plan titled, At risk for respiratory/cardiac complications related to diagnosis of cardiopulmonary obstructive disease [COPD- difficulty in breathing], initiated on May 8, 2016, did not include any intervention approaches related to neurological assessments to assess for signs and symptoms of a stroke. During an phone interview on May 24, 2016, at 2:09 p.m., Family Member 1 stated on May 9, 2016, he had informed a registered nurse (RN) supervisor and licensed vocational nurse (LVN) that Resident 1's speech had worsened, she was more fatigued, and was not able to walk farther than 150 steps. On May 10, 2016, FM 1 asked the LVN 1 (charge nurse) if Resident 1 needed tests due to refusal to eat and speech was worsening. According to FM 1, on May 11, 2016, during a physical therapy (PT) Resident 1 could not go more than 15 steps and speech had worsened. Resident 1 was speaking quietly and was more slurred. FM 1 informed the LVN 1 (charge nurse) that something was wrong. FM 1 requested labs and transfer to GACH for further evaluation. FM 1 stated GACH diagnosed Resident 1 with a stroke and dehydration. On June 2, 2016, during an interview at 10:50	F 274		

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a.m., the social services assistant (SSA) stated Resident 1 was able to answer the Brief Interview for Mental Status [BIMS - cognitive assessment] questions. The SSD further stated Resident 1 seemed confused at times. She was not oriented to month or day and could not express why she was in the facility.

On June 2, 2016 during an interview at 1l: 00 a.m., LVN 2 stated on May 12, 2016, Resident 1's FM 1 insisted that she should be transferred to the hospital because she was not doing better. LVN 2 stated physical therapy (PT) had worked with Resident 1 on May 12, 2016 and appeared weak. LVN 2 stated Resident 1 was verbal and did not appear in distress. She stated she recalls vital signs were stable. LVN 2 contacted the physician to relay FM 1's request to transfer Resident 1 to the GACH and phone order was obtained for transfer for further evaluation. LVN 2 stated Resident 1 was able to follow directions, had no loss of consciousness, during neurological assessment she was able to lift arms but was having trouble keeping arms up. She further stated no facial changes were noted upon assessment for Resident 1.

On June 2, 2016, at 12:00 p.m., during an interview the physician (MD) stated Resident 1 had no neurological signs and symptoms of stroke from her baseline. The SNF staff had informed him of the FM 1's request to transfer Resident 1. The MD further stated that Resident 1 had not complained of chest pain and she had altered mental status previous to admission to the SNF. He also stated a magnetic resonance imaging [MRI-pain-free non-invasive medical test used to produce two dimensional images of the structures of the body] indicated left anterior

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F 274	Continued From page 4 thalmic subacute infarct. The MD stated there were no changes to the treatment plan and Resident 1 became more functional and alert by her transfer date on May 18, 2016 to different SNF. A review of a GACH consultation report dated May 14, 2016, indicated the resident has a slight droopiness on the right side but difficult to assess as well as sluggish pupils. Additionally, Resident 1 was noted to have mild weakness in the right upper extremity Grade 4 (full range of motion with decreased strength) is weak on both sides and reflexes are absent. A review of the GACH CT-Brain without contrast [computed tomography of the brain- detailed x-rays), dated May 12, 2016, indicated a subacute lacunar infarct (stroke). A review of the "Situation, Background, Assessment and Recommendation" (SBAR-communication tool for medical staff) and progress note dated May 12, 2016, indicated Resident 1's change of condition was increased weakness that started on May 12, 2016, with decreased mobility weakness or hemiparesis. Physician was called and made aware of resident having poor appetite and increased weakness. Physician ordered transfer to GACH for further evaluation. A review of nursing assessments dated: May 09, 2016; May 10, 2016, May 11, 2016, and May 12, 2016, did not indicate a thorough neurological assessment were done.	F 274		