STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555739	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS AT PACIFIC REGENT	3884 NOBEL DRIVE SAN DIEGO, CA 92122

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Facility Reported Incident Number: CA00819021 Category: Quality of Care Representing the Department: Health Facilities Evaluator Nurse 39220 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were identified. (See F-604 and F-686).	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604	**F 604 Right to be free from Physical Restraints CFR (s): 483.10 (e)(1), 483.12 (a)(2)** ***Corrective action for residents found to have been affected by this deficiency:*** **Resident #1 is no longer at this facility** ***Corrective action for residents that may be affected by this deficiency:*** **Any patient currently in facility has been reviewed for any bed/chair alarms possibly in use on 2/7/2023. These resident's records were audited for MD order, Care plan, Assessment, and consent for the alarm in place. Any areas identified as insufficient were immediately corrected. No negative resident outcomes identified.** **Intradisciplinary Team (IDT) conducted a review of each patient with an alarm to determine removal/reduction if necessary during the audit.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/8/23

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.

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F 604	Continued From page 1 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from physical restraints, when a bed tab alarm (a devise that alerts staff when pressure is removed from the bed) was utilized without a physician ' s order or a written consent for one of three residents (Resident 1), reviewed for Quality of Care. As a result, there was the potential for Resident 1 to be confined to his bed and to not able to freely move about the facility. Findings: Resident 1 was admitted to the facility on 12/16/22, with diagnoses which included orthopedic aftercare following a repair from a left femur fracture (hip fracture) which occurred after a fall, per the facility ' s Admission Record. Resident 1 was listed on the Admission Record as his own responsible party (able to make his own medical and financial decisions). On 1/9/23, Resident 1 ' s clinical record was reviewed.	F 604	**Measures that will be put into place to ensure that this deficiency does not recur:** **Restraint policy/procedure reviewed by Administrator and Director of Nursing Services (DNS) on 1/10/2023.** **IDT and licensed nurses educated by DON beginning on 2/7/2023 with 100% compliance expected by 3/7/2023.** **DON/Designee will review medical record to ensure that all appropriate documentation (care plan, order, assessment, consent) is in place for any alarms placed as a fall intervention.** **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** **Alarms will be audited by DON/Designee twice weekly for 2 months beginning 2/7/23.** **All audits to be submitted through monthly QAPI for 2 months.**	3/7/23

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F 604	Continued From page 2 According to the Progress Note, dated 12/17/22 at 12:42 P.M., Resident 1 had a fall on 12/16/22 at 11:50 P.M., and the family voiced concern regarding resident ' s safety. LN 4 documented a bed tab alarm was placed, as well as a landing pad, with the bed being in the lowest position. There was no documented evidence the physician ordered a bed tab alarm or was notified a bed alarm was placed. There was no documented evidence a consent for a bed alarm had been signed by the resident or a family member. There was no documentation a care plan had been developed for the bed tab alarm ' s use. The Fall Committee Interdisciplinary Team meeting notes were reviewed, dated 12/21/22 at 9:54 A.M. The meeting notes made no mention of a bed alarm, and listed interventions of bed in lowest position, continue with neurological checks, and physical therapy to continue services for transferring and strengthening. According to the certified nurse assistant documentation under "TASK" a bed tab alarm was documented of being used and checked from 12/17/22 at 6:15 A.M., through 12/28/22 at 12:19 P.M. Per the 5-Day Minimum Data Set, (a clinical assessment tool), dated 12/25/22, Resident 1 had a cognitive assessment score of 4, indicating severely impaired cognition. The Restraints and Alarm Section "P" listed no restraints or alarms being used. On 1/9/23 at 11:29 A.M., an interview was	F 604		

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F 604	Continued From page 3 conducted with Licensed Nurse 2 (LN 2). LN 2 stated if a bed or chair alarms was requested, the LNs needed to ensure a physician ' s order, signed consent, and care plan was in place before the alarm could be implemented. LN 2 stated if these requirements were not in place prior to use, the alarm could be considered a restraint. On 1/9/23 at 11:34 A.M., an interview was conducted with LN 3. LN 3 stated before using a bed alarm, the LN was responsible to ensure a physician ' s order was obtained, consent from the family was received, and a care plan had been established. On 1/9/23 at 11:40 A.M. an interview and record review was conducted with the Director of Nursing (DON) of Resident 1 ' s clinical record. The DON was unaware Resident 1 had a bed alarm while at the facility. The DON reviewed the clinical record and stated a physician ' s order was not present for a bed alarm, so an alarm should not have had one placed. The DON stated he was unaware if the physician had been notified or a written consent should have been signed, before the alarm was implemented. The DON provided a policy for Care and Treatment of Restraints, Physical, undated, however, the policy did not give direction to staff of the legal requirements needed prior to the placement of a bed tab alarm.	F 604		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		

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F 686	Continued From page 4 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prevent a facility acquired pressure ulcer for one of three residents (Resident 1) reviewed for Quality of Care. As a result, Resident 1 developed an unstageable pressure ulcer (full-thickness ulcer with a wound base that is covered with necrotic tissue) which delayed the resident ' s recovery. Findings: Resident 1 was admitted to the facility on 12/16/22, with diagnoses which included orthopedic aftercare following repair of left femur fracture (hip fracture), per the facility ' s Admission Record. On 1/9/23, Resident 1 ' s clinical record was reviewed: According to the Admission Assessment, dated 12/16/22, Section 12. titled Skin Integrity: The resident had closed surgical incision on the left thigh and bruising in the left forearm. No other	F 686	**F 686 Treatment/Services to Prevent/Heal Pressure Ulcer CFR (s): 483.25 (b)(1)(i)(ii)** ***Corrective action for residents found to have been affected by this deficiency:*** **Resident #1 is no longer at this facility** ***Corrective action for residents that may be affected by this deficiency:*** **On 1/11/2023 the facility Director of Nursing (DON), Assistant Director of Nursing (ADON), Director of Staff Development (DSD), and QA nurse performed a skin sweep of all residents. No other residents were found to be affected.** **Measures that will be put into place to ensure that this deficiency does not recur:** **Wound care policy/procedure reviewed by DON.** **Licensed nurse and CNA education began by DON/DSD/QA/ADON on 1/12/2023 that all residents will have skin assessments performed on admission followed by a follow up skin assessment to be performed weekly by Treatment Nurse, licensed nurse and CNA (during brief changes, bed baths, showers, and clothing changes). All residents will be assessed by Nursing staff weekly for changes in skin integrity. Findings will be documented in the resident's clinical chart, physician notification will be made and appropriate interventions initiated as ordered. Licensed nurse and CNA education will continue until 100% compliance has been achieved by 3/7/2023.**	3/7/23

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F 686	Continued From page 5 skin issues were identified. According to the care plan, titled Potential for pressure ulcer development, dated 12/16/22, listed interventions of daily body checks, and frequent repositioning. Per the 5-Day Minimum Data Set, (a clinical assessment tool), dated 12/25/22, Resident 1 had a cognitive assessment score of 4, indicating severely impaired cognition. The Bowel and Bladder assessment was listed as always incontinent, and the skin assessment listed the resident "At risk for pressure ulcers." According to the shower sheets, Resident 1 had not received a shower or bed bath from 12/20/22 through 12/26/22. There was documentation that Resident 1 refused a bed bath on 12/27/22. According to the Progress Notes, dated 12/28/22 at 6 A.M., Licensed Nurse 1 (LN 1) documented a pressure related injury noted to the coccyx (bottom of the spine) area, approximately 2 inches long and 0.5 inches in width. The physician Progress Note, dated 12/28/22 at 8:29 A.M., documented an unstageable pressure injury, measuring 2.0 centimeters (cm) x 2.5 cm x 1.5 cm. Wound dressings were orders along with a low air loss mattress, a chair cushion, frequent repositioning, and vitamin supplements. According to the progress notes, dated 12/28/23, Resident 1 was admitted to the hospital for abnormal laboratory results. On 1/9/23 at 11:29 A.M., an interview was conducted with LN 2. LN 2 stated residents	F 686	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** **DON along with ADON, DSD, QA Nurse will oversee adherence to policy and procedure for wounds and treatment by auditing weekly notes, and skin assessments as recorded during rounds conducted by the treatment nurse and/or Licensed Nurses. Nurses will conduct weekly skin rounds and document the findings in all patient's clinical records, with physician notification as necessary for a period of 3 months. Trends will be reported at the Quarterly** **Quality Assurance meeting for 6 months (Until June 2023 QQA).**	

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F 686	Continued From page 6	F 686		

should receive showers a minimum of twice times a week. LN 2 stated she expected the certified nurse assistants (CNAs) to inspect the skin during those showers to identify any new skin issues. LN 2 stated maintaining skin integrity was important, so new issues such as infections or potential pressure could be identified early.

On 1/9/23 at 11:34 A.M., an interview was conducted with LN 3. LN 3 stated residents should receive regular showers to maintain dignity and ensure skin was cleaned and intact at least two times a week. LN 3 stated inorder to prevent skin issues, residents needed to be turned often. LN 3 stated pressure ulcers were preventable with consistent interventions.

On 1/9/23 at 11:40 A.M., an interview and record review was conducted with the Director of Nursing (DON) regarding Resident 1 ' s clinical record. The DON reviewed Resident 1 ' s shower sheet for the month of December 2022. The DON stated he expected staff to offer residents a shower at least twice a week and to document if it was done or refused. The DON stated shower sheet were important, so skin issues could be identified early. The DON stated his expectation was residents should be re-positioned every two hours and pressure injuries should not occur.

According to the facility ' s policy, titled Quality of Care, Skin Management System, undated, " ...the policy of this facility that any resident who enters the facility without a pressure ulcer will have appropriate preventive measures taken to ensure that a resident does not develop pressure ulcers ..."