STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR GLEN CARE CENTER	**1033 E. ARROW HIGHWAY GLENDORA, CA 91740**

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)
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide services to one of two sampled residents (Resident 1) to maintain range of motion (ROM) of the resident's fingers per physician's orders [REDACTED]. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. A review of Resident 1's Progress Note dated 9/26/17 at 17:06 (5:06 p.m.), indicated the resident was noted with swollen discoloration of the right hand, right 4th knuckle and the top part between the thumb and index finger. Ice pack was applied to hand. The resident was unable to explain what happened with period of confusion. At 15:53 (3:53 p.m.), the physician ordered right hand x-ray. Resident 1's right hand 2 views, x-ray result dated 9/27/17 indicated acute fifth proximal phalangeal fracture with possible [MEDICAL CONDITION] phalanx (broken right little finger). The physician was notified and ordered to apply hand splint to the affected finger. The physician also ordered to consult with orthopedic specialist. A review of Resident 1's orthopedic physician dated 10/6/17 indicated for to tape the resident's right little finger to the ring finger, and recommending ROM to the fingers with the tape on. On 10/10/17 at 1:16 p.m., during an observation, Resident 1 was lying in bed with the fourth and fifth fingers taped together. During an interview on 10/10/17 at 2:26 p.m., the Restorative Nursing Assistant (RNA) stated we do not have the order to do range of motion to the resident's fingers. A review of Resident 1's Restorative Nursing indicated no ROM provided to the the resident's fingers. A review of the facility's policy and procedure dated 11/2007, titled, Quality of Care/Range of Motion indicated the preventive care will be provided so that the resident will not experience a reduction in range of motion.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.