STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555659	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN DIEGO POST-ACUTE CENTER	**1201 SOUTH ORANGE AVE. EL CAJON, CA 92020**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the splinting program was not consistently performed as ordered by the physician for one sampled resident (1). This failure had the potential for Resident 1's hand contractures to worsen. Findings: Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Department of Health received a report on 11/21/19, related to a resident not receiving therapy for contractures. On 12/4/19, at 10:43 A.M., an observation of Resident 1 was conducted. Resident 1 was in bed, nonverbal, and both hands contracted. There were no devices applied to both Resident 1's contracted hands. A review of Resident 1's medical record was conducted. The OT (occupational therapist) Evaluation & Plan of Treatment note, dated 5/7/19, indicated, . screen secondary to increase BUE (bilateral upper extremities) stiffness c (with) contracture risk. The physician order, dated 5/15/19, indicated, RNA (restorative nurse's aide) Program Splinting (a medical device applied to protect a body part from further injury or damage) program c BUE wrist/hand extensor splint for 4-6 hours . QD (every day) 4x/wk. (four times a week) . Resident 1's care plan, ADL (activities of daily living) Functional/Rehabilitation Potential, dated 5/6/19, indicated the intervention, RNA Program Splinting program c BUE wrist/hand extensor splint for 4-6 hours as tolerated QD 4x x Week (four times a week). The Point of Care History for Restorative Nursing Record Progress, dated 9/15/19 to 12/4/19, indicated the following: - On the scheduled RNA week from 9/16/19 through 9/22/19, splinting was provided for three days on 9/16, 9/17 and 9/18/19. There was no entry to indicate splinting was completed on 9/19, 9/20, 9/21, or 9/22/19. - On the scheduled RNA week from 9/23/19 through 9/29/19, splinting was provided for two days on 9/23 and 9/24. There was no entry to indicate splinting was done from 9/26 through 9/29/19. - On the scheduled RNA week from 10/7/19 through 10/13/19, splinting was provided for three days, on 10/7, 10/8 and 10/9. There was no entry to indicate splinting was done on 10/10, 10/11, 10/12 or 10/13/19. - No records were provided for the dates from 10/16/19 through 10/31/19. - On the scheduled RNA week from 11/25/19 to 11/30/19, splinting was provided for three days, on 11/25, 11/26 and 11/28. There was no entry to indicate splinting was done on 11/27, 11/29 or 11/30/19. On 9/18/20 at 4:30 P.M., an interview and a joint record review with the director of nursing (DON) was conducted. The DON stated, the RNA was expected to complete the splinting program four times a week, as ordered by the physician. The DON further stated the splinting program was not completed as expected. A review of the facility's policy titled, Physician Orders, revised June 2013, indicated, . Physician orders [REDACTED].

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.