STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555739	A. BUILDING _____ B. WING _____	**03/05/2020**

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

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 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from physical restraints when a certified nursing assistant tied Resident 1's gown to another gown and wrapped it around the bed frame for one of one sample resident (1). This failure had the potential to restrict Resident 1's freedom of movement or activity. Finding: On 12/31/2019 at 17:04 P.M., the Department received an entity reported incident (ERI). This ERI indicated someone had tied a second gown onto the patient's gown to keep patient's gown in place. The suspected employee has been suspended. On 1/13/2020 at 10 A.M., the Department made an unannounced visit to the facility. Resident 1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An observation of Resident 1 on 1/13/20 at 11:50 A.M., in his room was conducted. Resident 1 laid on his back wearing hospital gown. An interview with the lead certified nursing assistant (LCNA) on 1/13/2020 at 12:40 P.M., was conducted. The LCNA stated, I noticed a gown wrapped around the bed frame. The LCNA further stated the gown wrapped around the bed frame was tied to the string of the gown Resident 1 was wearing. The LCNA stated she then reported to the licensed nurse (LN) 1. The LCNA stated she it was important to report it to the LN because, I'm a mandated reported, its for the safety of the resident. A phone interview was conducted with licensed nurse (LN) 1 on 1/15/2020 at 1:45 P.M. LN 1 stated LCNA had called her to Resident 1's room to, See something. LN 1 further stated she saw a secondary gown was tied to Resident 1's gown that he was wearing, the secondary gown was then tied to the bed frame. LN also stated, I couldn't untie the knot on the second gown so I had to cut it with the scissor. LN 1 stated the gown was tied to a non removeable part of the bed so it considered a restraint. LN 1 stated, It's our policy and the law, we can't use physical restraint. An interview with the Administrator (Admin) on 1/13/2020 at 11:50 A.M., was conducted. The Administrator stated the alleged CNA was terminated on 1/13/2020 because of this incident. The Admin stated, He shouldn't done that.

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.