

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2024
NAME OF PROVIDER OR SUPPLIER Escondido Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 421 E Mission Ave Escondido, CA 92025	

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)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46982</p> <p>Based on observation, interview and record review, the facility failed to 1). Correctly re- position the resident with the correct orthopedic devices as ordered by the physician. 2). Provide continued care with Restorative Nursing services 3). Failed to notify the physician that physical therapy services and restorative services were not provided. 4). Failed to notify the physician the brace was not being used as ordered, for 1 of 3 residents reviewed (Resident 1) for mobility.</p> <p>As a result of these failures, Resident 1 was at risk for a decrease in range of motion, and experienced psychosocial distress and fear of not achieving independence with Activities of Daily Living (ADL ' s) such as dressing, grooming, and being up in her wheelchair for periods of time.</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included multiple contractures (shortening of muscles, tendons, and skin that cause joint stiffness and limited movement. A BIMS (routine screening of memory and thinking) score of 14 on 7/11/24 and 10/11/24 indicated Resident 1 ' s cognition was intact.</p> <p>A medical records review began on 11/21/24. According to the Nursing Admission Assessment, dated 7/4/24, Resident 1 was admitted to the facility for physical therapy. Resident 1 ' s goal was to return to an assisted living environment after therapy, and a second surgery to allow her to position in her wheelchair again.</p> <p>Resident 1 ' s Hospital Discharge Instructions (After Visit Summary, dated 6/26/24-7/4/24) included instructions for: 1.) every two-hour turning and offloading; 2.) keeping the left hip internally rotated and the leg in neutral (straight leg, no outward bending) and 3.) continue the custom PRAFO (a special positioning device always sent from the hospital with Resident 1) with kickstand.</p> <p>Resident 1 ' s nursing admission assessment, dated 7/4/24, reflected that the resident is bed-bound with right and left hip and knee contractures and paralysis of her lower extremities, unable to voluntarily move her legs.</p> <p>The MDS (a required, comprehensive assessment) dated July 11, 2024, and October 11, 2024, recorded Resident 1 needed assistance for eating, and oral hygiene tasks (did less than 50% of the effort) and depended on staff (staff did all of the effort) for toileting hygiene, shower/bathing, upper and lower body dressing, and personal hygiene.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056040
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The same assessments also indicated Resident 1 was dependent on staff, unable to: roll left or right, change position from lying to sitting up or sitting up to lying down, or transfer to or from a chair.</p> <p>Beginning on 11/16/24, Resident 1 ' s nursing care plan was reviewed for how Resident 1 ' s mobility and Activities of Daily Living (ADL -dressing, hygiene, toileting, bathing) needs were being met.</p> <p>Resident 1 ' s care plan included direction for staff to assist to turn and reposition as indicated and tolerated, dated 7/22/24. On 7/11/24, it is noted that 1/4 side rails are used as an enabler for bed mobility, and the care plan noted Resident 1 required 1 staff assistance for hygiene.</p> <p>Resident 1 ' s care plan did not address the physician orders of 7/4/24 for turning Resident 1 every 2 hours, and keeping her left hip internally rotated and in a neutral position, and to use the PRAFO brace sent with Resident 1 from the hospital.</p> <p>On 11/21/24 at 4:20 P.M. Resident 1 was interviewed in her room. She was resting on an air mattress, on her back. Her left and right legs were bent at the knee, and rotated outward (frog position), with the left hip propped against rolled blankets and a pillow. Resident 1 ' s left lower leg was in an AFO (a soft foam boot worn in bed to prevent pressure on skin). Another AFO was on her small bedstand. Resident 1 stated it was not needed on her right lower leg. Her PRAFO brace was located under her bed. Resident 1 stated it does not fit as well as it should. Res. 1 stated she is upset and depressed that her left leg was not kept in a neutral position as ordered by her physician. Resident 1 stated after surgery in June, she could move her left leg through midline and towards her right leg, and cannot do that any longer.</p> <p>Resident 1 also stated since July she has asked therapy to evaluate her for a new brace to support the left leg in the correct position. Resident 1 stated she is afraid her left leg has been damaged because post operative care from the surgery was not done correctly, and the brace was not adjusted as needed. Resident 1 has surgery planned for her right leg, and is very worried staff will not follow the orders for her care plan. Resident 1 stated her surgeries are to allow her legs into a more natural position, and to get back into her wheelchair so she could return to an assisted living facility. Resident 1 stated she lived independently before her legs were contracted and she wanted to be independent again, as much as possible.</p> <p>On 11/22/24 at 4:20 P.M. Resident 1 was observed and interviewed. Resident 1 was lying in bed on her back, and her left leg was propped with three rolled blankets and a pillow, and was rotated outward, not in a neutral (straight) position. Resident 1 stated she is upset her left leg is not kept neutral, a brace has not been made as she has asked, and she is losing hope of getting back into a wheelchair, and the surgery will be for nothing.</p> <p>On 11/25/24 at 2:52 P.M. Resident 1 ' s Physician After visit Summary, dated 7/31/24, was reviewed with the supervising Registered Nurse (SRN). Handwritten Instructions from the doctor ' s office included: Clean hip incision/scar with soap and water daily; position change being on & off-loading hip every 2 hours; keep hip in neutral. Okay for slight hip external rotation every once in a while. These orders were noted 7/31/24 by nursing staff, but not transferred to the care plan or MD order sheet. Printed instructions from the surgeon were to: Continue wound care, washing entire incision with soap and water once daily. Continue hip brace. Start traction on the L (left) knee. Patient should position change at minimum every 2 hours, offloading the hip.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PT 1 stated Resident 1 was discharged initially from physical therapy on 7/17/24 due to Resident 1 ' s managed care insurance determining coverage limits. PT 1 stated when insurance ends coverage, even the doctor cannot change the date.</p> <p>PT 1 stated Resident 1 should have been started on the RNA program. PT1 reviewed the document titled, Physical Therapy PT Discharge Summary, and dated 7/17/24, noted that Resident 1 was discharged with recommendations for Assistance with ADL ' s and RNP (Restorative Nursing Program): to perform Range of Motion (ROM) during shift.</p> <p>PT 1 stated she did not see an order for RNA services to begin after physical therapy had ended.</p> <p>On 11/27/24 at 8:15 A.M. one of the surgeons (MD 1) for Resident 1 was interviewed.</p> <p>MD 1 stated Resident 1 needs a lot of assistance due to her condition. MD 1 stated Resident 1 ' s surgery (in June 2024) gave her new mobility in the left hip. Her left leg should have been kept in neutral, midline position or abducted (rotated toward the right). MD 1 said Resident 1 ' s concerns are correct: if the facility staff is not able to follow the program and keep her (leg) in a neutral position her muscles will tighten again.</p> <p>MD 1 stated she had not been notified the facility was not using the supplied brace; the facility should have used foam wedges or other orthopedics if the brace isn ' t on; pillows and other soft items would not be adequate.</p> <p>MD 1 further stated it was inappropriate to take (Resident 1) off physical therapy (PT). Because of her condition, (Resident 1) will always require skilled PT services to prevent contractures and maintain the movement and range Resident 1 has, and prevent loss of function.</p> <p>On 12/16/24 at 3:31 P.M. an concurrent record review and interview was held with the Director of Nursing (DON), the Administrator (ADM)and the Medical Records Director (MRD).</p> <p>The DON stated the normal process for Resident 1 should have been that the Physical Therapist created the RNA program, and identified the exercises, the goals, and the diagnosis (reason for the program). Resident 1 should have been given an RNA program to maintain her body positions and range of motion (ROM) when she was discharged from active physical therapy. The DON further stated the RNA program was not started for Resident 1 and so her ROM was not maintained or improved.</p> <p>The DON also stated either physical therapy or nursing staff should have notified the MD in July that the brace did not fit well, clarify the physician order, and have the brace re-fitted or another positioning device utilized.</p> <p>In the review of Resident 1 ' s record, no documentation was found the MD was notified Resident 1 did not wear the brace as ordered.</p> <p>The ADM stated the prior Case Manager (CM) did not notify the MD that physical therapy services were not continued in July, and it fell through the cracks. The ADM also stated the CM should have asked for additional days for physical therapy, it may have been approved.</p>		