DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING _____ B. WING _____	C 05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HEALTH & REHAB CENTER	64 RED MULBERRY WAY LILLINGTON, NC 27546

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey conducted on May 30, 2014. Event ID #1LF311.	F 000	Plan of Correction Revision 6/24/14 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulation the facility has taken or will take the actions set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	6/27/14
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and resident interviews, the facility failed to obtain permission from the residents or responsible parties to post signs regarding confidential or personal information about resident care for 3 of 28 residents sampled for dignity (Resident #90, #62, #84). Findings included: On tour of the facility on 5/27/14 at 10:15 AM a red and/or green leaf was observed next to 3 residents' names located next to the entrance to resident rooms. Resident #90, #62, and #84 had a red or green leaf next to their name plates. The leaf sign was observed on 5/27/14 @ 1:10 PM, 5/28/14 @ 2:00 PM, 5/29/14 @ 09:15 AM, and 5/30/14 @ 10:20 AM next to residents' names outside the entrance to their rooms. An interview with the (DON) Director of Nursing on 5/28/14 at 2:40 PM revealed that the facility used the leaf signage to alert facility staff to	F 241	**F241 Dignity and Respect of Individuality** For Resident # 90, #62, and #84 the leaf next to their name plates were removed on 5-30-14. Any resident that scored a 10 or higher on their fall assessment has the potential to be affected by the alleged deficient practice. On 5/30/2014, all leaves were removed from all the name plates outside resident rooms.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/24/2014

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 241	Continued From page 1 residents with increased fall risk. The DON stated that a leaf indicated that the resident was on the facility fall risk program. The DON further stated that she had not requested or received permission from residents to post the leaf signage. A review of the facility's current admission packet revealed there was not a provision for getting resident or responsible party permission for the use of signage to identify confidential clinical or personal information about the resident. In an interview on 5/28/14 at 4:15 PM with the RP (responsible party) for resident #90, it was stated that the RP had not been informed of the significance of the leaf signage. Resident #90 was assessed as severely cognitively impaired on the MDS Quarterly review dated 3/21/14. The residents' RP, who was the residents' POA (Power of Attorney), stated that she had not given permission for the facility to place identifying signage outside resident #90' s room. In an interview on 5/28/14 at 5:00 PM with resident #62 the resident stated that he had not given written or verbal permission for the facility to post leaf signage outside his door. The resident stated that he would prefer the leaf be removed from beside his name plate. Resident #62 was assessed as cognitively intact on the MDS Quarterly review dated 5/02/14. A review of the medical chart for residents #90, #62, and #84 did not reveal a consent form giving the facility permission to use signage to communicate personal information about the resident.	F 241	On 6/24/14 the IDT Interdisciplinary team were re-educated by the VP of Clinical Operations regarding the placement of the leaf signage on residents name plates. The Falling Leaf Program has been revamped to included consent for use of the leaf as an identifier for a resident at risk for falls. Daily X one week, during morning Environmental rounds, department heads will observe for any signage on resident doors. Weekly observation will take place 3 times week X 3 weeks. Variances will be taken to QA/QI for review monthly, for 3 months.	

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F 242 F 242 SS=D	Continued From page 2 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record reviews, the facility failed to accommodate a request to change shower days to allow for attendance to church services for 1 of 1 (resident #87) reviewed for choices. Findings included: Resident #87 was admitted on 3/15/13 with cumulative diagnoses of dementia and lack of coordination. The comprehensive MDS assessment dated 1/16/14 resident #87 had severe cognitive impairment and required total assistance with all of her activities of daily living. The assessment also indicated that participating in religious services was important to her. A review of the care plan dated 2/23/14 indicated resident #87 was encouraged to attend activities but made no mention of religious services specifically. A review of a care plan conference summary dated 4/22/14 indicated a family member was present and requested resident #87's shower days be changed to accommodate the attendance of church services held Wednesday	F 242 F 242	**F242 Dignity and Respect of Individuality** 5/28/14 Resident #87 shower days were changed from Wednesday and Saturday to Tuesday and Friday, to accommodate residents' choice to attend religious services. The responsible party has been notified of the change and agreed with the change All residents have the potential to be affected by the alleged deficient practice. On 6-16-14, the administrative team verbally asked each alert and oriented resident about their shower day preferences. The responsible party was notified with the same information for the cognitively impaired residents. Of the 72 residents, one requested that her showers be changed from evenings to the day time. This was completed on 6-17-14. An in-service was conducted on 6-23-14 by the Director of Nursing provided an in service to Department Managers and staff. The in-service topics included: a residents right to choose activities, schedules and healthcare consistent with his or her interests, assessments, and plans of care. The IDT (Interdisciplinary Team) were re-educated regarding the grievance forms and the follow through to ensure resident choices were addressed in a timely manner The Administrator, Director of Nursing or designee will monitor resident preference in shower days and times during the initial post admission care plan weekly X 4 weeks. Variances will be taken to QA/QI for review monthly, for 3 months.	6/27/14

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F 242	Continued From page 3 mornings. A grievance from was completed on 5/25/14 by the family regarding her request to change shower days so resident #87 could go to church. The grievance stated that last week, resident #87 was crying going to the shower room because she wanted to attend church. The nursing assistant (NA) reported she could not change resident #87's shower days. In an interview on 5/28/14 at 10:35 AM, a family member stated resident #87 she visited resident #87 a couple a times each week. Resident #87 was lying in bed and had received her shower and been to the beauty shop. Church services were in progress within ear shot of resident #87's room. The family member stated she recently requested resident #87 to be up for church services on Wednesday's and her shower days be adjusted. In an interview on 5/28/14 at 11:20 AM, NA #1 stated she was not aware of a change of resident #87's shower days to accommodate her attendance of the church services. NA #1 stated resident #87 was on the list to go the the beauty shop this morning so she got her up and did her shower before she went to have her hair done. In an interview on 5/28/14 at 4:00 PM, the activity director (AD) stated she was aware that there was a request to change resident #87's shower days to accommodate a request to attend church services on Wednesday mornings. The AD stated she spoke with the staff last week and again today about the request but there had been so much recent turn over in staff and staff was inconsistent. The AD stated she put out the	F 242		

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F 242	Continued From page 4 beauty shop list this morning. Resident #87 was to have her hair dyed as the family requested and today was the day the beautician was available to do it. The AD stated the staff could have the scheduled her shower to allow her to go to church then have her hair done but that did not happen. The AD stated the MDS nurse stated she would address the request to change her shower days during the care plan meeting last month. The AD stated she had the pastor go in and pray with resident #87 before he left after church services today. In an interview on 5/29/14 at 9:40 AM, the MDS nurse stated she recalled the care plan meeting and the request to change resident #87's shower days. She stated she discussed the request with the director of nursing (DON) after the care plan meeting last month. In an interview on 5/29/14 at 10:25 AM, the director of nursing (acting administrator) stated she did not recall the MDS telling her anything about a request to change resident #87's shower days. The DON indicated that she did recall telling the nursing staff to put request in writing such as on a grievance form and not just tell her something in passing. She further stated that resident #87 had to right to change her shower days at anytime. It was completely resident choice as to when they received their showers. The DON stated she received the grievance on Tuesday due to the holiday, acted on the request yesterday and spoke with the family yesterday as well.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	Continued From page 5 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F272 Comprehensive Assessment** Resident # 84 Care plan and resident care card has been reviewed and revised by MDS nurse on 5-30-14 Any Resident identified on the MDS as having a deficit in eating is at risk for the alleged deficient practice. -6/23/2014 the MDS nurse completed audit on resident care cards and care plans to ensure both reflected care of the resident. Resident Care Cards and Care plans will be corrected as needed to accurately reflect resident's needs by 6/23/2014. An in-service was conducted on 6-23-14 by the Director of Nursing or Designee for therapy, licensed nursing staff, and nursing assistants. The in service topics included special needs equipment and how it is relayed to nursing staff via care plan and care cards. Random audits will be completed to ensure the care card reflects the care plan of the resident. 7 random audits x 1 week, then 2 random audits x 2 weeks and them Variances will be reviewed and revisions made at monthly QA/QI monthly, for 3 months.	6/27/14

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F 272	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to identify functional limitations for a resident with impaired ability to feed him-self when identified on his comprehensive annual assessment for 1 of 18 residents reviewed for assessments. Findings included: Resident #84 was admitted on 11/21/11 with a diagnosis of cerebral vascular accident. The quarterly Minimum Data Set (MDS) dated 4/22/14 indicated severe cognitive impairment and limited assistance for eating. The care plan was recently updated 3/21/14 and did not address of assistance with eating. The undated Resident Care Card in front of the ADL flow record indicated resident #84 was a set up only for his meals. Resident #84's last annual comprehensive MDS assessment dated 10/3/13 indicated he required supervision only with eating. The Care Assessment Area (CAA) for his ADLs indicated resident #84 needed only supervision but the nutritional CAA indicated resident #84 was unable to feed him-self without physical assistance. There was no care plan for assistance with meals and the Resident Care Card located in front of the ADL flow record indicated resident #84 was a set up only for his meals A dietary quarterly assessment dated 4/7/14 indicated a mild weight loss and staff were feeding resident #84. The most recent care conference dated 5/20/14 indicated there were no new nursing issues,	F 272		

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F 272	Continued From page 7 resident #84 was on a regular diet and had to be fed. A resident representative was invited to the care plan conference but they did not attend. The MDS nurse conducted the care plan conference. In an observation on 5/27/14 at 12:35 PM, resident #84 fed him-self without any assistance or adaptive equipment. Food was observed on the table, in his lap and on the floor. Resident #84 ate the food he was able to reach using left hand off the table and his lap. He was also observed attempting to eat the plastic container his desert was served in. In an interview on 5/27/14 at 12:40 PM, NA #3 stated resident #84 was able to feed him-self without any assistance. She stated she obtained her information about caring for a resident from the Resident Care Card in front of the ADL flow records and that resident #84 was a set up only. NA #3 did not notice or intervene while resident #84 was eating from off the table. In an interview on 5/28/14 at 8:15 AM, NA #1 stated she fed resident #84 his breakfast. She stated resident #84 had good days and bad days and today was a bad day for him. In an interview on 5/29/14 at 9:40 AM, the MDS nurse stated that when a resident was coded as limited assistance on the MDS, it meant they required hands on assistance and not just verbal cueing. The MDS nurse stated at the time of the quarterly assessment on 4/22/14, she should have identified and care planned the need for assistance with eating while the previous MDS nurse should have identified and care planned on the comprehensive MDS assessment 10/3/13.	F 272		

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F 272	Continued From page 8 In an interview on 5/29/14 at 10:25 AM, the acting administrator indicated her expectation would have been that resident #84 was accurately assessed and, care planned for eating assistance.	F 272	**F 280 Right to Participate in Care Planning** Resident #87 was evaluated by Occupational Therapist 6/2/14 and is currently on Occupational Therapy caseload for staff education for donning/doffing splints. Any residents with orders for splints have the potential to be affected by the alleged deficient practice. Those residents Care plans and Resident Care Cards will be reviewed by MDS nurse and updated as needed by 6/25/14. The facility has completed a whole house chart and room audit to identify orders for splints and potentially splints utilized previously without orders. This was completed on 6/2/14. Any splint identified without orders, resident was referred to therapy. An in-service was conducted 6-23-14 by the Director of Nursing or Designee. Those who attended were therapy and all licensed staff to re educate communication of special needs equipment. The Director of Nursing designee will validate splint orders during risk rounds by checking orders against the Treatment Administration Records, Resident Care Card and Care Plan. This will be completed daily X 2 weeks, weekly X 4 weeks then monthly. Variances will be reviewed and revisions made at monthly QA/QI monthly, for 3 months.	6/27/14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to care plan an upper extremity splint for a resident with a decline in ROM (resident #87) for 1 of 18 reviewed for care planning. Findings included:	F 280		

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F 280	Continued From page 9 Resident #87 was admitted on 3/15/13 with cumulative diagnoses of dementia and lack of coordination. A review of the physician orders revealed an order dated 1/13/14 for resident #87 to be fitted for a right upper extremity resting hand splint and elbow extension splint. The splint was to be worn 5 hours on and 2 hours off. An annual comprehensive MDS assessment was completed on 1/16/14 for resident #87 which acknowledged a functional impairment to the upper extremity and indicated the OT services were provided. Occupational Services continued until 2/14/14 at which time the discharge summary indicated that resident #87 had developed increased elbow flexion contracture to her right upper extremity requiring an elbow extension splint and hand splint. The summary indicated education was done with a nursing assistant, two nurses and a restorative aide. A splint schedule was signed and dated by the staff. A Restorative Splint and Brace Program Daily Record was also provided by therapy and dated 2/14/14 with signatures of the staff in-serviced. The most recent quarterly Minimum Data Set (MDS) dated 4/16/14 indicated resident #87 had severe cognitive impairment, required total assistance for all activities of daily living (ADLs) and had functional limitations to the upper and lower extremities. A review of the care plan dated 2/23/14 did not include a care plan for range of motion, splinting or contractures. The care plan was not updated with the 4/16/14 quarterly MDS assessment. The Resident Care Card in front of the ADL flow sheets was not dated and did not indicate resident #87 was to have a splint to the right elbow and right hand. The ADL flow sheet also did not indicate splinting was ordered for resident #87.	F 280		

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F 280	Continued From page 10 In an observation on 5/27/14 at 3:20 PM, resident #87 was observed in bed. The right upper extremity was contracted with her fingers also contracted and entangled in her hair. Resident #87 had ROM of the shoulder and reached for the surveyor. There was no observed splint to the right elbow or right hand. The room did not reveal a splint lying anywhere observable. In an interview on 5/27/14 at 4:00 PM, nurse #1 stated resident #87 had a contracture to her right hand but was did not have an ordered splint. In an interview on 5/28/14 at 11:20 AM, nursing assistant (NA) #1 stated resident #87 did not have a splint ordered for her right upper extremity but she did ROM when her bathing. NA #1 stated she went by what is on the Resident Care Card in front of the ADL flow records. In an interview on 5/29/14 at 9:20 AM, the rehabilitation director stated resident #87 had an elbow and resting hand splint since February 2014. She stated the staff was provided in-servicing and teaching on the application of the splint and it was turned over to restorative services. She stated a copy of the forms was given to the MDS nurses. In an interview on 5/29/14 at 9:40 AM, the MDS nurse stated the MDS nurse does not update the Resident Care Card in front of ADL flow sheets. She stated the nurses on the floor were responsible for keeping it updated but that was where the aides went to look to see how to care for a resident. She stated as the MDS nurse, she was responsible for updating the care plan.	F 280		

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F 280	Continued From page 11 In an observation on 5/29/14 at 10:25 AM, resident #87 was in an activity with no splint observed to the right upper extremity were observed flexed with the hand to her face and fingers curled inward. In a second interview on 5/29/ 14 at 2:00 PM, the MDS nurse was unable to provide any splinting documentation for resident #87. The MDS nurse stated resident #87 was not on the list for services and therefore not care planned for ROM. The MDS nurse stated resident #87 should have been care planned for restorative services, contractures and a decreased ROM. In an interview on 5/30/14 at 2:10 PM, the acting administrator indicated the expectation would be for resident #87 to have been care planned for the decreased ROM with splinting.	F 280		6/27/14
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to provide needed eating assistance for 1 of 1 resident's (resident #84) reviewed for activities of daily living. Findings included: Resident #84 was admitted on 11/21/11 with a	F 312	**F312 ADL Care Provided for Dependent Residents** Resident # 84 Care plan and resident care card has been reviewed and revised by MDS nurse on 5-30-14 Any Resident identified on the MDS as having a deficit in eating is at risk for the alleged deficient practice. -6/23/2014 the MDS nurse completed audit on resident care cards and care plans to ensure both reflected care of the resident. Resident Care Cards and Care plans will be corrected as needed to accurately reflect resident's needs by 6/23/2014. An in-service was conducted on 6-23-14 by the Director of Nursing or Designee for therapy, licensed nurses and nursing assistants regarding the referral process for changes in residents eating assistant needs. Director of Nursing or designee will monitor this using the risk rounds and 24 hour reports to identify any referrals to therapy for eating assistance. This will be completed daily X 2 weeks, weekly X 4 weeks then monthly. Variances will be reviewed and revisions made at monthly QA/QI monthly, for 3 months.	

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F 312	Continued From page 12 diagnosis of cerebral vascular accident. The quarterly Minimum Data Set (MDS) dated 4/22/14 indicated severe cognitive impairment and limited assistance for eating. The care plan was recently updated 3/21/14 and did not address of assistance with eating. The undated Resident Care Card in front of the ADL flow record indicated resident #84 was a set up only for his meals. Occupational therapy (OT) services worked with resident #84 from 1/30/14 to 3/14/14 for positioning in his wheelchair. The discharge summary indicated resident #84 was able to feed him-self with minimal assistance. There was no referral or recommendations. A dietary quarterly assessment dated 4/7/14 indicated a mild weight loss and staff were feeding resident #84. A review of the weights for resident #84 over the last 6 months revealed minimal weight loss and variations were inconsistent. The most recent care conference dated 5/20/14 indicated there were no new nursing issues, resident #84 was on a regular diet and had to be fed. A resident representative was invited to the care plan conference but they did not attend. In an observation on 5/27/14 at 12:35 PM, resident #84 fed him-self without any assistance or adaptive equipment. The roast, potatoes and broccoli with cheese were observed on the table, in his lap and on the floor. He was only provided a knife and a fork to eat with. Resident #84 ate the food using the fork but eventually sat the fork down and using his left hand ate the food from	F 312		

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F 312	Continued From page 13 table top and his lap. He was then observed attempting to eat the plastic container his brownie was served in. There were two nursing assistants (NA) in the dining room at the time. One NA noticed resident #84 attempting to eat the plastic container and intervened. She stated she worked the other hall was unfamiliar with resident #84. In an interview on 5/27/14 at 12:40 PM, NA #3 stated resident #84 was able to feed him-self without any assistance. She stated she obtained her information about caring for a resident from the Resident Care Card in front of the ADL flow records and that resident #84 was a set up only. NA #3 did not notice or intervene while resident #84 was eating from off the table. In an interview on 5/28/14 at 8:15 AM, NA #1 stated she fed resident #84 his breakfast. She stated resident #84 had good days and bad days and today was a bad day for him. In an observation on 5/28/14 at 12:35 PM, resident #84 was feeding him-self. He had a spoon he was using to eat mashed potatoes and cooked cabbage. The food was again observed on the table on the right side of his plate and in his lap. In his lap was also noted a cookie still contained in its plastic wrapper. At 12:40 PM, resident # 84 dropped his spoon on the floor. After attempting to reach it, he picked up his knife and attempted to eat his cabbage using the knife. At 12:45 PM, resident # 84 laid the knife down and began eating with his fingers. NA #1 approached resident #84 and retrieved the cookie from his lap and removed the wrapper and laid the cookie on a napkin to the left side of his plate and walked away. He picked up two pink packs of artificial sweetener lying beside the cookie.	F 312		

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F 312	Continued From page 14 Reaching again, he was able to grasp the cookie while holding the artificial sweetener. Resident #84 began biting the artificial sweetener packs and cookie together and was unable to get any of the cookie into his mouth. NA #1 was observed approaching resident #84 and removed the cookie and the sweetener from his hand. She removed his clothing protector and wheeled him from the dining room. In an interview on 5/29/14 at 9:40 AM, the MDS nurse stated no assistance was given to resident #84 on 5/26/14 when she observed him during his lunch meal and she did not identify any needs with eating at that time. The MDS nurse stated if a resident was observed with food sliding from the plate onto the table or lap, it would indicated a need for assistance or an evaluation for adaptive equipment. The MDS nurse stated if resident #84 was observed attempting to eat non-edible items, staff should have intervened and stopped and fed resident #84. In an interview on 5/29/14 at 10:25 AM, the acting administrator indicated her expectation would have been that resident #84 received assistance with his meals and re-evaluated for current functional needs.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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F 318	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review, the facility failed to apply resting hand splint and an elbow splint as ordered by the physician to prevent a decline in range of motion (ROM) for 1 of 3 residents (resident #87) reviewed for ROM. Findings included: Resident #87 was admitted on 3/15/13 with cumulative diagnoses of dementia and lack of coordination. The most recent quarterly Minimum Data Set (MDS) dated 4/16/14 indicated resident #87 had severe cognitive impairment, required total assistance for all activities of daily living (ADLs) and had functional limitations to the upper and lower extremities. The MDS indicated resident # 87 was receiving physical therapy (PT) services, no occupational therapy (OT) services and no restorative services for splinting. A review of the care plan dated 2/23/14 did not include a care plan for range of motion, splinting or contractures. The first documented evidence of a concern related to the right arm was an occupational therapy evaluation only completed 5/8/13 which indicated resident # 87 exhibited evidence of right upper extremity contracture risk but no documented interventions. The quarterly MDS dated 7/15/13, indicated impaired upper extremity ROM. A review of the submitted MDS assessments from 5/20/13 to 8/6/13 indicated resident #87 was receiving PT for the lower extremities and no other therapies.	F 318	**F318 Increase/Prevent Decrease in Range of Motion** Resident Care plan and Resident Care Card for resident # 87 has been reviewed and updated by MDS nurses and updated by MDS nurses to accurately reflect ordered use of upper extremity splint on 6/3/2014 by MDS nurse. Any resident with splints has potential to be affected by this alleged deficient practice. All Residents with orders for splints will have Care plans and Resident Care Cards reviewed and updated as appropriate by MDS nurse by 6/25/14. CNA staff will be in-serviced on proper application of splints by rehab and MDS nurses, how to document splint application, and where splint documentation is located by 6/23/14. Random audits of the ADL flow records for splint application will be completed daily x 2 weeks, weekly x 4 weeks then monthly. Variances will be reviewed and revisions made at monthly QA/QI monthly, for 3 months.	6/27/14

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F 318	Continued From page 16 A Restorative Functional Data Collection and Decision Forms were completed on resident # 87 by the MDS nurse on 7/15/13 and again on 8/6/13. Both forms indicated multiple joint limitations to include the right elbow and right wrist and fingers. Both forms also indicate that resident #87 was working with therapy. The MDS nurse did not indicate what type off therapy and for what reason. A Therapy Referral Form dated 10/15/13 was completed by the same MDS nurse for resident # 87 due to a right upper extremity contracture. The OT evaluation form dated 10/15/13 indicated resident #87 had developed increased tone in the right elbow and hand held in a fisted position. Services were indicated with the focus of restoration and compensation. A review of the physician orders revealed an order dated 1/13/14 for resident #87 to be fitted for a right upper extremity resting hand splint and elbow extension splint. The splint was to be worn 5 hours on and 2 hours off. Occupational Services continued until 2/14/14 at which time the discharge summary indicated that resident #87 had developed increased elbow flexion contracture to her right upper extremity requiring an elbow extension splint and hand splint. The summary indicated education was done with a nursing assistant, two nurses and a restorative aide. A splinting schedule was signed and dated by the staff. A Restorative Splint and Brace Program Daily Record was also provided by therapy and dated 2/14/14 with signatures of the staff in-serviced. In an observation on 5/27/14 at 3:20 PM, resident	F 318		

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F 318	Continued From page 17 #87 was observed in bed with the right upper extremity flexed with her fingers also flexed and entangled in her hair. There was no observed splint to the right elbow or right hand. The room did not reveal a splint lying anywhere observable. In an interview on 5/27/14 at 4:00 PM, nurse #1 stated resident #87 had a contracture to her right hand but was did not have an ordered splint In an observation on 5/28/14 at 8:30 AM, a physical therapist was observed in the room. He stated he was uncertain where her hand splint was but he was going to check with OT. He stated he was working on her bilateral lower extremities only. In an interview on 5/28/14 at 10:35 AM, a family member stated resident #87 was supposed to have a splint to her right hand but she had not seen it on her in a long time. The family member stated she visited resident #87 a couple a times each week. There was no observed splint on resident #87 ' s right upper extremity and the arm was observed flexed with the hand to her face and fingers curled inward. In an interview on 5/28/14 at 11:20 AM, nursing assistant (NA) #1 stated resident #87 did not have a splint ordered for her right upper extremity but she did ROM when her bathing. In an observation on 5/28/14 at 4:00 PM, resident #87 was sitting up in a wheelchair in a common area. There was no observed splint to her right upper extremity and the arm was observed flexed with the hand to her face and fingers curled inward.	F 318		

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F 318	Continued From page 18 In an interview on 5/29/14 at 9:20 AM, the rehabilitation director stated resident #87 had an elbow and resting hand splint since February 2014. She stated the staff was provided in-servicing and teaching on the application of the splint and it was turned over to restorative services. In an interview on 5/29/14 at 9:40 AM, the MDS nurse stated she had been in her position for about 2 months but she was aware that restorative aide does splinting and the MDS nurses were responsible for the restorative case load. In an observation on 5/29/14 at 10:25 AM, resident #87 was in an activity with no splint observed to the right upper extremity and the arm was observed flexed with the hand to her face and fingers curled inward. In an interview on 5/29/14 at 1:40 PM, the restorative aide (RA) stated all aides were considered restorative aides. Each aide was now responsible for anything the resident needed. The RA stated she had an assignment today but was pulled off of it today to teach splinting for resident #87. The RA stated she found the splint in resident #87's room in her bedside table. In a second interview on 5/29/ 14 at 2:00 PM, the MDS nurse was unable to provide any splinting documentation for resident #87. The MDS nurse stated she had a list of resident who were receiving restorative services. The MDS nurse stated resident #87 was not on the list for services. In an interview on 5/29/14 at 4:40 PM, NA 2	F 318		

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F 318	Continued From page 19 stated first shift staff was responsible for applying the splint on resident #87. She stated she was not aware of a splint schedule for resident #87. In an interview on 5/30/14 at 2:10 PM, the acting administrator stated all aides were responsible for restorative services as ordered with oversight by the MDS nurses. The expectation would be for resident #87 to have splint in place as ordered with oversight and documentation.	F 318		