STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REX REHAB & NSG CARE CENTER	4420 LAKE BOONE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS 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		8/11/16

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

Electronically Signed | 08/03/2016

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed underlying causes, contributing factors, and risk factors for 2 of 3 residents (Resident #211 and #223) reviewed for dental assessment. Findings included: 1. Resident #211 had a diagnosis of dysphagia. Record review revealed a Dental Care Progress Note dated 12/18/15. It indicated Resident #211's remaining lower teeth were extracted on that date. It also indicated the resident had expressed a desire for upper and lower dentures. Resident #211's annual, comprehensive Minimum Data Set (MDS) dated 2/17/2016 indicated the resident was cognitively intact. The Oral/Dental assessment section of the MDS indicated there were no concerns. The MDS did not indicate the resident was edentulous. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment. During an interview on 7/12/2016 at 2:54 PM, Resident #211 stated, "They pulled seven teeth at one time." She also indicated she was expecting her dentures to arrive soon. During a follow-up interview on 7/13/2016 at 4:40 PM, Resident #211 specified the last of her teeth were extracted in December 2015. She added, "They were pulled 6 months ago so my mouth is healed." and "I been eating a pureed diet and I'm	F 272	1. The MDS Coordinator will complete a significant correction of a prior comprehensive assessment for residents #211 and #223 by 8/11/16 with the correct indication of edentulous for both residents. The dental CAA if triggered will be further assessed at that time and care planned if necessary. 2. A RN will complete a new dental assessment for all residents by 8/11/16 to ensure all residents have a current and accurate assessment. The MDS Coordinators will review the findings of these assessments and ensure that the current MDS for all residents is coded accurately by 8/11/16. 3. The MDS Coordinators will review the instructions in the Resident Assessment Instrument (RAI) Manual for completion of Oral/Dental Status (Section L) of the MDS by 8/11/16. The MDS Coordinators will complete a quarterly dental assessment for all residents when they complete the quarterly pain interview for the MDS assessment. They will accurately code for dental status including edentulous so that the CAA will trigger appropriately. The Director of Nursing (DON)/Clinical Educator/Clinical Manager will audit a random sample of 10% of completed oral assessments and completed Section L's of the MDS weekly for 4 weeks to verify accurate coding and CAA completion. 4. The facility Quality Assurance and Performance Improvement (QAPI) Committee will review the results of the	

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F 272	Continued From page 2 ready to chew on something good real soon." MDS Coordinator #2, who had completed the dental portion of the assessment, was unavailable for interview. An interview was conducted on 7/14/2016 at 2:10 PM, with MDS Coordinator #1. She indicated when completing the oral/dental section of the MDS she would expect to review the resident's record and do an oral exam with the resident to ensure accuracy of the assessment. She indicated that completing the Care Area Assessment would ensure discussion among the interdisciplinary team members to see if the resident ' s status required a plan of care. During an interviews on 7/14/2016 at 2:54 PM, the Administrator stated it was his expectation that the assessment would accurately reflect the resident's status. 2. Resident #223 had a history of malignant neoplasm of the mouth. Resident #223's most recent comprehensive Minimum Data Set (MDS) was completed on 9/8/2015. The Oral/Dental assessment section of the MDS indicated there were no concerns. The MDS did not indicate the resident was edentulous. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment. On 7/14/2016 at 9:15 AM, MDS Coordinator #1 stated she had just completed an oral exam on Resident #223. It revealed the resident was	F 272	audits in the monthly QAPI meeting for one month to monitor for completion and accuracy.	

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F 272	Continued From page 3 edentulous, but she did not know how long that had been the case. MDS Coordinator#1 added she had reviewed the record and a Speech Therapy evaluation in March 2016 also said Resident #223 was edentulous. During an interview on 7/14/16 at 1:12 PM, a family member specified Resident #223 had radiation 3 years ago and had not had any teeth since that time. The family member confirmed Resident #223 did not have any teeth when he entered the facility in 2015. MDS Coordinator #2, who had completed the dental portion of the assessment, was unavailable for interview. An interview was conducted on 7/14/2016 at 2:10 PM, with MDS Coordinator #1. She indicated when completing the oral/dental section of the MDS she would expect to review the resident's record and do an oral exam with the resident to ensure accuracy of the assessment. She indicated that completing the Care Area Assessment would ensure discussion among the interdisciplinary team members to see if the resident ' s status required a plan of care. During an interviews on 7/14/2016 at 2:54 PM, the Administrator stated it was his expectation that the assessment would accurately reflect the resident's status.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		8/11/16

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F 278	Continued From page 4 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, family and staff interviews the facility failed to accurately code the Minimum Data Set to reflect cognition (Resident #121), range of motion (Resident #160), dental status (Resident #211 and #223), and Level II Preadmission Screening and Resident Review status (Resident #265) for 5 of 26 sampled residents. Findings included: 1. Resident #211 had a diagnosis of dysphagia.	F 278	1. The dental status for residents #211 and #223 will be corrected and accurately coded via a significant correction of a prior comprehensive assessment by 8/11/16. The MDS Coordinators will correct and properly code cognition for resident #121, range of motion for resident #160, and Level II status for resident #265 via MDS modifications/corrections/new complete MDS assessment by 8/11/16. 2. The MDS Coordinators/DON/Clinical	

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F 278	Continued From page 5 Record review revealed a Dental Care Progress Note dated 12/18/15. It indicated Resident #211's remaining lower teeth were extracted on that date. It also indicated the resident had expressed a desire for upper and lower dentures. Resident #211's annual, comprehensive Minimum Data Set (MDS) dated 2/17/2016 indicated the resident was cognitively intact. The Oral/Dental assessment section of the MDS indicated there were no concerns. The MDS did not indicate the resident was edentulous. The Dental Care Progress Note dated 4/11/16, specified initial dental impressions were done for full upper and lower dentures. The Dental Care Progress Note dated 5/31/16 indicated final dental impressions were taken and the dentures would be delivered at the next visit. During an interview on 7/12/2016 at 2:54 PM, Resident #211 stated, "They pulled seven teeth at one time." She also indicated she was expecting her dentures to arrive soon. During a follow-up interview on 7/13/2016 at 4:40 PM, Resident #211 specified the last of her teeth were extracted in December 2015. She added, "They were pulled 6 months ago so my mouth is healed." and "I been eating a pureed diet and I'm ready to chew on something good real soon." MDS Coordinator #2, who had completed the dental portion of the assessment, was unavailable for interview. An interview was conducted on 7/14/2016 at 2:10 PM, with MDS Coordinator #1. She indicated	F 278	Manager/Clinical Educator will audit all of the most recent comprehensive MDS assessments for residents to ensure they are accurately coded and reflect the resident's current status by 8/11/16. The MDS Coordinators will correct any found inaccuracies via MDS modifications/corrections/new complete MDS assessment by 8/11/16. 3. The Director of Nursing (DON)/Clinical Educator/Clinical Manager will audit a random sample of 10% of completed MDS assessments weekly for 4 weeks to verify accurate coding and that they reflect the resident's current status. The facility Interdisciplinary team (IDT) will review the residents current MDS during their quarterly care plan meeting for 3 months to verify it is accurately coded and that it reflects the resident's current status. Any findings of inaccuracies will be corrected via MDS modifications/corrections/new complete MDS assessment. 4. The facility Quality Assurance and Performance Improvement (QAPI) Committee will review the results of the audits in the monthly QAPI meeting for one months to monitor for completion and accuracy.	

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F 278	Continued From page 6	F 278		

when completing the oral/dental section of the MDS she would expect to review the resident's record and do an oral exam with the resident to ensure accuracy of the assessment.

During an interviews on 7/14/2016 at 2:54 PM, the Administrator stated it was his expectation that the assessment would accurately reflect the resident's status.

2. Resident #223 had a history of malignant neoplasm of the mouth.
Resident #223's most recent comprehensive Minimum Data Set (MDS) was completed on 9/8/2015. The Oral/Dental assessment section of the MDS indicated there were no concerns. The MDS did not indicate the resident was edentulous.

On 7/14/2016 at 9:15 AM, MDS Coordinator #1 stated she had just completed an oral exam on Resident #223. It revealed the resident was edentulous, but she did not know how long that had been the case. MDS Coordinator#1 added she had reviewed the record and a Speech Therapy evaluation in March 2016 also said Resident #223 was edentulous.

During an interview on 7/14/16 at 1:12 PM, a family member specified Resident #223 had radiation 3 years ago and had not had any teeth since that time. The family member confirmed Resident #223 did not have any teeth when he entered the facility in 2015.
MDS Coordinator #2, who had completed the dental portion of the assessment, was unavailable for interview.

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F 278	Continued From page 7	F 278		

An interview was conducted on 7/14/2016 at 2:10 PM, with MDS Coordinator #1. She indicated when completing the oral/dental section of the MDS she would expect to review the resident's record and do an oral exam with the resident to ensure accuracy of the assessment.

During an interviews on 7/14/2016 at 2:54 PM, the Administrator stated it was his expectation that the assessment would accurately reflect the resident's status.

3. Resident #265 had diagnoses including depression and anxiety.

Record review revealed a letter of Preadmission Screening and Resident Review (PASRR) Level II Determination Notification, dated 1/15/16. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.

Resident #265's admission Minimum Data Set (MDS) dated 1/30/16 indicated the resident was not considered by the state PASRR process to have a serious mental illness and/or intellectual disability.

A review of the facility's list of Level II PASRR residents, provided on 7/12/2016, revealed Resident #265 was included among the residents named on the list.

MDS Coordinator #2, who had completed the PASRR portion of the assessment, was unavailable for interview.

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F 278	Continued From page 8	F 278		

An interview was conducted on 7/14/2016 at 2:10 PM, with MDS Coordinator #1. She indicated when completing the PASRR status of the MDS, she would find the information in the front of the resident's record.

During an interviews on 7/14/2016 at 2:54 PM, the Administrator stated it was his expectation that the assessment would accurately reflect the resident's status.

4. Resident # 121 was admitted to the facility on 11/30/15 with diagnoses that included dementia with behaviors, hypertension and arthritis.

The 6/14/16 quarterly Minimum Data Set (MDS) indicated Resident #121 was able to understand, be understood and had clear speech in Section B. The Brief Interview for Mental Status (BIMS), found in Section C of the MDS, was not attempted citing the resident was rarely or never understood.

MDS Nurse #1 was interviewed on 7/14/16 at 12:46 PM. The MDS Nurse stated the MDS nurses were responsible for the completion of Section B and completion of Section C was the responsibility of the Social Worker (SW). The MDS nurse added it was the responsibility of the person completing each section to make sure the information included was accurate and she was only responsible to make sure the MDS had been completed. MDS Nurse #1 reviewed Section C of Resident 121 ' s MDS and stated the instructions directed staff to attempt completion of the BIMS unless the resident was rarely or never

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understood. The MDS nurse stated even after reading the instructions for Section C, she was unable to determine if the information entered by the SW was inaccurate since she had not completed that section of the MDS. The MDS nurse stated the information she had entered in Section B was correct, but continued to say she was unable to determine if Section C was inaccurate since she had not completed the section.

The SW was interviewed on 7/14/16 at 2:13 PM. The SW stated the MDS training she had received had been when the MDS was first introduced in long term care. She added she was unaware that she was to complete Section C of the MDS based on the answers coded in Section B of the MDS that described the Resident #121 ' s ability to understand and to be understood. The SW reviewed the MDS for Resident #160 and stated based on the answers posted in Section B and the instructions for Section C, her section had been coded inaccurately.

5. Resident #160 was admitted on 6/6/12 with diagnoses that included hypertension and arthritis.

Review of the most recent Occupational Discharge summary indicated Resident #160 had a contracture of her left hand.

An Annual Minimum Data Set (MDS), dated 5/3/16, indicated Resident #160 was cognitively intact. She was not identified with functional limitation in range of motion (ROM) of her upper extremities including fingers and her wrist.

An observation was made on 7/13/16 at 11:00

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AM. Resident #160 was lying in bed with rolled washcloths in her bilateral contracted hands.

On 7/14/16 10:25 AM, the Occupational Therapist (OT) was interviewed. She reviewed the most recent OT plan of care and discharge summary and stated based on the assessments, Resident #160 ' s left hand was contracted. On observation at this time, the OT confirmed Resident # 160 ' s right and left hand were contracted.

Nursing Assistant #1 was interviewed on 7/14/16 at 10:45 AM. The NA stated she had worked with the resident for the past 3 months on the day shift and confirmed Resident #160 ' s hands had been contracted when she began working with her.

Nurse #1 was interviewed on 7/14/16 at 11:27 AM. The nurse confirmed Resident #160 ' s left hand had been contracted since admission.

Nurse #2 was interviewed on 7/14/16 at 12:20 PM. She stated she worked with Resident #160 at least 2 days per week and confirmed the resident ' s hands had been contracted "for a while."

The MDS coordinator was interviewed on 7/14/16 at 1:02 PM. The MDS nurse stated she was responsible for completing Section G of the MDS that addressed range of motion. Information for Section G was gathered from therapy notes, direct observation, and interviews with staff. The MDS nurse stated she had not reviewed the OT notes prior to completion of Resident #160 ' s most recent MDS since she usually only reviewed information written during the assessment period. She stated she had not observed Resident #160

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F 278	Continued From page 11 with any contractures of her hand during observations made during the assessment period. The MDS nurse would not confirm an error had been made in failing to document upper extremity contractures for Resident #160.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to care plan specific dental needs for 1 of 3 sampled residents (Resident #121) that was reviewed for dental care and failed to care plan the presence of a contracture and contracture management for 1 of	F 279	1. The care plan for resident #121 will be updated by the MDS Coordinator by 8/5/16 to reflect specific dental needs after clarification with the dentist and attending physician. The care plan for resident #160 will be updated by the MDS	8/11/16

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F 279	Continued From page 12 3 residents (Resident #160) reviewed for contractures. Findings included: 1. Resident #121 was admitted to the facility on 11/30/15 with diagnoses that included dementia with behaviors, anxiety, hypertension and arthritis. Dental exam and evaluation notes dated 4/11/16 assessed oral cleanliness as unsatisfactory with heavy plaque covering Resident #121's teeth. The resident was identified as dependent on staff for daily oral care. Recommendations for daily oral care included hand holding, head support, retraction of lips and cheeks and to have 2 staff people present to assist with the daily cleaning. Additionally, the dentist recommended using a soft toothbrush and fluoride toothpaste. . The Quarterly Minimum Data Set (MDS), dated 6/14/16 indicated Resident #121 was severely cognitively impaired. The MDS also indicated the resident required extensive assistance with personal hygiene. Resident #121's care plan, reviewed on 6/16/16, did not include the dental recommendations for oral care. Nursing Assistant (NA) #2 was interviewed on 7/13/16 at 2:25 PM. The NA stated she had not been made aware of any special instructions for Resident #121's oral care and usually used the pink toothettes for cleaning her teeth. NA #3 was interviewed on 7/13/16 at 3:39 PM. The NA stated Resident #121 was not combative and did not refuse care. She stated she provided oral care before bedtime for Resident #121 using either a toothette or a tooth brush. She stated	F 279	Coordinator by 8/5/16 to reflect the presence of contracture and contracture management including therapy recommendations. 2. The MDS Coordinators/DON/Clinical Manager/Clinical Educator will audit all of the care plans for residents to ensure they include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment by 8/11/16. The MDS Coordinators/DON/Clinical Manager/Clinical Educator will update the care plans as needed at that time. 3. The Director of Nursing (DON)/Clinical Educator/Clinical Manager will audit a random sample of 10% of completed care plans after a comprehensive assessment weekly for 4 weeks to verify that they have been developed, reviewed, and revised to meet the residents needs and include objectives and timetables. They will update care plans as needed at that time. The facility Interdisciplinary team (IDT) will review the residents current comprehensive care plan during their quarterly care plan meeting to verify it has been developed, reviewed, and revised to meet the residents needs and includes objectives and timetables for 3 months. The IDT will update care plans as needed at that time. 4. The facility Quality Assurance and Performance Improvement (QAPI) Committee will review the results of the audits in the monthly QAPI meeting for one month to monitor for completion and accuracy.	

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she had received no special instructions for the resident's oral care.

Nurse #3 was interviewed on 7/13/16 at 4:00 PM. The nurse reviewed the 4/11/16 dental recommendations and stated the care plan would be revised to reflect the specific oral care techniques by the Clinical Manager that received the order.

On 7/13/16 at 4:25 PM, Clinical Manager #1 was interviewed. She stated any recommendation for dental recommendations would be placed on the care guide for the NAs to follow. The Clinical Manager reviewed the 4/11/16 dental recommendations and stated she expected the recommendation to be added to the care plan and the care guide. The care plan revision would be done by either her or the nurse on the hall. The Clinical Manager stated she had not updated the care plan and care guide because she had been unaware of the recommendations.

A telephone interview was held with the Director of Operations (DOO) for the contracted dental service on 7/14/16 at 12:03 PM. She stated the Dental Care Oral Exam and Evaluation form was a worksheet and included recommendations the dentist wished the facility to carry out for the resident. The DOO stated it was the intention of the dentist for the recommendations to be followed in order to provide the best oral care for the resident; adding that ' s why the recommendations had been made for Resident #121.

The dentist that made the recommendations was out of the office and unavailable for interview.

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Nurse #2 stated on 7/14/16 at 12:31 PM that she had received no special instructions for completing oral care for Resident #121.

MDS nurse #1 was interviewed on 7/14/16 at 12:46 PM. She stated any nurse in the facility could revise the care plan; adding the person that had knowledge of the April 2016 dental consult would be the person expected to revise the care plan with the new recommendations. The MDS nurse stated the care plan team had found the recommendations made by the dentist as restraining; therefore, the care plan and care guide for Resident #121 had not been revised to reflect the recommendations. She stated she had not called the dentist to clarify the dental recommendations and had not advised the dentist the facility had no intentions of complying with the recommendations.

The SW was interviewed on 7/14/16 at 2:13 PM. She stated Resident #121 had no care plan for refusing treatment at this time since she had not been informed of any recent refusal of care and the problem had been resolved

2. Resident #160 was admitted to the facility on 6/6/12 with diagnoses that included hypertension and arthritis.

An Annual Minimum Data Set (MDS), dated 5/3/16, indicated Resident #160 was cognitively intact. She was not identified with contractures or limited range of motion in her upper extremities.

The June 2016 Monthly Nursing Summary indicated the resident had contractures/limited range of motion in her arm including shoulder and elbows. There was no indication of hand/wrist

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contractures.

A physician's progress note dated 6/2/16 indicated the resident had degenerative disease and had lost the ability to hold up her head. The MD also noted there was no functional ability in the resident's upper or lower extremities.

The resident's care plan, last reviewed on 6/28/16 did not address the resident's current contractures, contracture management and did not include interventions to prevent the development of further contractures. Review of the undated care guide used by the nursing assistants to direct care revealed no documentation for contracture management or prevention.

An observation was made on 7/13/16 at 11:00 AM. Resident #160 was lying in bed with rolled washcloths in her bilateral contracted hands.

An observation was made and an interview held with the resident on 7/14/16 at 9:53 AM. Resident #160 denied any decline in mobility of any extremity.

On 7/14/16 10:25 AM, the Occupational Therapist (OT) was interviewed. On review of OT notes, written more than a year ago, the OT confirmed at that time, Resident #160 had a left hand contracture, but per documentation had no contracture in her right hand. During an observation at the same time, the OT confirmed Resident #160 was contracted in both hands...

MDS nurse #1 was interviewed on 7/14/16 at 1:02 PM. She stated all nurses were able to revise care plans as needed and there was not one

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F 279	Continued From page 16 person responsible to make sure all resident issues were care planned. The Clinical Manager for Resident #160 was interviewed on 7/14/16 at 2:30 PM. She reviewed the care plan for Resident #160 and confirmed there was no care plan for her contractures or contracture management.	F 279		
F 317 SS=D	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to refer 1 of 2 sampled residents (Resident #160) for therapy services for evaluation and placement of interventions to prevent the development of a right hand contracture. Findings included: Resident #160 was admitted to the facility on 6/6/12 with diagnoses that included hypertension and arthritis. An Annual Minimum Data Set (MDS), dated 5/3/16, indicated Resident #160 was cognitively intact. She required extensive/total assistance for	F 317	1. Resident #160 was evaluated by the Occupational Therapist on 7/15/16 and was started on therapy caseload on this day to be seen five times per week for contracture management, bilateral upper extremity range of motion, and splinting. 2. A licensed therapist performed a therapy screening on all residents not currently on therapy caseload on 7/27 and 7/28/16 to assess for range of motion limitations and contractures. Three other residents were placed on therapy caseload after the screenings for contracture management and/or splinting. 3. The facility has created a Rehab Referral Form to be used to refer	8/11/16

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F 317	Continued From page 17 activities of daily living. Limitation in functional range of motion (ROM) of the upper extremity was not identified on the MDS. Resident #160 was not coded as receiving any therapy services or restorative services during the assessment period. The June 2016 Monthly Nursing Summary indicated Resident #160 had contractures/limited ROM in her arm including shoulder and elbows. A physician's progress note dated 6/2/16 indicated the resident had a physical condition that had caused her to lose the ability to hold her head up and the physician also noted Resident #160 had no use of her upper extremities or lower extremities. The resident's care plan, last reviewed on 6/28/16 did not address the resident's contractures and did not include interventions to limit decline in existing contractures or prevent further contractures. During an interview with Nurse # 1 on 7/12/16 at 11:30 AM, she stated Resident #160 had bilateral hand contractures and received no ROM or splinting. An observation was made on 7/13/16 at 11:00 AM. The resident was lying in bed with rolled washcloths in bilateral contracted hands. An observation was made and an interview held with the resident on 7/14/16 at 9:53 AM. The resident was lying in bed with her head forward. Her chin was laying on her chest. Rolled washcloths were seen in both hands. The resident stated without the washcloths, she was	F 317	residents to therapy who are identified with range of motion and/ or contracture problems. All nursing staff will be inserviced by the Therapy Manager or Clinical Educator by 8/11/16 on the need to refer range of motion and/or contracture problems to therapy and the process for doing so including completion of the Rehab Referral Form. New nursing staff will be inserviced upon hire. The facility Standards of Care committee will review the roster/sample matrix (form CMS 802)in its weekly meeting for 4 weeks to identify residents who have triggered for range of motion, contracture, or positioning declines. The Committee will complete the Rehab Referral Form for those identified with a decline at that time. 4. The minutes of the Standards of Care Committee meetings will be reviewed in the monthly QAPI meeting for 3 months to ensure the Committee is reviewing the sample matrix. The QAPI Committee will also review the Rehab Referral Forms monthly for 3 months to ensure they are being completed as required.	

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able to open her hands fully and added she was able to raise her arms above her head. Review of the care guide at this time, found on back of the bathroom door did not address ROM or any interventions to prevent contractures or further contractures.

On 7/14/16 at 10:11 AM, the Rehabilitation Department Manager (DDM) stated residents were screened upon referral from the nursing department. She added several weeks ago, staff had been in-serviced and rehabilitation rounding had started. The rounding staff included her and the Director of Nursing (DON). The purpose was to make note of any changes in a resident's positioning or functional abilities. The RDM added Resident #160's name had been added to the list; pointing to a handwritten note above her computer that included the resident's name with the word "positioning" beside the resident's name.

At 10:25 AM on 7/14/16, the Occupational Therapist (OT) was interviewed. She stated splinting was important to prevent contractures and maintain skin integrity and hygiene. The OT reviewed the last OT evaluation for Resident #160 that had been completed over a year prior and stated at the time of the evaluation, Resident #160 had a left hand contracture, but had no right hand contracture. At 10:45 AM, the OT observed Resident #160 and verified the resident was unable to fully extend her right or left hand.

On 7/14/16 at 11:03 AM, the RDM and the OT were again interviewed. The OT stated based on the last OT evaluation, Resident #160's right hand contracture had developed in the last year. The RDM stated when she and the DON had made rounds they noticed Resident #160 had not

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been positioned properly. She acknowledged she had not completed a rounding rehabilitation form for Resident #160. Both the OT and the RDM stated in the year they had been working in the facility, they had not received a referral for a screening or evaluation for Resident #160 and no staff member had informed them of Resident #160's functional decline.

An interviewed was held with the Restorative Aide (RA) on 7/14/16 at 11:15 AM. She stated she had worked as a RA for over a year and in that time, Resident #160 had not been on the restorative case load.

Nursing Assistant (NA)#1 was interviewed on 7/14/16 at 11:20 AM. The NA stated she had been working with the resident about 3 months. The NA added when she started working with Resident #160, both her right and left hands had been contracted. NA #1 stated during morning care she tried to gently open the resident's hand to make sure the inside of her hand was clean and tried to keep washcloths in the resident's hands.

Nurse #1 was interviewed on 7/14/16 at 11:27 AM. Nurse #1 stated she was the primary day shift nurse for Resident #160. She added if a decline in ROM was reported or observed, the observation was expected to be placed in the physician's book and a request for a OT evaluation was made. The nurse added she had not observed a right hand contracture and staff had not reported a decline in ROM to her. Nurse #1 stated she had seen wash cloths in the resident's hands for the past two days. She added they had been placed after the surveyor had asked if Resident #160 received any ROM or

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splinting for her contractures.

On 7/14/16 at 12:20 PM, Nurse #2 was interviewed. She stated she had been working with Resident #160 since her admission. The nurse stated the resident did not have a lot of ROM in any extremity. Nurse #2 stated she knew the resident's hands were contracted. At times, the nurses or the NAs would try to provide ROM or place rolled washcloths in her hands to prevent Resident #160's hands from becoming more contracted. Nurse #1 stated she was unsure when Resident #160's right hand had started to contract and had not received any reports of a decline in ROM.

Clinical Manager (CM) #1 was interviewed on 7/14/16 at 2:40 PM. The CM stated the expectation was for any decline in ROM to be reported to the nurse on the hall, who in turn, reports it to the resident's physician. With the physician's order the resident was referred to therapy for an evaluation. The CM stated while she had not made rounds on a daily basis, she had made rounds but had not noticed the development of Resident #160's right hand contracture.

The DON was out of the building and not available for interview.