STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / OXFORD	**500 PROSPECT AVENUE OXFORD, NC 27565**

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 02/07/22 through 02/10/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # YWAO11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted from 02/07/22 through 02/10/22. Event ID # YWAO11. 2 of the 2 complaint allegations were not substantiated.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		3/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/07/2022

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 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review, the facility failed to maintain accurate advance directive information throughout the medical record for 3 of 8 residents reviewed for formulation of advance directives (Resident #29, Resident #38, Resident #85). The findings included: 1. Resident #29 was admitted to the facility on 11/30/21 with diagnoses that included end stage renal disease and dependence on renal dialysis. Resident #29's annual minimum data set (MDS) dated 12/05/21 revealed she was cognitively intact. A review of Resident #29's hard copy chart revealed a Medical Orders for Scope of Treatment (MOST) form dated 12/09/21. The	F 578	F578 Resident #29 code statis was added to the Care Plan, Director of Nursing and/or MDS Nurse by 2/9/22 Resident #38 Physician order clarified and changed to a DNR by the Director of Nursing/designee 2/9/22 Resident #85 code statis was corrected to reflect DNR on Care Plan and the Electronic Medical Record by MDS Nurse on 2/9/22 100% audit was completed by MDS Nurse on 2/9/22, for All residents' charts for physician orders, E.H.R, bed board, and Care plans, any discrepancies were corrected on 2/9/22 Nurses and Interdisciplinary team have in serviced on proper procedure by DON/Designee, by 3/15/11	

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F 578	Continued From page 2 form stated Resident #29 should have full scope of treatment and cardiopulmonary resuscitation (CPR) should be initiated. Resident #29's hard copy chart had a signed Full Code Agreement form dated 12/09/21. A review of the electronic health record (EHR) revealed Resident #29's information bar (referred to as Bed Board by facility staff) listed resident specific information. It indicated Resident #29 was a Do Not Resuscitate (DNR). The DNR status was added 12/14/21. Review of Resident #29's EHR revealed an active physician's order for Full Code status dated 12/15/21. On 02/08/22 at 10:05 AM, a review of Resident #29's medical records revealed there was no care plan for code status. In an interview with the resident on 02/09/22 at 10:12 AM, she stated she had spoken with facility staff regarding her advance directives. Resident #29 wanted to be a full code and stated, "I told them they better" perform CPR if needed. An interview was conducted with Nurse #1 on 02/09/22 at 11:50 AM. Nurse #1 stated when a nurse needed to know a resident's code status, they can look in the hard copy chart and in the EHR. Nurse #1 reviewed Resident #29's code status in the EHR. She indicated the resident's information bar revealed a DNR status and the physician's orders revealed the resident was a Full Code. Nurse #1 stated she was unsure of why there was a discrepancy, but it was a good reason why nurses should look in a resident's	F 578	Code status is created upon admission per resident, family. Physician collaboration, by Admissions Director. New communication form created and implemented for hall nurses, on 2/10/22. Nurse and admissions to sign off as receiving and emailed to the interdisciplinary team. During the admission process the code status will be part of the admission packet and included in the E.H.R, physician order, golden rod, and MOST form will be placed on the resident chart, Admissions Director, and Charge Nurse. Code status will be updated with the quarterly assessments, significant changes, annual assessments, and per resident, by MDS Nurse/designee. A weekly audit will be completed by the interdisciplinary team weekly for 4 weeks, then monthly for 3 months, The Director of Nursing and/or Administrative Staff will complete a summary of these audit results and present at the facility monthly Quality Assurance and Performance Improvement (QAPI), to ensure continued compliance.	

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F 578	Continued From page 3	F 578		

hard copy chart for advance directive information.

An interview with MDS Nurse #1 and MDS Nurse #2, on 02/09/22 at 2:04 PM revealed they were responsible for care planning advance directives. Code statuses and MOST forms were verified at every care plan meeting. The physician's orders for code status were printed and reviewed with the resident or resident representative and care plan changes were made if needed. MDS Nurse #1 and MDS Nurse #2 reviewed Resident #29's care plan and stated there was no care plan for code status, indicating "she fell through the cracks."

2. Resident #38 was admitted to the facility on 07/20/21 with diagnoses that included cerebrovascular disease and aphasia following cerebral infarction.

A review of Resident #38's EHR revealed an active physician's order for Full Code status dated 07/20/21.

A review of Resident #38's hard copy chart revealed a MOST form dated 07/22/21. The form stated Resident #38 should not be resuscitated and was indicated as a DNR with limited additional interventions.

Resident #38's hard copy chart had a signed No Code Agreement form dated 07/22/21 as well as a physician signed DNR form dated 07/22/21.

A review of Resident #38's EHR revealed the resident's information bar indicated he was a DNR. The DNR status was added on 07/23/21.

On 02/08/22 at 10:48 AM, a review of Resident

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F 578	Continued From page 4	F 578		

#38's care plan dated 11/01/21 revealed a care plan for DNR status. The care plan indicated the resident wished to be honored as a DNR through the next review.

Resident #38's quarterly MDS dated 12/02/21 revealed his cognition was not assessed due to him being rarely understood.

In an interview with Nurse #1 on 02/09/22 at 11:50 AM, she reviewed the code status documentation for Resident #38. She stated the resident's information bar indicated he was a DNR, and the physician's order indicated he was a Full Code. Nurse #1 stated a nurse or doctor would have to update a code status order.

An interview was conducted with the resident's representative on 02/09/22 at 1:56 PM. She stated she did not remember if staff spoke with her regarding the resident's wishes. She further explained the last time she discussed advance directives with Resident #38, he stated he didn't want life sustaining measures.

3. Resident #85 was admitted to the facility on 10/26/21 with diagnoses that included end stage renal disease and dependence on renal dialysis.

A review of Resident #85's hard copy chart revealed a MOST form dated 10/14/21. The form stated Resident #85 should not be resuscitated and was indicated as a DNR with limited additional interventions.

Resident #85's hard copy chart had a signed No Code Agreement form dated 10/14/21 as well as two physician signed DNR forms dated 10/11/21 and 10/22/21.

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A review of Resident #85's EHR revealed an active physician's order for DNR status dated 10/26/21.

Review of the EHR revealed Resident #85's information bar indicated CPR should be attempted for the resident. The CPR status was added on 10/27/21.

On 02/08/22 at 1:52 PM, a review of Resident #85's care plan dated 07/26/21 and reviewed on 01/14/22 revealed the resident wished to be a Full Code.

Resident #85's quarterly MDS dated 01/14/22 revealed she was cognitively intact.

An interview was conducted with Nurse #1 on 02/09/22 at 11:50 AM. She reviewed Resident #85's medical record and stated CPR was indicated in the resident information bar and there was an active physician's order for DNR.

In an interview with Resident #85 on 02/09/22 at 3:45 PM, the resident stated she had spoken with her daughter regarding her wishes and did not want to discuss the issue further.

An interview was conducted with Nurse #2 on 02/09/22 at 11:16 AM. Nurse #2 stated she looked in a resident's hard copy chart when she was unfamiliar with the code status. She did not look in the EHR for code status information.

An interview was conducted with the social work coordinator on 02/09/22 at 12:35 PM. She stated she did not have a role in code status documentation.

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F 578	Continued From page 6 In an interview with the admissions coordinator on 02/09/22 at 12:40 PM, she stated advance directive paperwork was completed upon a resident's admission. Nurses wrote orders for code statuses and completed updates when there was a change in status. In an interview with the director of nursing (DON) on 02/09/22 at 4:01 PM, she stated MDS nurses entered and updated care plans for code status as they received copies of the physician's orders. Nurses could look in Bed Board for code status information, but the most current information was in the hard copy chart. This information included MOST forms and DNR forms. The DON stated the physician's order should be updated when a code status changed, and code status documentation should be the same in all places. She further indicated education had been provided to staff to look in the hard copy chart for the most current advance directive information. An interview was conducted with the Administrator on 02/10/22 at 9:30 AM. She stated nurses and the admissions coordinator updated code status information in the EHR. All residents should have a care plan for code status and code status information should be the same in all areas that it was documented.	F 578		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		3/15/22

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F 679	Continued From page 7 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an on-going resident centered activities program based on identified individual interests for 2 of 2 cognitively impaired residents reviewed for activities (Resident #61 and #79). The findings included: 1. Resident #61 was admitted to the facility on 10/29/21. The diagnoses included cognitive impairment and communication deficit. The quarterly Minimum Data Set (MDS) dated, coded Resident #61 ' s cognition was moderately impaired and needed assistance with activities of daily living. Review of the activity assessment dated 11/2/21, revealed resident preference in group activities with interest in religious services, listening to music, books, magazines, newspaper, outdoor activities, and current events. Review of the care plan dated 11/2/21 identified the problem as Resident #61 was unable to participate in usual daily routine. Resident #61 was at risk for loneliness, anxiety, and sadness related to isolation precaution implemented due to COVID-19. The goal included Resident #61 would return to usual routine in 90 days. Interventions included: Resident#61 would be assisted to get to preferred activities. Additional,	F 679	F678 On 2/13/22 Resident # 61 and #79 were added to the 1:1 activity log by the Activity Director. -100% audit was completed by Activity Director/designee on all activity assessments, 2/10/22, to verify resident preference for activities for daily living. Activity staff in serviced by L.N.H.A, on 3/2/22, on proper procedure. Upon admission new residents will have activity assessment completed by the Activity Director/designee and determine residents' preference for activities On 2/11/22 Weekly room visits have been added to the monthly calendar by the Activity Director to ensure all residents requiring one on one receive appropriate stimulation. On 2/11/22 an in-room visit documentation book was developed by the Activity Director and visits will be documented as they occur The Activity Director/Interdisciplinary team will review activity assessments on admission and on a quarterly basis, with a	

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F 679	Continued From page 8 interventions included Resident #61 would be assisted phone calls; emails; social media; or other cyber contact with loved ones, 1:1 visit with staff; reading; playing with puzzles; conversations or other resident desired activity. Activities to maintain engagement and provide a calming atmosphere and music small groups. Review of the facility scheduled activity calendar for 2/7/22 indicated at 10:30 AM work out, 11:15 AM horse race (held in main dining room), 2:00 PM jewelry making and 3:00 PM social. A continuous observation was conducted 2/7/22 at 2:30 PM to 3:30 PM, Resident #61 was in her room sitting in wheelchair with no television on or stimulation of any. The scheduled activities during the time of observation were jewelry making and social event. Review of the facility scheduled activity calendar for 2/8/22 indicated: at 10:30 AM bible reading, 11:15 AM nail salon, 2:00 PM bingo, and 3:00 PM collage art. A continuous observation was conducted on 2/8/22 at 8:00 AM to 11:30 AM, Resident #61 was in her room sitting in her wheelchair with no television on or any other form of stimulation. The scheduled activities during the time of the observation were bible reading and nail salon. A continuous observation was conducted on 2/8/22 at 11:30 AM to 12:30 PM, Resident #61 was in sitting in her room in wheelchair with no television on and was observed staring ahead with a flat affect. Resident remained in room 12:30 PM resident in room with no television on /or other stimulation. Staff were observed in and out of the resident ' s room with the lunch meal.	F 679	significant change, and annual assessments. 5 charts per week x 4 weeks, then monthly times 3 months. The Activities director will complete a summary of audit results and present at the facility monthly QAPI meeting, to ensure continued compliance.	

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Review of the activity sheet which was a piece of paper dated 2/8/22 completed by Activity Assistant who documented the activity staff provided Resident #61 1:1 music activity at 12:30 PM.

A continuous observation was conducted 2/8/22 at 2:00 PM to 3: 30 PM of Resident #61 seated in her room. The observation revealed she was not provided with any form of activity or stimulation while in her room. The television and the radio were off. The scheduled activities during the time of the observation were bingo at 2:00 PM and collage art at 3:00 PM.

An interview was conducted 02/09/22 at 8:54 AM, the Activity Director (AD) who stated that 1:1 in room activities were Resident# 61 ' s preference which included story time, music, sensory stimulation of hand rubs and television of her choice and family visits. The AD further stated the documentation of the resident's response would be in the activities note. The Activity Director could not confirm Resident #61 received any 1:1 activity or been offered any group activities of preferences based on the activities that were being provided. The AD further stated he did not have a specific 1:1 schedule that was consistent with residents who needed 1:1 activity or that assistance was provided for residents to participate in small group activities. The AD further stated the resident participation in group activities were not rotated among other residents who had an interest in the group activity being conducted.

An interview was conducted on 2/10/22 9:26 AM with the Activity Assistant (AA). The activity sheet

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for Resident #61 that indicated a 1:1 activity was provided on 2/8/22 at 12:30 PM was review with the AA. The AA revealed that a 1:1 activity was not provided or offered to Resident #61 on 2/8/22 at 12:30 PM and she was unable to explain why this was documented on the activity sheet.

An interview was conducted on 2/9/22 at 4:45 PM, the Director of Nursing (DON) who stated the activities team was responsible for ensuring all residents were offered and encouraged to participate in activities of interest. The activities staff could ask for assistance from unit staff to escort residents to activities and rotate resident participation in activities while maintaining the COVID-19 protocol. The DON stated the AD should have a designated scheduled to provide 1:1 activity for residents who need assistance.

An interview was conducted on 2/10/22 at 9:15 AM, the Administrator stated the expectation was for the activities team to develop a program, to include residents in small group activities and develop a system to ensure residents received 1:1 activity. The activities staff would be documenting participation and refusal of activities in notes.

2. Resident #79 was admitted to the facility on 1/29/15. The diagnoses included cognitive impairment, communication deficit. The quarterly Minimum Data Set (MDS) dated, coded Resident #79 ' s cognition was severely impaired and needed assistance with activities of daily living.

Review of the activity assessment dated 9/30/21, revealed Resident #79 ' s activity preference was for group activities with interests in, music, religious, outdoor activities, current events,

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movies, plays/theatre and dining out.

Review of the care plan dated 10/10/21 identified the problem as Resident #79 was at risk for loneliness, anxiety, sadness related to isolation implemented due to COVID. The goal included Resident #79 would indicate when additional support was needed to address feelings of loneliness, anxiety, and sadness. Interventions included as follows: Resident #79 would be assisted with phone calls, emails, social media, other cyber contact with loved one; and 1:1 visit with staff for reading, playing puzzles, conversations or other resident desired activity; activities to maintain engagement and provide a calming atmosphere; music, small groups aroma therapy, favorite movies, audio books or another activity preferred by the resident; and Resident #79 would be assisted with diversional activities.

Review of the facility scheduled activity calendar for 2/7/22 indicated: at 10:30 AM work out, 11:15 AM horse race (held in main dining room), 2:00 PM jewelry making and 3:00 PM social.

Observation was conducted on 2/7/22 at 1:00 PM. Resident #79 was seated in her room in a geriatric chair (a cushioned reclining chair). There were no activities or stimulation provided to Resident #79.

Observation was conducted 2/7/22 at 2:00 PM, Resident #79 was sitting in her geriatric chair (geri-chair) with no activities provided or other stimulation. The television remained off. The jewelry making activity was scheduled at 2:00 PM.

Review of the facility scheduled activity calendar

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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F 679	Continued From page 12	F 679		

for 2/8/22 indicated: at 10:30 AM bible reading, 11:15 AM nail salon, 2:00 PM bingo, and 3:00 PM collage art.

Observation was conducted on 2/8/22 at 1:30 PM. Resident #79 was seated in her geri-chair in her room with no television/radio or other stimulation in place. The resident was observed talking to self.

Observation was conducted on 2/8/22 at 3:00 PM. Resident #79 was seated in her geri-chair in her room and there were no activities provided, there was no television/radio on. Resident #79 was observed talking to self. The collage art activity was scheduled at 3:00 PM.

An interview was conducted 02/09/22 at 8:54 AM, the Activity Director (AD) who stated that 1:1 in room activities were Resident #79 ' s preference which included story time, music, sensory stimulation of hand rubs and television of her choice and family visits. The AD further stated the documentation of the resident's response would be in the activities note. The Activity Director could not confirm Resident #79 received any 1:1 activity or that she had been offered any group activities of preferences based on the activities that were being provided. The AD further stated he did not have specific 1:1 schedule that was consistent with residents who needed 1:1 activity or that assistance was provided for residents to participate in small group activities. The AD further stated the resident participation in group activities were not rotated among residents who had an interest in the group activity being conducted.

An interview was conducted on 2/10/22 9:26 AM

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F 679	Continued From page 13 with the Activity Assistant (AA) who stated she had been informed by the AD on 2/8/22 a new system would be implemented to ensure residents were encouraged and assisted to activities of interest. In addition, a new schedule or 1:1 resident activity would be developed for residents who require 1:1 activity on a weekly basis. An interview was conducted on 2/9/22 at 4:45 PM, the Director of Nursing (DON) who stated the activities team was responsible for ensuring all residents were offered and encouraged to participate in activities of interest. The activities staff could ask for assistance from unit staff to escort residents to activities and rotate resident participation in activities while maintaining the COVID-19 protocol. The DON stated the AD should have a designated scheduled to provide 1:1 activity for residents who need assistance. An interview was conducted on 2/10/22 at 9:15 AM, the Administrator stated the expectation was for the activities team to develop a program, to include residents in small group activities and develop a system to ensure residents received 1:1 activity. The activities staff would be documenting participation and refusal of activities in notes.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		3/15/22

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F 688	Continued From page 14 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed provide splinting application per therapy recommendations for 1 of 1 sample residents (Resident # 79) reviewed for range of motion/contracture. The findings included: Resident #79 was admitted to the facility on 1/29/15, with diagnoses included cerebral vascular accident and hemiplegia/ hemiparesis and left side contractures of wrist and hand. The quarterly Minimum Data Set (MDS) dated 9/30/21, revealed Resident #79 was cognitively impaired and required total assistance with all activities of daily living. The MDS revealed Resident #79 had functional impairment to the upper and lower extremities on one side. The MDS did not documented the use of the splint. Review of physician orders dated 9/27/21, revealed Resident #79 wear left hand/wrist orthotic 4-6 HOURS DAILY. Review of care plan dated 10/10/21 identified the problem as Resident #79 had impaired mobility to	F 688	F688 Resident #1 did not have any negative outcomes due to this deficient practice. Therapy evaluated resident #1 on 2/10/2022 and determined resident would benefit from the use of splints. Splints were applied on 2/10/22. -Facility will identify any current and future residents related to the need for splints. A 100% audit of all current residents has been completed, by the Rehab Director to be completed by 3/15/22. Residents identified that would benefit from the use of splints were evaluated by therapy and necessary interventions were implemented. Therapy and Nursing staff were reeducated on Range of Motion policy by the Rehab director/designee, by 3/15/22. A communication form was implemented for the nursing staff by therapy to communicate the use of splints/assistive devices by any resident requiring this	

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F 688	Continued From page 15 left upper and lower extremity related to Hemiplegia. The goal included Resident #79 would have evidence no decline in contracture status without interventions in place. Interventions include Resident #79 would be periodically assessed for the status of range of motion (ROM) to bilateral upper and lower extremities and notify physician of changes. Refer to therapy as needed, Notify physician of change or pain with ROM. The care plan did not document the frequency for the use of the splint or measurable goals. Review of the Occupational Therapy discharge summary dated 1/7/22, documented diagnoses as hemiplegia, following unspecified cerebrovascular disease affecting right non-dominant side, contracture of left hand. The short-term goal included Resident #79 would tolerate passive range of motion (PROM)/prolong stretch to L-wrist and fingers x 10 minutes to maintain flexible wrist contracture and improve ROM for hand hygiene and orthotic wear. Resident #79 would safely wear a wrist cock up splint and hand roll on left wrist/hand for up to 1 hour without signs/symptoms of redness, swelling discomfort or pain. Resident #79's primary caregivers would demonstrate ability to perform left-hand don/off orthotic according to wear schedule with 100% accuracy to maintain optimal skin and joint integrity. Functional maintenance program/established/trained: L wrist cock up splint with T-bar style foam buildup x 2hour daily wear left hand washcloth handroll following daily splint wear for skin integrity. Observation was conducted on 2/07/22 at 1:00 PM. Resident #79 had a left-hand contracture and there were no splints or hand roll present.	F 688	equipment. This communication form will be discussed daily Monday thru Friday in the clinical morning meeting, Rehab director and nursing staff, to ensure the use of adaptive equipment is communicated to staff and available for use. The care plans will be updated accordingly by the MDS Nurse/designee. This meeting will begin Rehab will audit all residents who have recommendations for splints weekly for 4 weeks and then monthly times 3 months, to ensure compliance. The Rehabilitation director will complete a summary of these audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 688	Continued From page 16 The splint was in a yellow mesh bag place inside of a Christmas bag located on the resident nightstand behind the privacy curtain. Observation was conducted 2/7/22 at 2:00 PM, Resident #79 was sitting in her geri-chair with no activities provided or other stimulation, television playing resident and resident had no comprehension of what was playing. There was no splint / hand roll in place. The splint remained located in the Christmas bag on bedside table behind privacy curtain. Observation was conducted on 2/8/22 at 1:30 PM, Resident #79 was seated in geri-chair with no splint/hand roll in place, The splint remained located in Christmas bag on the nightstand. Observation was conducted on 2/8/22 at 3:00 PM, Resident #79 was seated in geri-chair in her room with no splint/handroll in place. The splint remained in the Christmas bag located on the nightstand. Observation was conducted on 2/9/22 at 9:58 AM, Resident #79 was seated in geri-chair nicely groomed with no splint or hand roll in place. The splint was in a Christmas bag. An interview was conducted on 2/9/22 at 11:38 AM, Nurse #2 stated she was unaware Resident #79 wore a splint or where the splint was located. Nurse #2 checked Resident #79 ' s skin condition on her hands prior to NA#1 applying the splint. An interview was conducted on 2/9/22 at 11:40 AM, Nurse Aide #1(NA) informed Nurse #2 that Resident #79 should wear the left-hand splint daily and therapy and restorative aides were	F 688		

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responsible for the application of the splint. NA#1 removed the splint from the Christmas bag that was located on the nightstand behind the privacy curtain. She applied the splint in the presence of Nurse #2. NA#1 further stated she was unaware of Resident #79 ' s full restorative program.

An interview was conducted on 2/9/22 at 11:50 AM, Nurse#1 stated when a resident was involved in therapy, the therapy department would be responsible for the application of splint until completion of therapy. Therapy would then provide the restorative coordinator and restorative aides and nurse aide with specific training on the application process and frequency. The Restorative Coordinator would then update the treatment administration record (TAR), verify physician orders, and submit order forms for treatment and give information to the Minimum Data Set (MDS) coordinators to update the care plan. Nurse #1 further stated the restorative aide (RA)/NA all have access to resident care plan so they can review the updates to the care plan. Nurse #1 reviewed the physician order dated 9/27/21 and confirmed the left-hand splint should be worn for 4-6 hours. There was not frequency of when to start or end the splint application. Nurse #1 stated she was unaware of the specifics of the resident's actual restorative program or her needs.

An interview was conducted on 2/9/22 at 12:00 PM, the Physical Therapist stated when a resident was receives services through therapy, therapy would perform the splint application until therapy completion. Once therapy was completed, the physician orders would be verified, staff would receive education/training on the application, the restorative nurse/coordinator

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would be responsible for ensuring the RA were performing the application of the splint.

An interview was conducted on 2/9/22 at 12:05 PM, NA#2 stated she was not responsible for the application of splint, the RA was responsible for the application. When asked about handroll application she stated she was unaware the resident should have a hand roll.

An interview on 2/9/22 at 12:10 PM, Restorative Aide #2(RA) stated she was unaware of Resident #79 ' s restorative program for splint/hand roll application. RA#2 stated she only worked with the resident during meals. She reported when the restorative nurse and/or DON give her the restorative program with the specifics on what needed to be done for a resident was how she knew what needed to be performed. RA#2 stated she had no paperwork for the resident splint or hand roll.

An interview on 2/9/22 at 12:30 PM, the Director of Nursing (DON) stated the therapy would apply splints during therapy session until completion of therapy. Therapy would provide nursing with the recommendations/orders to be conveyed to the physician so the orders could be written, and training/education would be provided to Ras/NAs. The restorative coordinator/nurse would then verify orders and develop the program guidelines and specifics that would include time for donning/doffing frequency in the care plan as well as the TAR. The DON further stated all staff are expected to receive training/education on the application of splints and assist the RA in ensuring the splints were applied as ordered. The Restorative nurse/coordinator was responsible for follow-up/monitoring to ensure splints were being

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F 688	Continued From page 19 applied. Nursing was responsible for documenting on the TAR and MDS responsible for updating the care plan.	F 688		