STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165284	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNY KNOLL CARE CENTRE	**135 WARNER STREET ROCKWELL CITY, IA 50579**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy review, the facility failed to report an allegation of physical abuse to the Iowa Department of Inspections & Appeals (DIA) immediately as required for 1 of 1 residents reviewed. (Resident #8) The facility reported a census of 18 residents. Findings included: According to the Minimum Data Set ((MDS) dated [DATE], Resident #8 admitted to the facility on [DATE]. The MDS listed Resident #8 as an assist of 2 staff for transfers and the assistance of 1 staff for bed mobility. Resident #8 had the following Diagnoses: [REDACTED]. The MDS listed the resident scored 4 out of 15 on the Brief Interview for Mental Status (BIMS) indicating severely impaired cognitive function. During a staff interview on 7/15/20 at 12:29 p.m. Staff A - Certified nurse aide, (CNA) stated Staff B an Agency Licensed Practical Nurse (LPN) handled Resident #8 roughly. Staff A stated that she and Staff B transferred the resident into bed the other night and Staff B grabbed Resident #8 up by the front of his shirt and roughly tossed him back into his bed as Staff A lifted Resident #8's feet into bed. Staff A stated she reported the incident to the Director of Nursing (DON) the same morning it occurred. During an interview with DON on 7/16/20 at 1:39 p.m., she stated she did not receive any recent allegations of abuse of staff towards a resident. The DON stated she did not speak to Staff A regarding the incident with Resident #8. Review of the facility's policy for Abuse Prevention and Reporting, revised 08/2019, listed the definition of Physical abuse included hitting, slapping, pinching, scratching, spitting, holding roughly, etc. The policy further stated that staff are to notify their shift supervisor immediately if suspected abuse, neglect, mistreatment or misappropriation of property occurs. They are to report to the Administrator and/or DON immediately so that they can notify appropriate state agencies.
F 0636 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to complete an comprehensive Minimum Data Set (MDS) assessments for 5 of 16 resident's reviewed (Resident #9, #12, #13, #14, and #16). The facility reported a census of 18 residents. Findings include: 1. Resident # 9 admitted into the facility on [DATE]. The resident's clinical record revealed the following Diagnoses: [REDACTED]. Clinical record review of the Electronic Health Record (EHR) on 7/16/20 at 10:26 a.m. revealed that Resident #9 admission Minimum Data Set (MDS) contained an assessment reference date (ARD) of 7/13/20 and required completion by 7/15/20. The facility did not complete the MDS assessment On 7/21/20 at 9:32 a.m., the Director of Nursing (DON) verified she did not complete Resident #9's admission MDS within the 1st 14 days as required due to the corporate registered nurse consultants assigned to complete the MDS completion task. The DON did not know that the admission/comprehensive MDS was not completed on time. A facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,[DATE] defined the RAI/ MDS as an assessment tool that assists skilled nursing facility staff to accurately and routinely compile information regarding resident needs and strengths to facilitate the development of an individualized care plan for the resident. The policy further stated the initial admission comprehensive assessment must be completed within 14 days of admission to the nursing home by assigned members of the interdisciplinary team. Comprehensive assessments or full assessments include the admission, significant change, significant correction or prior full assessment, and annual assessments. 2. According to the Minimum Data Set ((MDS) dated [DATE], Resident #12 admitted to the facility on [DATE]. The MDS listed resident was independent with bed mobility, transfers, eating and walking in room. The MDS listed BIMS score of 0 out of 15 which indicated severely impaired cognitive function. The MDS listed [DIAGNOSES REDACTED]. Clinical record review of the EHR on 7/20/20 at 8:30 a.m. revealed that Resident #12's admission Minimum Data Set (MDS) had an ARD of 7/10/20 and required completion by 7/13/20. On 7/21/20 at 9:32 a.m., DON verified Resident #12's admission MDS not completed within the 1st 14 days as required. DON stated the MDS assessments were not completed by facility staff at this time as the corporate registered nurse consultants completed the MDS task. The DON did not know the admission/comprehensive MDS was not completed on time. A facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,[DATE] defined the RAI/ MDS as an assessment tool that assists skilled nursing facility staff to accurately and routinely compile information regarding resident needs and strengths to facilitate the development of an individualized care plan for the resident. The policy further stated the initial admission comprehensive assessment must be completed within 14 days of admission to the nursing home by assigned members of the interdisciplinary team. Comprehensive assessments or full assessments include the admission, significant change, significant correction or prior full assessment, and annual assessments. 3. According to the MDS dated [DATE], Resident #13 admitted to the facility on [DATE]. The MDS listed resident as an extensive assist of 2 staff with bed mobility, transfers, dressing and toileting. The MDS listed BIMS score of 5 out of 15 which indicated severely impaired cognitive function. The MDS listed [DIAGNOSES REDACTED]. Clinical record review of the EHR on 7/20/20 at 8:30 a.m. revealed Resident #13's annual MDS contained an ARD (assessment reference date) of 7/3/20 and required completion by 7/17/20. The facility did not complete the MDS assessment within 366 days of the last annual MDS which was completed on 7/7/19. On 7/21/20 at 9:32 a.m., DON verified Resident #13's annual MDS not completed within the 366 days as required per RAI schedule due to the corporate registered nurse consultants assigned the MDS completion task. The DON did not know the annual/comprehensive MDS was not completed on time. A facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,[DATE] defined the RAI/ MDS as an assessment tool that assists skilled nursing facility staff to accurately and routinely compile information regarding resident needs and strengths to facilitate the development of an individualized care plan for the resident. The policy further stated the initial admission comprehensive assessment must be completed within 14 days of admission to the nursing home by assigned members of the interdisciplinary team. Comprehensive assessments or full assessments include the admission, significant change, significant correction or prior full assessment, and annual assessments. Annual assessments with CAAS (Care Area Assessments) must be completed within 366 days of previous full assessment. 4. According to the MDS dated [DATE], Resident #14 admitted to the facility on [DATE]. The MDS listed resident as an extensive assist of 2 staff with bed mobility, transfers, dressing and toileting. The MDS listed BIMS score of 10 out of 15 which indicated moderately impaired cognitive function. The MDS listed [DIAGNOSES REDACTED]. Clinical record review of the EHR on 7/20/20 at 8:30 a.m. revealed that Resident #14's annual MDS had an ARD of 7/3/20 and required completion by 7/16/20. The facility did not complete the MDS assessment within 366 days of the last annual MDS which they completed on 7/7/19. On 7/21/20 at 9:32 a.m., DON verified Resident #14's annual MDS not completed within the 366 days as

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) required per RAI schedule due to the corporate registered nurse consultants assigned the MDS completion task. The DON did not know the annual MDS was not completed on time. A facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,[DATE] defined the RAI/ MDS as an assessment tool that assists skilled nursing facility staff to accurately and routinely compile information regarding resident needs and strengths to facilitate the development of an individualized care plan for the resident. The policy further stated the initial admission comprehensive assessment must be completed within 14 days of admission to the nursing home by assigned members of the interdisciplinary team. Comprehensive assessments or full assessments include the admission, significant change, significant correction or prior full assessment, and annual assessments. Annual assessments with CAAS (Care Area Assessments) must be completed within 366 days of previous full assessment. 5. According to the MDS dated [DATE], Resident #16 admitted to the facility on [DATE]. The MDS listed resident as an extensive assist of 2 staff with bed mobility, transfers, dressing and toileting. The MDS listed BIMS score of 0 out of 15 which indicated severely impaired cognitive function. The MDS listed [DIAGNOSES REDACTED]. Clinical record review of the EHR on 7/20/20 at 8:30 a.m. revealed that Resident #16's annual MDS had an ARD of 7/3/20 and required completion by 7/17/20. The facility did not complete the MDS assessment within 366 days of the last annual MDS which was completed on 7/7/19. On 7/21/20 at 9:32 a.m., DON verified Resident #16's annual MDS not completed within the 366 days as required per RAI schedule due to the corporate registered nurse consultants assigned the MDS completion task. The DON did not know the annual MDS was not completed on time. A facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,[DATE] defined the RAI/ MDS as an assessment tool that assists skilled nursing facility staff to accurately and routinely compile information regarding resident needs and strengths to facilitate the development of an individualized care plan for the resident. The policy further stated the initial admission comprehensive assessment must be completed within 14 days of admission to the nursing home by assigned members of the interdisciplinary team. Comprehensive assessments or full assessments include the admission, significant change, significant correction or prior full assessment, and annual assessments. Annual assessments with CAAS (Care Area Assessments) must be completed within 366 days of previous full assessment.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment for 1 of 16 resident's reviewed (Resident #11). The facility reported a census of 18 residents. Findings included: 1. The Quarterly MDS dated [DATE] revealed Resident #11 required extensive assist of 1 staff with bed mobility, transfers, dressing, and toileting. Resident #11 scored 9 out of 15 on the Brief Interview for Mental Status (BIMS) test indicating moderately impaired cognitive functioning. The MDS documented [DIAGNOSES REDACTED]. Clinical record review of the Electronic Health Record (EHR) on 7/20/20 at 8:30 a.m. revealed Resident #11's quarterly MDS with an assessment reference date (ARD) of 7/2/20 required completion by 7/16/20. The MDS assessment was still open in the EHR and was not completed. The resident's previous quarterly MDS completed on 4/7/20. On 7/21/20 at 9:32 a.m., Director of Nurses (DON) verified Resident 11's quarterly MDS as late. The DON stated facility staff did not complete MDS assessments at this time. The corporate registered nurse consultants were assigned to complete the MDS task. The DON did not know Resident # 11's quarterly MDS did not get completed on time. A facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,[DATE] defined the RAI/ MDS as an assessment tool that assists skilled nursing facility staff to accurately and routinely compile information regarding resident needs and strengths to facilitate the development of an individualized care plan for the resident. The policy further stated quarterly assessments need to be completed within 92 days of the previous ARD.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to complete a baseline care plan within 48 hours of admission into the facility for 1of 2 residents reviewed (Resident# 9). The facility reported a census of 18 residents. Findings included: Resident # 9 admitted into the facility on [DATE]. Review of Resident #9's medical record lacked documentation of a completed baseline care plan or that the facility reviewed a plan of care with the resident or with the resident's representative. On 7/21/20 at 9:32a.m. DON (Director of Nursing) stated she started Resident # 9's baseline care plan on 7/2/20 but never completed it. DON confirmed that facility did not have a policy for baseline care plan.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview the facility failed to assure residents received 2 baths per week for 3 of 8 sampled residents reviewed, (Resident #3, Resident #6 and Resident # 8) . The facility reported a census of 18 residents. Findings included: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #3 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assist of 2 staff with activities with daily living (ADL's) including bed mobility, transfer, toileting, dressing and bathing. The MDS listed [DIAGNOSES REDACTED]. The current care plan revised 6/25/20 identified the resident with an ADL self-care performance deficit related to activity intolerance, [MEDICAL CONDITION] and deconditioning. The care plan lacked interventions for bathing. The facility bath records lacked documentation the resident received a bath twice weekly between: a. 5/31/20-6/6/20 b. 6/7/20-6/13/20 c. 6/28/20 -7/4/20 (received 1 bath on 7/2/20). 2. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #6 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assist of 1 staff with activities with daily living (ADL's) including bed mobility, transfer, toileting, dressing and bathing. The MDS listed [DIAGNOSES REDACTED]. The current care plan revised 4/20/20 identified the resident with an ADL self-care performance deficit related to impaired balance. The care plan stated that Resident #6 required staff supervision to transfer on to bath chair and assist of 1 with bathing. The facility bath records lacked documentation resident received a bath twice weekly between: a. 5/31/20-6/6/20 (received 1 bath on 6/3/20) b. 6/14/20-6/20/20 (received 1 bath on 6/15/20) c. 6/28/20 -7/4/20 (received 1 bath on 6/29/20) 3. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #8 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assist of 1 staff with activities with daily living (ADL's) including bed mobility, transfer, toileting, dressing and bathing. The MDS listed [DIAGNOSES REDACTED]. The current care plan revised 7/20/20 identified the resident with an ADL self-care performance deficit related to activity intolerance, dementia, impaired balance, and stroke. The care plan stated that Resident #8 required an assist of 1 with bathing. The facility bath records lacked documentation resident received a bath twice weekly between: a. 6/7/20-6/13/20 b. 6/14/20-6/20/20 (received 1 shower on 6/14/20) c. 6/21/20-6/27/20 c. 6/28/20 -7/4/20 (received 1 shower on 6/29/20) During an interview on 7/21/20 at 9:32 a.m., the Director of Nursing (DON) stated the facility worked on getting the residents at least 2 baths per week and that most resident's usually get 1 bath per week. During an interview with the Administrator on 7/21/20 at 1021 am, the Administrator stated she expected all residents would receive 2 baths a week unless they refused.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, resident interview and facility policy review, the facility failed to ensure resident's with limited range of motion or assistive devices received appropriate care, treatment and services to maintain current range of motion and/or to prevent further decrease in range of motion for 4 of 4 residents reviewed. (Resident # 1, Resident #2, Resident #5, and Resident #10). The facility reported a census of 18 residents. Findings included: 1. According to the MDS dated [DATE], Resident # 1 had a BIMS score of 15 that indicated intact

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) cognitive function. She required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting and did not ambulate. The MDS documented Resident # 1 had functional limitations in range of motion in 1 lower extremity and no functional limitations in upper extremities. The MDS listed the following Diagnoses: [REDACTED]. Observation and interview with Resident #1 on 7/20/20 at 9:33 a.m. revealed her laying in bed in her room. The resident stated she was concerned that she did not receive restorative nursing exercises on a regular basis as the facility did not have enough staff to do the exercises with her. Resident #1 stated that due to staffing issues and the lock down due to Covid-19, she did not receive her restorative exercises. She reported she did upper exercises on her arms but needed help with the lower extremity exercises. Review of the current care plan for Resident #1 with revision date of 7/12/20 revealed the resident did not have a focus listed for Restorative Active Range of Motion (AROM). Review of Resident #1's task list in the electronic health record (EHR) identified she should receive nursing restorative: Active ROM Supine lower extremity exercises including hip flex/extension, hip abduction/adduction, knee flex/extremity, ankle dorsiflexion/plantar flexion, 15 repetitions X 1 to 2 sets, 6-7 days per week twice per day. Audit of Resident #1's restorative nursing program documentation in the EHR for June 2020, revealed she did not receive/complete her twice daily active ROM program to her lower extremities 12 days out of 30. Clinical record review of Resident #1's progress notes revealed no notes in the record that mentioned the need for her to receive restorative care. Review of resident's Restorative Nursing Program Plan documentation revealed 1 incomplete assessment dated [DATE]. There were no notes within the record to verify what services the resident was provided and what he response and/or progress was with her current active ROM restorative nursing plan. During an interview on 7/16/20 at 11:39 AM, Staff D- Director of Rehabilitation stated she did not know what restorative plans residents had and that they do not have a designated restorative aide to do exercises with residents. Staff D stated the nursing department is responsible for doing the programs and certified nurse aides are able to do the programs with the residents. Staff D stated the Director of Nursing (DON) knew of the resident's restorative programs and if nursing had concerns with a program, nursing would need to request a therapy screen. During an interview with the DON on 7/16/20 at 1:39 p.m., discussed Resident #1 did not receive restorative programs. The DON stated that they do not have the staff to do the restorative programs. Review of the facility's Restorative Nursing Policy dated 5/14 stated the facility strives to enable residents to attain and maintain their highest practicable level of physical, mental and psychosocial functioning. The inter-disciplinary team works with the resident and family to identify measureable restorative goals and practical interventions that can be implemented and achieved with nursing support. A licensed nurse manages the restorative nursing process with assistance of nursing assistants trained in providing restorative care. Components of the restorative program include, but are not limited to, the following: 1. Interdisciplinary process to identify residents who would benefit from a restorative nursing program. 2. Development of measureable goals and individualized interventions for a specific restorative program. 3. Evaluation of progress towards goals and effectiveness of interventions. 4. Inter-disciplinary process to identify when a resident is appropriate to discharge from restorative nursing. Determine with the interdisciplinary team, if the resident meets criteria for a restorative program. Criteria includes but is not limited to: A. Resident requiring contracture prevention and management, (including passive range of motion (PROM); active range of motion (AROM); splint/brace assistance. B. Resident requiring skill practice and/or training in: Mobility (ambulation, bed mobility, transfer, amputation /prosthetic care, wheelchair mobility). The policy further instructed staff to document resident's daily participation and actual number of minutes participating in the restorative intervention. 2. According to the MDS dated [DATE], Resident # 2 had a BIMS score of 12 that indicated intact cognitive function. She required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting and did not ambulate. The MDS documented Resident # 2 had functional limitations in range of motion in 1 lower extremity and functional limitations in 1 upper extremity. The MDS listed the following Diagnoses: [REDACTED]. Observation and interview with Resident #2 on 7/20/20 at 9:42 a.m. revealed her sitting in her wheelchair in her room. The resident reported she felt concerned that she did not wear her weighted hand brace to help with tremors in her right hand. The resident stated that they do not help her with it like they should. Review of the current care plan for Resident #2 revised 6/30/20 and revealed resident did not have a focus listed for Restorative Active Range of Motion (ROM) for use of the blue hand splint to her right hand. Review of Resident 2's task list in the electronic health record (EHR) identified she should have nursing rehab: Assistance with blue weighted brace to right hand twice a day.e Audit of Resident #2's restorative nursing program documentation in the EHR for June 2020, revealed she did not receive her twice daily assistance with wearing her right hand brace for 11 days out of 30. Clinical record review of Resident #2's progress notes revealed the last notes in the record that mentioned restorative care as 6/11/19. Review of resident's Restorative Nursing Program Plan documentation revealed 1 incomplete assessment dated [DATE]. The record contained no information to verify what services the resident was provided and what the response and/or progress was with her current restorative nursing plan. During an interview on 7/16/20 at 11:39 AM, Staff D- Director of Rehabilitation stated she did not know what restorative plans residents had and they do not have a designated restorative aide to do exercises with residents. Staff D stated that the nursing department is responsible for doing the programs and certified nurse aides able to do the programs with the residents. Staff D stated the Director of Nursing (DON) knew of the resident's restorative programs and if nursing had a concern with a program, nursing needed to request a therapy screen. During an interview with the DON on 7/16/20 at 1:39 p.m., discussed Resident #2 not receiving their restorative program as written to assist resident with her blue hand brace. DON stated that they do not have the staff to do the restorative programs. Review of the facility's Restorative Nursing Policy dated 5/14 stated the facility strives to enable residents to attain and maintain their highest practicable level of physical, mental and psychosocial functioning. The inter-disciplinary team works with the resident and family to identify measureable restorative goals and practical interventions that can be implemented and achieved with nursing support. A licensed nurse manages the restorative nursing process with assistance of nursing assistants trained in providing restorative care. Components of the restorative program include, but are not limited to, the following: 1. Interdisciplinary process to identify residents who would benefit from a restorative nursing program. 2. Development of measureable goals and individualized interventions for a specific restorative program. 3. Evaluation of progress towards goals and effectiveness of interventions. 4. Inter-disciplinary process to identify when a resident is appropriate to discharge from restorative nursing. Determine with the interdisciplinary team, if the resident meets criteria for a restorative program. Criteria includes but is not limited to: A. Resident requiring contracture prevention and management, (including passive range of motion (PROM); active range of motion (AROM); splint/brace assistance. B. Resident requiring skill practice and/or training in: Mobility (ambulation, bed mobility, transfer, amputation /prosthetic care, wheelchair mobility). The policy further instructed staff to document resident's daily participation and actual number of minutes participating in the restorative intervention. 3. According to the MDS dated [DATE], Resident # 5 had a BIMS score of 14 that indicated intact cognitive function. She required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting. The MDS documented Resident # 5 had functional limitations in range of motion in both lower extremities and no functional limitations in upper extremities. The MDS listed the following Diagnoses: [REDACTED]. Observation and interview with Resident #5 on 7/20/20 at 9:23 a.m. revealed her sitting in her wheelchair in her room. Resident reported she did not do her exercise plan very often. The resident stated that doing her exercise plans helped to pass the time. Review of the current care plan for Resident #5 revised 3/30/20 and revealed the resident did not have a focus listed for Restorative Active Range of Motion (ROM). Review of Resident 5's task list in the electronic health record (EHR) identified the following restorative plan: hip abduction/adduction flexion/extension 10 times- 2 sets and ankle flexion on left ankle, eversion on right-3 repetitions, hold for 30 seconds each. Please do the following exercise in bed daily. Audit of Resident #5's restorative nursing program documentation in the EHR for June 2020, revealed she did not receive assistance with completing her daily restorative exercises for 13 days out of 30. Clinical record review of Resident #5's progress notes revealed no progress notes completed for services the resident should receive. Review of resident's Restorative Nursing Program Plan documentation revealed 1 incomplete assessment dated [DATE]. The record contained no notes to verify what services the resident should receive and what the response and/or progress was with her current restorative nursing plan. During an interview on 7/16/20 at 11:39 AM, Staff D- Director of Rehabilitation stated she did not know what restorative plans residents had and that they do not have a designated restorative aide to do exercises with residents. Staff D stated that the nursing department is responsible for doing the programs and certified nurse aides are able to do the programs with the residents. Staff D stated the Director of Nursing (DON) knew of the resident's restorative programs and if nursing had a concern with a program, nursing would need to request a therapy screen. During an interview with the DON on 7/16/20 at 1:39 p.m., discussed Resident #5 not receiving their restorative program as written. DON stated that they do not have the staff to do the restorative programs. Review of the facility's

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Evaluation of progress towards goals and effectiveness of interventions. 4. Inter-disciplinary process to identify when a resident is appropriate to discharge from restorative nursing. Determine with the interdisciplinary team, if the resident meets criteria for a restorative program. Criteria includes but is not limited to: A. Resident requiring contracture prevention and management, (including passive range of motion (PROM); active range of motion (AROM); splint/brace assistance. B. Resident requiring skill practice and/or training in: Mobility (ambulation, bed mobility, transfer, amputation /prosthetic care, wheelchair mobility). The policy further instructed staff to document resident's daily participation and actual number of minutes participating in the restorative intervention. 4. According to the MDS dated [DATE], Resident # 10 had a BIMS score of 10 that indicated moderately impaired cognitive function. She required limited assistance of 1 staff for bed mobility, transfers, toileting. Resident required extensive assist of 1 staff with walking and dressing. The MDS documented Resident # 10 with functional limitations in range of motion in both lower extremities and functional limitations in both upper extremities. The MDS listed the following Diagnoses: [REDACTED]. Observation and interview conducted with Resident #10 on 7/20/20 at 9:42 a.m. regarding her walk to dine program. Observation showed the resident seated in her wheelchair in her room. The resident stated staff don't bother to walk her anymore since all of the quarantine started. She further stated she didn't know why they did not walk her in the hallways. The resident reported concerns that she really should walk more. Review of the current care plan for Resident #10 revised 3/23/20 revealed resident did not have a focus listed for Restorative Walk to dine program. Review of Resident 10's task list in the electronic health record (EHR) listed she should to walk to dine (all three meals) and activities as tolerated with front wheel walker, gait belt and one staff assistance with wheelchair following for at least 15 mins a day. Audit of Resident #10's restorative nursing program documentation in the EHR for June 2020, revealed she did not received her three times daily walks in the hallways for 15 days out of 30. Clinical record review of Resident #10's progress notes revealed the last notes in the record that mentioned restorative care as 6/11/19. The resident's Restorative Nursing Program Plan documentation was last completed on 9/19/19. The assessment identified the resident on walk to dine program for all three meals and activities with a wheelchair to follow. The assessment summary of her walk to dine program identified the intervention as appropriate. The record contained no notes to verify what services the resident received and what the resident's response was and/or progress with her current restorative nursing plan. During an interview on 7/16/20 at 11:39 AM, Staff D- Director of Rehabilitation stated she did not know what restorative plans residents had and that they do not have a designated restorative aide to do exercises with residents. Staff D stated that the nursing department is responsible for doing the programs and certified nurse aides are able to do the programs with the residents. Staff D stated the Director of Nursing (DON) knew of the resident's restorative programs and if nursing had a concern with a program, nursing would need to request a therapy screen. During an interview with the DON on 7/16/20 at 1:39 p.m., discussed Resident #10 not receiving their restorative program as written to assist resident with her walk to dine program. DON stated that they do not have the staff to do the restorative programs. Review of the facility's Restorative Nursing Policy dated 5/14 stated the facility strives to enable residents to attain and maintain their highest practicable level of physical, mental and psychosocial functioning. The inter-disciplinary team works with the resident and family to identify measureable restorative goals and practical interventions that can be implemented and achieved with nursing support. A licensed nurse manages the restorative nursing process with assistance of nursing assistants trained in providing restorative care. Components of the restorative program include, but are not limited to, the following: 1. Interdisciplinary process to identify residents who would benefit from a restorative nursing program. 2. Development of measureable goals and individualized interventions for a specific restorative program. 3. Evaluation of progress towards goals and effectiveness of interventions. 4. Inter-disciplinary process to identify when a resident is appropriate to discharge from restorative nursing. Determine with the interdisciplinary team, if the resident meets criteria for a restorative program. Criteria includes but is not limited to: A. Resident requiring contracture prevention and management, (including passive range of motion (PROM); active range of motion (AROM); splint/brace assistance. B. Resident requiring skill practice and/or training in: Mobility (ambulation, bed mobility, transfer, amputation /prosthetic care, wheelchair mobility). The policy further instructed staff to document resident's daily participation and actual number of minutes participating in the restorative intervention.