STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525513	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINNIC HEALTH AND REHAB	1663 E DIVISION ST RIVER FALLS, WI 54022

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 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 observation, record review and interview, the facility did not ensure a resident who enters the facility with limited range of motion did not experience a reduction in range of motion or receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This occurred for 4 of 5 sampled residents (Resident (R) R1, R10, R20 and R43). R1 did not receive restorative services to increase or maintain current range of motion. No assessment of current range of motion status was identified to include whether the resident received treatment and services for range of motion, whether the range of motion has declined or why range of motion services were not provided. R10 did not receive restorative services to increase or maintain current range of motion. No assessment of current range of motion status was identified to include whether the resident received treatment and services for range of motion, whether the range of motion has declined or why range of motion services were not provided. R20 did not receive restorative services to increase or maintain current range of motion. No assessment of current range of motion status was identified to include whether the resident received treatment and services for range of motion, whether the range of motion has declined or why range of motion services were not provided. R43 has decreased mobility due to a [MEDICAL CONDITIONS]. A restorative assessment or program was not established for R43 to increase range of motion or to prevent a decrease in range of motion. This is evidenced by: 1. R1's [DIAGNOSES REDACTED]. On 03/02/20 at 9:30 a.m., Surveyor observed R1. R1 was sitting in his wheelchair, in the common area used for activities. Surveyor reviewed R1's Minimum Data Set ((MDS) dated [DATE]. The record indicated R1 required 2 person assistance for transfers and Activities of Daily Living (ADL) assistance. R1's Brief Interview for Mental Status (BIMS) was 11, indicating moderate cognitive impairment. The record (Section O-0500) indicated R1 was not receiving range of motion services. The record also indicated R1 did not wear a splint or brace, although R1 wears a splint on his left hand during the night. Surveyor reviewed R1's care plan. The care plan did not include range of motion exercises. However, under the title Increase independence with ADL's, a section noted .05/19/18 .left hand splint, elevate left hand apply splint at bedtime .ok (sic) for resident to take off splint if c/o (sic) discomfort. Mobility .2 person assist .with EZ (a type of partial lift) stand. Hoyer (a type of full lift) when weak. The record did not contain an assessment for R1's range of motion status. The plan of care did not include an assessment for current range of motion status, interventions to prevent a decrease in range of motion or a reason range of motion services were not provided. On 03/03/20, Surveyor interviewed Director of Nursing (DON) B. DON B stated R1 was at end of life, and staff provide repositioning for comfort. DON B stated R1 wears a splint on his left hand at night, which is removed during the day. There was no data in the clinical record to indicate if the splint was effective in controlling contracture. DON B stated residents are not placed on a restorative program unless they have contractures. DON B did not produce evidence a restorative program was developed and implemented in the facility. 2. R10's [DIAGNOSES REDACTED]. On 03/02/20, Surveyor observed R10 during the meal service. R10 chose to eat while in bed, with the head of the bed elevated. R10 was able to feed self by reaching a tray table after the food had been served. On 03/03/20 at 8:30 a.m., Surveyor reviewed R10's clinical record. R10's BIMS score was 12, indicating mild cognitive impairment. The MDS indicated R10 required 2 person assistance with repositioning, ADLs (except eating) and transfers. The MDS indicated R10 was not receiving restorative services, and did not use a brace or splint. R10's care plan read, R10 transfers with 2 person assist using a partial lift. The care plan stated staff were to apply left lower leg brace as resident allows, when up in chair. There was no evidence in the clinical record R10 had been assessed for range of motion ability or decline or a range of motion program, based on the facility assessment, had been instituted. On 03/03/20 at 9:03 a.m., Surveyor interviewed DON B. DON B stated R10 is able to reposition herself in bed, and had not been started on a restorative program or was receiving services since R10 did not have a contracture. 3. R20's [DIAGNOSES REDACTED]. On 03/02/20 at 9:20 a.m., Surveyor observed R20. R20 was self positioned in bed, watching television. At 11:45 a.m., R20 was observed independently pedaling wheelchair into the dining room. Surveyor reviewed R20's clinical record. The most recent MDS, dated [DATE], read R20's BIMS score was 15, indicating R20 is cognitively intact. The MDS further showed R20 was independent with ADLs with set up assistance. Functional range of motion limitation was coded as 0; however, R20 was wheelchair bound. The MDS indicated R20 was independent with mobility. On 03/03/20 at 8:48 a.m., Surveyor interviewed DON B and Licensed Practical Nurse (LPN) C, who is responsible for MDS coordination. LPN C stated she was not here when R20's current MDS was completed, and the MDS is in error, since R20 has not walked since admission. Surveyor confirmed this with Registered Nurse (RN) D and Certified Nursing Assistant (CNA) E. Surveyor reviewed R20's care plan. The care plan read that R20 was independent with ADLs and transfers. At 3:33 p.m., Surveyor interviewed DON B. DON B stated R20 had not had an assessment to determine whether range of motion has decreased or if R20 could benefit from restorative services. R20's range of motion status was not identified for whether the range of motion has declined or why range of motion services were not provided. DON B told Surveyor the facility does not have a restorative program in place. 4. R43 was admitted on [DATE], with [DIAGNOSES REDACTED]. The Annual MDS dated [DATE] indicates R43 has a BIMS score of 1, meaning severe cognitive impairment. This MDS documents no limited range of motion on upper and lower extremities. R43 is extensive assist of one for all ADLs. R43 uses a sit to stand lift for transfers. R43 is unable to ambulate, putting R43 at risk for a decline in range of motion. R43 had a hospital admission on 01/20/20. R43 was diagnosed with [REDACTED]. On 03/03/20, Surveyor reviewed R43's medical record for a restorative assessment. Surveyor did not locate a restorative care plan or documentation for restorative services. On 03/03/20 at 8:20 a.m., Surveyor interviewed Nursing Home Administrator (NHA) A asking where to locate the restorative information in the electronic record. NHA A said she would check and get back to Surveyor. At 8:30 a.m., NHA A came to Surveyor and stated R43 has no contractures so is not on a restorative program. On 03/03/20 at 9:00 a.m., Surveyor interviewed DON B and asked what restorative was provided to R43. DON B stated there is no program, only walk to dine for residents. Surveyor asked if R43 walks. DON B indicated R43 does not ambulate and uses a sit to stand lift for all transfers. Surveyor asked how they will prevent R43 from having a decline in joint function and why R43 did not have a restorative program. DON B stated, It was deemed not appropriate.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**

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

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that residents who have not used [MEDICAL CONDITION] drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. This occurred for 1 of 8 residents reviewed for [MEDICAL CONDITION] medications, Resident (R) 23. The facility did not assess, monitor, track or re-assess the use of a [MEDICAL CONDITION] medication for sleep and provide necessity for continued use of the medication. This is evidenced by: Surveyor reviewed R23's medical record and identified current [DIAGNOSES REDACTED]. Review of physician orders [REDACTED]. The medical record dated 1/7/20 inidcates documentation of a resident mood interview score of 0, which identifies no mood issues. Review of the Minimum Data Set ((MDS) dated [DATE] with depression screen PHQ-9 score 0, which identifies no signs of depression. The MDS dated [DATE] had a PHQ-9 score of 0 and MDS 5 day, dated 10/16/19 had a PHQ-9 score of 0. Review of the medical record did not document a sleep assessment, monitoring or tracking of sleep, or re-evaluations of the necessity to continue the medication. On 03/03/20 at 9:27 AM, Surveyor interviewed Director of Nursing (DON) B about sleep and mood assessments and monitoring. DON B indicated there is just mood monitoring with assessments and not monitoring for targeted behaviors. On 03/04/20 at 8:44 AM, Surveyor interviewed Licensed Practical Nurse (LPN) C about completed sleep assessments or sleep tracking for R23. LPN C indicated the facility has no [MEDICAL CONDITION] assessments or tracking of sleep. Surveyor reviewed R23 is receiving a [MEDICAL CONDITION] medication for sleep and should be assessed and monitored and non-pharmacological interventions reviewed to identify if the medication is appropriate. On 03/04/20 at 1:50 PM, Surveyor interviewed DON B asking about the assessing and monitoring/tracking of sleep and the rationale of the continued use of the use of [MEDICATION NAME] for sleep. DON B indicated understanding of there being no assessments, or tracking and monitoring of sleep and will be putting tracking into place.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not store and distribute food in accordance with professional standards for food service safety. This has the potential to affect almost all 53 residents who reside in the facility. *Stored open, undated, expired food. *Dietary Manager observed 2 of 3 days of survey without facial hair coverage. This is evidenced by: On [DATE] at 8:45 AM, Surveyor conducted an initial tour of the facility with Dietary Manager (DM) F. Surveyor found the following items in the free-standing refrigerator in the kitchen: -2 liter pitcher of pineapple juice not dated -Bottle of red wine vinegar: date in-[DATE], use by date of [DATE]. No date when opened. DM F discarded the pineapple juice and the red wine vinegar. Surveyor observed during the initial tour of the kitchen with DM F, no beard net was used by DM F to cover facial hair when DM F entered the kitchen, dry storage, walk-in cooler, or walk-in freezer. On [DATE] at 11:25 AM, Surveyor observed DM F was not wearing beard net to cover facial hair while in kitchen, service area for dining room, or in dining room during lunch meal. On [DATE] at 8:24 AM, Surveyor observed DM F in dining room serving area and in dining room with no beard net to cover facial hair. On [DATE] at 12:28 PM, Surveyor voiced concerns to DM F of expired items in refrigerator and DM F not wearing beard net. DM F acknowledged the expired items. DM F stated he did not realize he needed a beard net.