STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	**739 4TH STREET SOUTH BALDWYN, MS 38824**

(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 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey along with a complaint investigation (CI) MS #22064, CI MS #22071, and CI MS #22099 at the facility from 9/5/23 through 9/7/23. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F550, F656, F677, F761 and F812. The SA identified non-compliance and cited F565 for failure to resolve a resident's grievance and F688 for failure to provide range of motion exercises for CI MS #22099. There were no deficiencies cited for CI MS #22064 and CI MS #22071. The census at the time of the survey was 98 with a bed capacity of 107.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon	F 565		10/19/23

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

Electronically Signed | 09/26/2023

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F 565	Continued From page 1 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to promptly address and provide a follow up to grievances for four (4) of 32 residents reviewed. Resident #45, Resident #47, Resident #62, and Resident #64. Findings Include Record review of facility policy titled, "Resident Rights: Complaint/Grievance Policy and Procedure" dated 10/17, revealed, "Policy: To provide a timely mechanism for receiving, responding, resolving, and documenting the outcome of patient complaints and grievances that is in compliance with current Resident Rights guidelines." The policy also revealed, "5. Response to a grievance is expected to take place within five business days of receipt of	F 565	1. Documented resident grievances for 45, 47, 62, and 64 concerning cell phone use in patient care areas, updated grievance policy, and resident follow-up was individually addressed on 9/27/2023 by the Nursing Home Administrator (NHA) and Licensed Social Worker (LSW). 2. All residents have the potential to be affected by this deficient practice. 3. All employees will be in-serviced by the Clinical Educator starting 9/29/2023 concerning the Grievance Policy, the follow-up process to residents, and the use of electronic devices by employees and be completed by 10/19/2023. NHA and LSW will visit with the Resident Council upon invitation on 9/27/2023 to review the Grievance Policy and the Follow-up process with residents to resolve grievances. Any open grievances	

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grievance and acknowledged in writing appropriately to the resident council, resident, or his/her representative."

Record review of facility policy titled, "Electronic Device Guidelines", undated, revealed, "The use of electronic devices and social media has become a part of many employees' daily lives, but is not appropriate activity during work time.... If electronic devices are allowed to be brought into the workplace, responsible use is expected and required. The following are examples of minimum expectations... 3. Employees should not use personal electronic devices in patient areas or in halls where patients or family members are present, except for common eating areas."

On 9/6/23 at 3:00 PM, a Resident Council meeting was held with nine (9) residents attending. During this meeting, Resident #47, Resident #62, and Resident #64 revealed they had a concern with the staff's use of personal cell phones while providing care in the residents' rooms. They revealed this was an ongoing concern that had been mentioned in multiple Resident Council meetings, yet the issue had not been resolved. Resident #62 and Resident #64 revealed the staff did not respond and give follow-ups to their grievances. Resident #47 who is the Resident Council President revealed he had gone to the Administrator on several occasions and asked if a grievance were addressed and the follow-up to the grievance, but he felt this information should be provided without the residents having to ask.

An interview with the Licensed Social Worker (LSW) on 9/7/23 at 9:00 AM, revealed she will be reviewed by the administrative council weekly.

4. Starting on 9/18/23 the Baldwyn Administrative Team will round on employees three times a week for four weeks, then twice a week for four weeks, and then once a week for four weeks to ensure the Grievance Policy, follow-up process to residents, and the use of electronic devices by employees is being followed. Deviations from these policies will be immediately investigated and appropriate corrective actions will be taken to correct these deviations.
The results based from verbal exit and the written statement of deficiencies report (CMS-2567) from the State Survey Team was reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 9/26/2023. These rounds/results and the facility Plan of Correction (POC) were up for review at our QAPI meeting on 9/26/23. Recommendations from this committee were implemented as required and will be monitored until compliance is achieved. These rounds/results will be reviewed on the (10/17/23) QAPI Meeting and on-going for the next 2 scheduled quarterly QAPI meetings (January 2024 and April 2024) to ensure solutions are sustained.
5. 10/19/23.

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attended the Resident Council meetings and would take the minutes for the meeting. She revealed the concern with staff using their cell phones in resident care areas had been a concern for several months now. She stated when a nursing concern was discussed in the Resident Council meeting, she provided the information to the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Administrator. She confirmed that the staff received in-services, but she was unaware of other measures that were put in place to resolve this issue. She confirmed when a grievance is filed, it is the staff's responsibility to address the grievance and to notify the residents with a follow-up to their grievance and she confirmed that this was not done.

An interview with the DON on 9/7/23 at 9:15 AM, revealed he was aware of the residents' ongoing concern of employees using personal cell phones in resident care areas. He confirmed the facility had in-serviced the staff, but they continued to use their phones during care of the residents and that the facility failed to resolve the residents' grievances and provide follow-ups to the residents timely.

An interview with the Administrator on 9/7/23 at 9:40 AM, revealed cell phone use by staff was a concern of the residents and had been voiced in several Resident Council meetings. He confirmed the facility failed to find a solution to the grievance and failed to notify the residents with a response to the grievance timely. He confirmed this was an unresolved grievance from multiple Resident Council meetings and the facility failed to resolve this grievance.

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Record review of "Resident Council Minutes," dated 1/25/23, revealed, "All residents feel as they are ignored by staff and that staff are coming into their rooms with earphones in their ears and talking on the phone."

Record review of "Resident Council Minutes", dated 2/22/23, revealed, "Resident on B and C halls mentioned Certified Nursing Assistants (CNAs) are still on their cellphones via (by) earbud."

Record review of "Resident Council Minutes", dated 3/30/23, revealed, "Several residents reported that some CNAs are still talking on their cellphone while in the rooms."

Record review of "Resident Council Minutes", dated 4/21/23, revealed, "Resident stated, when staff give her care, they are always on the phone."

Record review of "Resident Council Minutes", dated 6/27/23, revealed, "Several residents mentioned that staff continue to talk on their phones via earbuds while entering their rooms."

Record review of "Resident Council Minutes", dated 7/26/23, revealed, "It was mentioned that CNAs continue using cellphones in the rooms."

Record review of "Resident Council Minutes", dated 8/24/23, revealed, "It was mentioned CNAs are lazy, sit at the desk all the time, stay on the work phone and their cellphones."

Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/13/23, revealed Resident #47 had a Brief

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Interview for Mental Status (BIMS) score of 15 which indicated resident was cognitively intact.

Review of Resident #62's MDS with ARD of 7/28/23, revealed a BIMS score of 15 which indicated the resident was cognitively intact.

Review of Resident #64's MDS with ARD of 6/21/23, revealed a BIMS score of 15 which indicated the resident was cognitively intact.

Resident #45

During an interview on 9/5/23 at 10:55 AM, with Resident #45 he stated that the facility does not notify him of what has been done about issues that he reports or follow up with him to find out if the issue has been resolved.

Record review of the facility Resident Grievance Form, dated 5/16/23, filed by Resident # 45, revealed that the resident reported he was not receiving range of motion (ROM) exercises, he was not being turned, staff did not assist him to bed when he requested, his bed is not always made up after he gets up, his dirty clothing is left in his room, his hair is not getting washed, and staff have been on their cell phones. A record review of the response provided by the ADON revealed a formal schedule was put in place for ROM exercises, staff was provided in-service education regarding, turning, making beds, assisting residents, answering call lights, and cell phone usage.

During an interview on 9/6/23 at 9:15 AM, with the DON stated he was aware of the grievance and

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F 565	Continued From page 6 that the staff was provided an in-service. The DON confirmed that the resident grievances were not resolved with the in-service. During an interview on 9/6/23 at 1:58 PM, with LSW, verified she forwards grievances to the DON, ADON and Administrator but does not follow up with residents to ensure grievances are resolved. She stated she was not aware that she needed to do the follow up. She assumed that the DON, ADON and the Administrator took care of the issues. During an interview on 9/6/23 at 2:00 PM, with the DON he agreed that there is no evidence that Resident #45's grievance was resolved. During an interview on 9/6/23 at 3:30 PM, with the Assistant Administrator he agreed that there is no evidence that Resident # 45's grievance was resolved. Record review of Resident #45's "Clinical Summary" revealed the resident was admitted to the facility on 2/1/22 with medical diagnoses that included Compression of the Spinal Cord with Myelopathy and Paraplegia at T9 level. Record review of the MDS, with an ARD of 6/27/23, revealed a BIMS score of 15, indicating that the resident is cognitively intact.	F 565		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		10/19/23

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resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) 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 §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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F 656	Continued From page 8 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review and facility policy review the facility failed to develop and implement a comprehensive care plan for a resident requiring nail care Resident #71 and for a resident with limited range of motion (ROM) Resident #26 and Resident #45 for three (3) of 23 resident care plans reviewed. Findings include: A record review of the facility Policy, Titled, "Care Plan Policy" with a revision date of October 2012, revealed, "...Procedure...In accordance with each resident's plan of care, all services provided or arranged by the facility should meet professional standards of quality and should be provided by qualified persons". A record review of the facility handout titled "Facility Specific Handout" with no revision date revealed under the title "Providing Excellent Resident Care... 6. Nail care: clean nails every shift/PRN (as needed) and file as needed. RN/LPN (Registered Nurse/Licensed Practical Nurse". Resident #71 A record review of Resident #71's Care plan, Problem/Need dated 02/09/2022 revealed, ADL's (Activities of Daily Living): Resident requires assist with ADL's r/t (related to): TBI (Traumatic Brain Injury) and Left hemiplegia and under approaches: Provide appropriate level of	F 656	1. Resident numbers 71, 26, and 45 care plans were reviewed by Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 9/7/2023. 2. All residents of the facility have the potential to be affected by this practice. 3. Nursing leadership will round starting 9/18/2023 on resident numbers 71, 26, and 45 specifically to ensure proper Range of Motion (ROM), proper Activities of Daily Living (ADL) care, and contracture management is being caried out. An in-service education will be conducted by the Clinical Educator with all direct care staff starting on 9/29/2023 addressing the significance of developing and implementing a baseline care plan and comprehensive care plan for each resident, consistent with resident rights, medical, physical, mental, and psychological needs for their desired outcomes to be done by 10/19/2023. 4.Nursing leadership started screening five residents baseline and comprehensive care plans on 9/18/2023 to ensure proper ROM, proper ADL care, and contracture management is being caried out for residents with active orders. Nursing leadership will continue to screen five different residents weekly for one month (September), then every two weeks for one month (October) and once monthly (November). The results based from verbal exit and the	

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F 656	Continued From page 9 assistance with ADLs, as needed. Personal hygiene and bathing total dependent. Observations on 09/05/23 at 11:05 AM and 4:36 PM revealed Resident #71's fingernails were approximately one-half (1/2) inch long and jagged past the tips of his fingers with a brown substance underneath his fingernails bilaterally. An interview on 09/06/23 at 10:05 AM, Certified Nurse Aide (CNA) #1 confirmed that Resident #71's nails were long and had a brown substance underneath them. An observation and interview on 09/06/23 at 10:21 AM, with the Director of Nurses (DON) confirmed Resident #71's nails were long and needed to be cleaned. An interview on 09/06/23 at 1:16 PM with the DON confirmed that on Resident #71's ADL care plan that nail care was not specifically listed. He revealed that he thinks it may just fall under personal hygiene but confirmed that regardless the care plan was not being followed regarding his nails and it should have been. An interview on 09/06/23 at 1:32 PM with the Minimum Data Set (MDS) Nurse revealed when a resident is admitted the admitting nurse does the baseline care plan, and the comprehensive care plan is developed by her or the other MDS nurse. She revealed the care plan is developed individually for each resident so the staff will know how to care for them, and that nail care is part of their bathing care plan. She confirmed if the residents' nails were long and not cleaned then the plan of care was not being followed.	F 656	written statement of deficiencies report (CMS-2567) from the State Survey Team was reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 9/26/2023. These rounds/results and the facility Plan of Correction (POC) were up for review at our QAPI meeting on 9/26/23. Recommendations from this committee were implemented as required and will be monitored until compliance is achieved. These rounds/results will be reviewed on the (10/17/23) QAPI Meeting and on-going for the next 2 scheduled quarterly QAPI meetings (January 2024 and April 2024) to ensure solutions are sustained. 5. 10/19/23.	

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An interview and record review on 09/06/23 at 1:48 PM of the facility handout titled "Facility Specific Handout" with the DON revealed under "Providing Excellent Resident Care...#6. Nail care: clean nails every shift/prn (as needed) and file as needed. He stated this is part of the care plan for all the residents. He once again confirmed that it was not being followed for Resident #71.

A record review of Resident #71's "Face Sheet" revealed he was admitted to the facility on 2/09/22 with medical diagnoses that include Unspecified Intracranial Injury, Hemiplegia, Dysphagia, Neuralgia, and Neuritis. Review of the MDS with an Assessment Reference Date (ARD) of 8/9/23 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident had a severe cognitive impairment.

Resident #26

Record review of Resident # 26's Care Plans revealed under, "Problem onset 9/15/2020, Risk for new skin breakdown r/t (related to): ... Cast/Brace ..." and "Problem onset 7/14/2020, ADL's (activities of daily living): ... contractures ..."

An observation on 9/05/23 at 10:45 AM, of Resident # 26 revealed the resident lying in bed with eyes closed and a right-hand contracture without a device in place.

An observation and interview on 9/06/23 at 10:48 AM, with the DON confirmed that Resident # 26 did not have a palm protector to his right hand. The DON revealed that the resident could

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develop worsening contracture by not applying the palm protector as ordered.

An interview with MDS Nurse #1 on 9/07/23 at 8:30 AM, confirmed that the staff did not follow the care plan for applying the palm protector for Resident # 26. She revealed the purpose of the care plan was to inform the staff of the resident care and needs.

An interview with the DON on 9/07/23 at 9:45 AM, confirmed that the facility was not following Resident # 26's care plan for applying the palm protector daily and revealed the purpose of the care plan was to provide individualized care for the resident to meet their needs.

Record review of the "Face Sheet" revealed that Resident # 26 was admitted to the facility on 4/24/23 with medical diagnoses that included Hemiplegia, Type 2 Diabetes Mellitus, Seizures, Gastrostomy Status, Contracture Right Hand, and Contracture Unspecified Knee. Review of the MDS with an ARD of 8/01/23 revealed under "Section C" a BIMS score of 99, which indicated that the resident is severely cognitively impaired and in "Section G" under functional limitation in range of motion an impairment on both sides (Upper and Lower) extremity.
Resident #45

A record review of Resident # 45's Care Plan with an onset date of 4/28/21, revealed Approaches: Make sure range of motion exercises are done when resident goes to bed-report when done to hall nurses.

A record review of Resident # 45's Instant Care Plan, with an onset date of 2/21/22, revealed

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F 656	Continued From page 12 Problem/Risk: Risk for contractures, Goal: prevent contractures, new order/other: ROM to be done every morning Monday through Friday. During an interview and record review with the Assistant Director of Nursing (ADON) on 9/7/23 at 8:32 AM revealed she was unable to locate documentation that the range of motion exercises were performed on Resident # 45 during the months of July, August, or September 2023. A record review and interview with the DON and ADON on 9/7/23 at 8:45 AM, of Resident # 45's Care Plan and Instant Care plan they verified that Resident # 45 was at risk for contractures and t the care plan indicated that ROM was to be performed daily, and both agreed that the care plan was not being followed. Record review of Resident # 45's MDS, with an ARD of 6/27/23, revealed a BIMS score of 15, indicating that the resident is cognitively intact. "Section G" Functional Limitation in Range of Motion revealed that the resident had impairment on both sides of lower extremities. A record review of Resident # 45 "Face Sheet" revealed he was admitted to the facility on 02/01/22 with a diagnosis of Paraplegia at T9 level.	F 656		
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	F 688		10/19/23

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F 688	Continued From page 13 condition demonstrates that a reduction in range 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 observations, staff and resident interviews, record review and facility policy review, the facility failed to provide range of motion (ROM) exercise for a resident at risk for contractures Resident #45, and a splint for a resident with contractures Resident #26 for two (2) of 44 residents reviewed with limited ROM. Findings include: Record review of the facility policy titled "Restorative Care Program" with a revision date of 08/18 revealed under, "Policy: It is the policy of (proper facility name) that residents' maximum functional potential and independent living should be promoted." Also revealed under, "a. Range of Motion ... These exercises should be planned, scheduled, and documented in the clinical record." ... Also revealed under, "Splint or Brace Assistance: ... 2) where staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned,	F 688	1. Resident numbers 26 and 45 care plans were reviewed by Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 9/7/2023. On 9/6/2023 Licensed Practical Nurse (LPN) number 1 applied a palm protector to resident number 26. On 9/6/2023 Certified Nursing Assistant (CNA) number 2 provided resident number 45 with Range of Motion (ROM) and documented it on the calendar hanging in the resident room. 2. All residents of the facility have the potential to be affected by this practice. 3. Nursing leadership will round starting 9/18/2023 to ensure proper ROM and contracture management is being caried out for resident numbers 26 and 45. An in-service education will be conducted by the Clinical Educator with all direct care staff started by 9/29/2023 addressing the significance ROM and importance of proper protection against worsening contractures to be done by 10/19/2023. 4. The Baldwyn leadership team will	

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F 688	Continued From page 14 scheduled, and documented in the clinical record." ... Resident #26 Record review of Resident # 26's "Active Orders Report" revealed an order dated 11/17/20, "Frequency: < User Schedule > (every 1 day: 08:00, 20:00) -Wash right hand with soap and water. Apply palm protector/rolled wash cloth to right palm daily." An observation on 9/05/23 at 10:45 AM, of Resident # 26 revealed the resident lying in bed and a right-hand contracture without a device in place. An observation on 9/06/23 at 10:00 AM, of Resident #26 revealed the resident lying in bed and a right-hand contracture without a device in place. An observation and interview on 9/06/23 at 10:40 AM, with Registered Nurse (RN) # 1 confirmed that Resident #26 did not have a palm protector inside his right hand. She confirmed that the resident had a physician order to apply a palm protector/rolled wash cloth daily, scheduled for 08:00 (8:00 AM) and 20:00 (8:00 PM). An observation and interview on 9/06/23 at 10:48 AM, with the Director of Nursing (DON) confirmed that Resident # 26 did not have a palm protector or a washcloth inside his right hand. The DON revealed that the resident could develop worsening of the contracture by not applying the palm protector as ordered. An observation and interview on 9/06/23 at 10:53	F 688	round on all residents with orders for ROM and/or worsening contractures starting 9/18/2023, weekly for one month (September) then every two weeks for one month (October), and once monthly (November) to ensure these active orders are being done. The results based from verbal exit and the written statement of deficiencies report (CMS-2567) from the State Survey Team was reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 9/26/2023. These rounds/results and the facility Plan of Correction (POC) were up for review at our QAPI meeting on 9/26/23. Recommendations from this committee were implemented as required and will be monitored until compliance is achieved. These rounds/results will be reviewed on the (10/17/23) QAPI Meeting and on-going for the next 2 scheduled quarterly QAPI meetings (January 2024 and April 2024) to ensure solutions are sustained. 5. 10/19/23.	

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AM, with Licensed Practical Nurse (LPN) # 1, with the DON in attendance, revealed that she was the nurse for Resident # 26, and stated that the resident's right hand was supposed to have a palm protector/rolled washcloth applied inside the hand. She confirmed that she did not apply the palm protector yesterday or today. She revealed that the resident could develop worsening contracture by not performing the care.

Record review of the "Face Sheet" revealed that Resident # 26 was admitted to the facility on 4/24/23 with medical diagnoses that included Hemiplegia, Contracture Right Hand, and Contracture Unspecified Knee.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/01/23 revealed under "Section C" a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired and in "Section G" under functional limitation in range of motion an impairment on both sides (Upper and Lower) extremity.

Resident #45

During an interview with Resident #45 on 9/5/23 at 10:55 AM, he stated that he did not consistently receive his ROM exercises.

A record review of Resident #45's care plan revealed Approaches: Make sure range of motion exercises are done when resident goes to bed-report when done to hall nurses. Problem/Risk: Risk for contractures, Goal: prevent contractures, new order/other: ROM to be done every morning Monday through Friday.

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A record review of the monthly ROM schedule for July, August and September 2023 revealed that there are specific staff members listed on the schedule to perform ROM exercises Monday through Friday for Resident #45.

Record review of Certified Nursing Assistant (CNA) #2's weekly schedule revealed that she was scheduled to perform ROM exercises for Resident #45 on Monday, Wednesday, and Friday at 0800.

During an interview with CNA #2 on 9/5/23 at 1:23 PM, she stated that she performs ROM for Resident #45 on Monday, Wednesday and Friday and documents it on the calendar that hangs on Resident #45's wall. She stated she has provided ROM exercises on all the days she was scheduled unless the resident refuses the ROM. CNA#2 confirmed that she does not document the completed ROM in the computer.

During an interview with the Assistant Director of Nursing (ADON) on 9/6/23 at 3:20 PM she stated that the monthly ROM schedule is posted on the resident's wall so he will know who is going to perform his ROM exercises. She stated that it is divided up among the staff that assists with providing ROM for the resident. The ADON stated that the exercises are documented under the CNA tasks in the computer and that the staff initials the calendar hanging in his room.

During an interview with Licensed Practical Nurse #2 (LPN) on 9/7/23 at 8:02 AM, revealed she was assigned to Resident # 45 today, but was unfamiliar with his ROM schedule.

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An interview with CNA #4 on 9/7/23 at 8:20 AM, stated that she provided ROM exercises to Resident #45's legs on the days she is scheduled. She stated that she documents the care provided on the schedule posted on the resident's wall. CNA #4 stated that she has only missed providing ROM exercises for Resident # 45 if he refused but confirmed that she is not documenting it in the computer.

During an interview and record review with the ADON on 9/7/23 at 8:32 AM, confirmed that she was unable to locate documentation that the ROM exercises were performed on Resident #45 during the months of July, August, or September 2023. She stated that usually it could be pulled up under completed care, but no documentation was showing up. She stated she no longer had the July or August calendars that staff initialed the care had been provided as they had been shredded. She verified that there was no documentation to prove that Resident #45 had received ROM exercise for July, August, or September of 2023.

During an interview with the DON and ADON on 9/7/23 at 8:40 AM, they agreed that failure to perform range of motion could cause contractures.

During an interview with the ADON on 9/7/23 at 10:09 AM, she verified that they did not have a Restorative Program, but they would follow the Restorative Care Program policy when providing range of motion and splinting or brace assistance.

Record review of Resident # 45's MDS, with an ARD of 6/27/23, revealed a BIMS score of 15,

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F 688	Continued From page 18 indicating that the resident is cognitively intact, "Section G", Functional Limitation in Range of Motion revealed that the resident has impairment on both sides of lower extremities. Review of the "Clinical Summary Report" revealed he was admitted to the facility on 02/01/22 with a Diagnosis of Paraplegia at T9 level.	F 688		