STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115353	A. Building B. Wing	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehabilitation	101 Old Talbotton Rd Thomaston, GA 30286

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31565 Based on observations, record review, document review, staff and resident interviews, and facility policy review, the facility failed to maintain a safe and comfortable environment for one (300 Hall) of three halls of the facility. Observations revealed walls and equipment were not in good condition. Findings included: Review of a facility policy titled, Skilled Inpatient Services Work Orders, dated 12/04/2021, indicated, In order to establish a priority for maintenance service, work orders should be filled out in the TELS [a computerized system to communicate maintenance concerns] work orders system. The policy further indicated, It should be the responsibility of all Associates to fill out and forward such work orders to the Engineering Safety Manager. 1. A review of Resident #38's quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive deficit. Resident #38's care plan noted a concern with limited mobility, dated 09/30/2021, that had interventions including use of assist rails. A review of Resident #48's (the roommate) quarterly MDS, dated [DATE], revealed a BIMS score of 15, indicating no cognitive deficit. On 12/27/2022 at 11:30 AM, an observation of Resident #38's grab bar on the right side of the bed (room [ROOM NUMBER]) revealed the bar was hanging down to the floor. Normal upright position would be the u-shaped bar would rise above the mattress. At the right edge of Resident #38's headboard, stretching across the wall behind Resident #38's roommate's (Resident #48) bed to the corner of the room, was an area where a six-inch-wide board had been attached to the wall. The board would protect the wall from damage caused if the headboard struck the wall. The board was lying on the floor against the wall. On 12/27/2022 at 11:31 AM, an interview was completed with Resident #38. Resident #38 stated the bar had been broken for a year and the Maintenance Supervisor was aware but had not fixed it. Resident #38 said they used the bar to reposition, and it being broken made moving difficult. (continued on next page)

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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Resident #48 on 12/28/2022 at 4:36 PM. Resident #48 said the board that was supposed to be attached to the wall behind the head of the bed had been on the floor as long as Resident #48 had been in that room. Resident #48 was not sure when they were placed in that room. On 12/28/2022 at 4:42 PM, an interview was completed with Licensed Practical Nurse (LPN) #2. LPN #2 stated the facility had a computer system called TELS where maintenance requests were entered. LPN #2 was assigned to Resident #38 and Resident #48's room as part of her normal assignment, but she had not noticed the broken grab bar or the board lying on the floor. An interview was completed with the Financial Controller (FC) on 12/28/2022 at 4:53 PM. The FC reviewed the record of Resident #48 and stated Resident #48 moved to their current room on 03/23/2022. 2. An observation was made in the bathroom shared by room [ROOM NUMBER] and room [ROOM NUMBER] on 12/27/2022 at 2:42 PM. On the right wall there was an area approximately 10 inches by 12 inches with the paper cover torn off the sheetrock and two round holes that were 0.75 inches through the sheetrock. On the wall above the sink, there was an area approximately 8 inches by 10 inches where there had been a repair to the sheetrock with patch material, but the area had not been painted. Above the mirror, there was an area approximately 12 inches by 12 inches where the wall was a different color than the rest of the bathroom. On 12/28/2022 at 4:37 PM, an interview was completed with Certified Nursing Assistant (CNA) #1. CNA #1 stated that if there was anything that needed repaired, she would tell the charge nurse or write it down on the to-do list for maintenance. CNA #1 reported her normal assignment was caring for Resident #38 and Resident #48, and she had never noticed the broken grab bar or the board lying on the floor. CNA #1 also stated room [ROOM NUMBER] and room [ROOM NUMBER] were part of her normal assignment. She said she had not noticed the damage to the walls in the shared bathroom. An interview was completed with the Maintenance Supervisor (MS) on 12/28/2022 at 4:55 PM. The MS stated staff could submit maintenance requests directly to him in person or over the phone or requests were entered into the TELS system. The MS stated he was the only maintenance personnel managing two facilities until the hiring process was completed for a new maintenance supervisor for this facility. He had to prioritize repairs so if it's touching up paint or something, it will wait. During the interview, the MS reviewed the pending work orders in TELS with the surveyor. There were no work orders for the bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] or the room shared by Resident #38 and Resident #48. Observations of those rooms were completed at the conclusion of the interview. The MS stated he was not aware of the issues but did say those things should be reported for work orders. The MS stated maintenance staff did routine rounds of each room, looking for any needed repairs, twice a year. The MS stated the TELS system prompted the staff to do the rounds and it's about time to do it again. An interview was completed with the Director of Nursing (DON) on 12/30/2022 at 8:29 AM. The DON stated if there was a maintenance issue, staff should call or page the maintenance supervisor. The DON was not aware of the TELS system and stated that if an issue put a resident in jeopardy, the issue should be reported immediately. Otherwise, issues should be reported during the same shift of the same day. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Administrator on 12/30/2022 at 8:44 AM. The Administrator stated any maintenance issue found by the staff should be added to the TELS system or reported to a staff member who had access to the TELS system. Reporting should be as soon as it's found.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34575 Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to provide necessary care and services to maintain or improve a resident's ability to carry out activities of daily living (ADLs) for three (Resident #17, Resident #41, and Resident #56) of six residents reviewed. Specifically, Resident #17, Resident #41, and Resident #56 did not receive restorative care services as recommended by the therapy department to maintain mobility. Findings included: Review of a facility policy titled, Skilled Inpatient Services - Restorative, dated 12/04/2021, specified the intent of the policy was, To provide nursing interventions that promote the patient's ability to adapt and adjust to living as independently and as safely as possible. When clinically appropriate, these interventions may be captured in a formalized restorative nursing care plan overseen by Restorative Nursing Supervisor(s). The policy further indicated, The plan of care will be outlined in EMR [electronic medical record] software and will be followed by staff trained in restorative care and the restorative nursing supervisor shall complete a summary evaluation of the patient's progress monthly. 1. A review of a Face Sheet indicated the facility admitted Resident #17 with diagnoses that included a displaced fracture of the lateral left tibia, hemarthrosis (bleeding into a joint) of the left knee, pain in the left knee, and generalized muscle weakness. The quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS further indicated the resident required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #17 required limited assistance to walk in the room and corridor. The MDS also indicated the resident was not steady when walking. Review of Resident #17's Care Plan, reviewed on 05/30/2022, revealed the resident had limited mobility related to a history of falls and impaired balance. Interventions included to refer to therapy as indicated and assist with activities of daily living (ADLs) as needed. Review of Resident #17's Restorative Care Plan, initiated on 07/28/2022 indicated a plan for walking with a frequency of once daily, 6 days per week. The intervention was to assist the patient with performance of walking using a rolling walker up to 50 feet. Review of Resident #17's Occupational Therapy Daily Note, dated 09/21/2022, revealed the resident was discharged from occupational therapy (OT) due to reaching the resident's maximum potential and the resident was to start with a restorative nursing program on 09/22/2022 in order to maintain the patients functional discharge status. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/27/2022 at 9:31 AM, Resident #17 stated there was not sufficient staff to conduct the restorative services that were started when therapy ended. The resident stated there was a goal for them to get stronger and potentially return home, and this would involve being able to walk. Resident #17 stated the staff only came sometimes to walk them. On 12/27/2022 at 3:24 PM, Resident #17 was observed seated in a wheelchair beside the bed. During an interview on 12/29/2022 at 9:05 AM, Resident #17 stated the staff had not offered the restorative services for at least three weeks. The resident stated the last time a staff member walked with them was Certified Nursing Assistant (CNA) #10 and that was almost three weeks ago. Throughout the survey from 12/27/2022 through 12/30/2022, Resident #17 was not observed up walking with staff members. In an interview on 12/28/2022 at 2:17 PM the Director of Rehabilitation stated during discharge planning the therapy department determined whether a resident would benefit from the restorative program. If determined appropriate, the plan would be provided to the restorative nurse to initiate the program once the resident was discharged from therapy. The Director of Rehabilitation stated the therapy department would help with training the staff and then the restorative program nurse would manage the service. The Director of Rehabilitation stated Resident #17 was placed on the restorative program to maintain strength. The Director of Rehabilitation stated if restorative nursing services were not being provided the impact would be a decline in function for the resident. In an interview on 12/28/2022 at 2:45 PM CNA #10 stated she filled in to do restorative care when CNA #5 was not at the facility. CNA #10 further stated she had only provided restorative care to Resident #17 one time and that was about three weeks prior. CNA #10 stated restorative care was not being provided as there was not enough staff. During an interview on 12/28/2022 at 2:48 PM the Assistant Director of Nursing (ADON) stated she oversaw the restorative program and that there were two CNAs who were considered the restorative aides, CNA #10, and CNA #5. The ADON stated there were times everyone had to do their own restorative. The ADON stated she verified the restorative care was being provided by seeing residents being walked. The ADON also stated she documented all restorative care and wrote a note if the residents refused. The ADON stated Resident #17 participated sometimes but often refused and although the resident had stated the staff were not assisting with walking, they were doing range of motion which was counted as the restorative care. The ADON was unable to provide any documented evidence of Resident #17 refusing to be walked as outlined in the plan of care. 2. A review of a Face Sheet indicated the facility admitted Resident #41 with diagnoses that included diabetes with diabetic neuropathic arthropathy (disease of a joint), morbid obesity, and below the knee amputation of the left leg. The quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The resident required extensive assistance of one person for bed mobility, dressing, toilet use, and personal hygiene. The MDS indicated Resident #41 did not walk. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #41's Care Plan, reviewed on 11/21/2022, revealed the resident had limited mobility due to a left below the knee amputation. The goal was for the resident to maintain or improve physical function in mobility. The interventions included to assist with activities of daily living (ADLs) as needed. Review of Resident #41's Occupational Therapy Daily Note, dated 09/09/2022, revealed the resident was evaluated to determine the appropriate restorative nursing program (RNP). The plan included wheelchair mobility and transfers. Review of Resident #41's Physical Therapy Discharge Summary, dated 09/12/2022, revealed a functional mobility program (FMP) was established for the resident that included range of motion (ROM). Review of Resident #41's Nursing Restorative Care Program documentation revealed the goal for the resident was to maintain/improve adequate active range of motion of full body to allow daily participation in mobility and other functional activities. The documentation further indicated the program was to be provided once daily, six days per week. Resident #41 was observed on 12/27/2022 at 9:00 AM; 12/27/2022 at 12:30 PM; 12/27/2022 at 3:29 PM; 12/28/2022 at 8:15 AM and 12/28/2022 at 11:45 AM. Resident #41 was not observed during any of these dates and times up out of the bed. During an interview on 12/28/2022 at 11:45 AM Resident #41 stated they were placed on a restorative program for ROM and self-propelling the wheelchair. The resident further stated an aide would get the resident to move their arms around and straighten their leg every couple of days. Resident #41 stated it did not occur every day but several times a week. Resident #41 further stated that the staff had not helped them get out of bed and into a wheelchair for a number of weeks. The resident stated they would get up in the past and self-propel to visit a relative in another room but now that relative comes to Resident #41's room so the resident stays in bed. 3. A review of a Face Sheet indicated the facility admitted Resident #56 with diagnoses that included diabetes, chronic respiratory failure, difficulty in walking, and muscle weakness. The significant change Minimum Data Set (MDS), dated [DATE], revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated the resident required extensive assistance of one person for bed mobility and dressing, and the resident was dependent on one to two people for transfers, toilet use, and personal hygiene. The MDS further indicated Resident #56 did not walk. Review of Resident #56's Care Plan, reviewed on 12/21/2022, revealed the resident had limited mobility related to neuropathy and shortness of breath. The goal was for the resident to maintain or improve physical function in mobility. The interventions included to assist with activities of daily living (ADLs) as needed. Review of Resident #56's Occupational Therapy Discharge Summary, dated 10/18/2022, revealed a functional mobility program was established for the resident that included exercise provided through the facility's skilled nursing facility restorative program. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #56's Nursing Restorative Care Program documentation revealed the goal was for the resident to be able to tolerate range of motion (ROM) exercises to maintain joint mobility. The interventions included for the resident to complete upper extremity and lower extremity ROM exercises. The documentation indicated another goal for the resident related to bed mobility for the resident to be able to sit at the edge of the bed with supervision and the intervention included to sit the patient at the edge of the bed with supervision for 10 minutes. The program documentation further indicated the exercises were to be provided once daily, five days per week. During an interview on 12/28/2022 at 2:42 PM CNA #5, the restorative aide, stated she had not conducted any restorative care for the past two to three weeks. In an interview on 12/28/2022 at 2:45 PM CNA #10 stated she filled in to do restorative care when CNA #5 was not at the facility. CNA #10 further stated she had not provided restorative care to Resident #56. During an interview on 12/29/2022 at 11:50 AM, Resident #56 stated the staff had not conducted any restorative exercises with the resident. The resident stated the facility was short staffed, and the resident could not remember the last time an aide worked with assisting the resident to sit on the side of the bed. During an interview on 12/29/2022 at 2:15 PM the Assistant Director of Nursing (ADON) stated she was unaware that the residents were not being provided daily restorative care. She stated the residents may have been getting some ROM, but she really did not know. The ADON further stated she just assumed the restorative care was being done and she was involved in too many things to be able to ask about every single person on restorative. The ADON stated that she would ask the aides if they completed their work at the end of the shift and if they reported they had, then she assumed that included the restorative care piece. On 12/29/2022 at 3:29 PM the Administrator and Director of Nursing (DON) were interviewed regarding the concern that restorative care was not being provided. The Administrator stated it was her expectation that restorative services be conducted.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38570 Based on observation, interview, record review, and facility policy review, the facility failed to ensure four (Residents #25, #45, #47, and #17) of six residents reviewed for activities of daily living (ADL) care, who were unable to carry out ADLs, received the necessary services to maintain good grooming. Specifically, the facility failed to provide nail care for Residents #25, #45, and #47 and failed to provide showers for Resident #17. Findings included: A review of a facility policy titled, Care of Fingernails/Toenails, revealed, It is the intent of this center to provide appropriate nail care to all patients. The policy further indicated guidelines for providing care that included, Identify resident. Gently, clean under each nail. You may have to soak hand before cleaning. Trim the fingernails/toenails. Smooth with nail file or emery board if needed. 1. A review of a Face Sheet revealed the facility admitted Resident #25 to the facility with diagnoses including Alzheimer's disease, dementia, psychotic disturbance, anxiety, chronic obstructive pulmonary disease (COPD), peripheral vascular disease, and hypothyroidism. A review of a quarterly Minimum Data Set (MDS) for Resident #25, dated 11/24/2022, revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Per the MDS, Resident #25 was totally dependent on one-person for physical assistance with personal hygiene. A review of Resident #25's Care Plan, last reviewed/revised on 10/15/2022, revealed the resident had a self-care deficit and had a history of not participating in ADL care. The interventions included staff to assist with ADLs as needed. An observation on 12/27/2022 at 11:51 AM revealed Resident #25 was in the resident's room sitting up in a wheelchair beside the bed. The resident's nails were noted to be long, untrimmed, jagged, and sharp. The resident stated in an interview at this time that the resident needed help with their nails but did not get help and their nails were sharp and long. On 12/29/2022 at 1:52 PM, Resident #25's fingernails were observed with the Director of Nursing (DON), and it was noted all 10 fingernails were one-quarter to one-half inches long and some were slightly jagged. The resident indicated that they would like their nails trimmed. During an interview conducted on 12/29/2022 at 2:00 PM, the DON stated that nail care should be done on a regular basis with showers or whenever they got long, jagged, or dirty. He stated the nursing staff should have trimmed or filed Resident #25's nails as a part of their ADL care. 2. A review of a Face Sheet revealed the facility admitted Resident #45 to the facility with diagnoses including Alzheimer's disease, dementia, osteoporosis, stroke, hypertension, degenerative joint disease (DJD), and macular degeneration. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a quarterly Minimum Data Set (MDS) for Resident #45, dated 12/20/2022, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Per the MDS, Resident #45 was totally dependent on one-person for physical assistance with personal hygiene. A review of Resident #45's Care Plan, last reviewed/revised on 12/21/2022, revealed the resident had a self-care deficit related to decreased mobility, impaired vision, and need for staff assistance with ADLs. Interventions included to assist with activities of daily living (ADLs) as needed and to encourage the resident to complete as much self-care as possible independently or with minimal assistance. An observation on 12/27/2022 at 12:14 PM revealed Resident #45 was in the resident's room, sitting up in a wheelchair beside the bed. The resident's nails were noted to be long, untrimmed, and jagged. There was a black substance noted under several of the resident's nails. The resident was unable to be interviewed about their nails due to cognitive impairment. On 12/29/2022 at 1:56 PM, Resident #45's fingernails were observed with the Director of Nursing (DON), and it was noted all 10 fingernails were at least one-quarter inch long, with a black substance under each nail. During an interview conducted on 12/29/2022 at 2:00 PM, the DON stated that nail care should be done on a regular basis with showers or whenever they got long, jagged, or dirty. He stated the nursing staff should have trimmed or filed Resident #45's nails as a part of their ADL care. 3. A review of a Face Sheet revealed the facility admitted Resident #47 with diagnoses that included Parkinson's disease, dementia, hypothyroidism, difficulty walking, muscle weakness, dysphagia, and need for assistance with personal care. A review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Per the MDS, Resident #47 required extensive assistance of one-person for assistance with personal hygiene. A review of Resident #47's Care Plan, last reviewed/revised on 08/12/2022, revealed the resident had a self-care deficit related to decreased mobility and need for assistance with activities of daily living (ADLs). The care plan interventions included to assist with ADLs as needed. An observation on 12/27/2022 at 10:56 AM revealed Resident #47 was in the resident's room, sitting up in a wheelchair beside the bed. The resident's nails were noted to be one-quarter to one-half inches long. The resident did not respond to questions asked about their nails. On 12/29/2022 at 1:50 PM, Resident #47's fingernails were observed with the Director of Nursing (DON), and it was noted that four of the resident's 10 fingernails were more than one-quarter inch long and the other six nails appeared to be chewed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 12/28/2022 at 12:34 PM, Licensed Practical Nurse (LPN) #8 stated that certified nursing assistants (CNAs) were supposed to do nail care on shower days or whenever they saw that the resident's nails were long, jagged, or dirty. She stated they were to use a clipper and emery board and a little nail stick to clean under the nails if dirty. The nurse stated there had been days that they only had two to three CNAs staffed and they had not been able to do the nail care. During an interview conducted on 12/28/2022 at 1:03 PM, CNA #5 stated she checked residents' nails on shower days. She stated that on shower days she trimmed them with a clipper or used an emery board and filed them, and she cleaned under them. CNA #5 went to the resident's room and showed the surveyor the resident's nails that were approximately one-quarter inch long and had a brown substance under the nail. She stated she needed to soak the nails to clean them. The CNA also stated that on Sundays they did not have to do showers, so she often tried to do resident nails on Sunday. CNA #5 stated she had not been able to do the resident's nails all the time because the staffing had been short. During an interview conducted on 12/28/2022 at 12:39 PM, CNA #11 stated that each time she gave a resident a shower, she checked their nails and trimmed and cleaned them. She reported that if the nails were dirty, long, or jagged, she used the clippers and emery board to file them. She stated that most of the time she could do this, but when they were short-staffed it was hard to get to everything. During an interview conducted on 12/29/2022 at 2:00 PM, the DON stated that nail care should be done on a regular basis with showers or whenever they got long, jagged, or dirty. He stated the nurse staff should have trimmed or filed Resident #47's nails as a part of their ADL care. 34575 4. A policy related to bathing was requested from the facility, but a policy was not provided by the end of survey. A review of a Face Sheet indicated the facility admitted Resident #17 with diagnoses that included a displaced fracture of the lateral left tibia, hemarthrosis of the left knee, pain in the left knee, and generalized muscle weakness. The quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated the resident required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident required assistance of one person for bathing. Review of Resident #17's Care Plan, reviewed on 05/30/2022, revealed the resident had limited mobility related to a history of falls and impaired balance. Interventions included to refer to therapy as indicated and assist with activities of daily living (ADLs) as needed and to honor bathing preferences. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/27/2022 at 9:31 AM, Resident #17 stated there was not sufficient staff to provide a shower and the resident could not remember the last time the staff had assisted with a shower. The resident further stated they had not received a shower for almost three weeks, and they were supposed to get a shower on Tuesdays, Thursdays, and Saturdays. A review of Resident #17's Resident ADL Documentation between 09/01/2022 and 12/23/2022 revealed Resident #17 had not received a shower three times per week as requested and the last date Resident #17 had received a shower was on 12/09/2022. During an interview on 12/28/2022 at 10:55 AM Certified Nursing Assistant (CNA) #12 stated staffing usually consisted of two nurses and three or four aides, occasionally five aides. CNA #12 stated the staff tried to split the hallways to get the workload done and they helped each other complete the tasks. During an interview on 12/28/2022 at 11:23 AM CNA #5 stated there were usually only four aides in the building, occasionally five. CNA #5 further stated the residents were supposed to receive their showers three times each week based on their room numbers. Odd numbered rooms were showered Tuesday, Thursday and Saturday and even numbered rooms on Monday, Wednesday, and Friday. During an interview on 12/28/2022 at 12:05 PM Licensed Practical Nurse (LPN) #4 stated they were currently staffing with one to two aides less than required. LPN #4 stated the residents did not get baths when there were less than five aides. LPN #4 stated the staffing was impacting meeting the needs of the residents. Review of the facility grievance logs over the past six months revealed a grievance dated 08/30/2022 submitted by a family member of Resident #17. The grievance indicated the resident was not receiving a bath on the scheduled days. The Administrator had reviewed the grievance and discussed it with the resident and the complainant. The grievance was marked as resolved. There were no other resident grievances related to baths/showers. During an interview on 12/29/2022 at 7:57 AM the Staffing Coordinator (SC) stated the staffing on dayshift was supposed to be seven CNAs and the facility had been unable to sustain five CNAs for the past few months. The SC stated the staff were worn out and she believed the baths were not being done because of the low staffing. During an interview on 12/29/2022 at 3:29 PM the Administrator, along with the Director of Nursing (DON), stated staffing ratios should be where the facility can meet the resident needs. The DON and Administrator stated despite attempts to augment staffing, the facility had been unable to increase their CNA staff and the facility had dropped the census to 65 to address the staffing issue. The Administrator was not aware the residents were not being showered.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38570 Based on observations, interviews, record review, document review, and facility policy review, it was determined the facility failed to provide adequate assistance during incontinence care to prevent a fall with injury for one (Resident #56) of three sampled residents whose clinical records were reviewed for accidents. This deficient practice resulted in Resident #56 sustaining lacerations to both lower extremities and being sent to a hospital for treatment. Findings included: A review of the facility policy titled, Positioning and Moving the Patient, last reviewed on 12/04/2021, revealed for log rolling a resident It is the intent of this center to provide patients with care that promotes good body alignment. According to the policy guidelines, staff should Slide both your arms under the patient's back to his/her far shoulder. Slide the patient's shoulder toward you on your arms. Slide both your arms (as far as you can) under the patient's buttocks. Slide the patient's buttocks toward you. Slide the patient's feet between the knees and ankles. Slide the patient's feet towards you. Place the pillow between the patient's legs. Cross the patient's legs in the direction that he/she should be rolled. Roll the patient onto his/her side like a log. A review of Resident #56's Face Sheet revealed the resident had diagnoses that included diabetes, hypertension, atrial fibrillation, anemia, anxiety, depression, arthritis, obesity, unsteadiness, and need for assistance with personal care. A review of Resident #56's significant change Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS indicated the resident needed extensive assistance of one staff member for bed mobility (turning side to side and positioning). The MDS also indicated the resident was always incontinent of bowel and bladder and was dependent on one staff member for toileting and personal hygiene. Further review revealed Resident #56 had no history of falls since the previous assessment/entry/reentry and weighed 206 pounds. According to Resident #56's MDS, activity of daily living (ADL) functional/rehabilitation potential and falls were triggered care areas and were addressed on the resident's care plan. A review of Resident #56's care plan, updated on 12/28/2022, revealed the resident was at risk for falls related to osteoarthritis, atrial fibrillation, diabetes, hypertension, a history of falls, obesity, anemia, neuropathy, anxiety, shortness of breath, and a fall sustained on 12/28/2022. Prior to the 12/28/2022 update, interventions to prevent falls included assisting the resident with ADLs and mobility as needed, keeping the bed in the low position, keeping personal items within reach, educating the resident and family on risks for falls with injury, and reminding the resident to call when assistance was needed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #56's care plan, updated on 11/02/2022, revealed the resident had a self-care deficit related to obesity, anemia, anxiety, shortness of [NAME], falls, and assistance needed with toileting and hygiene. The facility developed interventions that included providing assistance bars to the head of the bed, assisting with ADLs as needed, and offering to turn and reposition frequently as the resident allowed. During an interview conducted on 12/27/2022 at 11:42 AM, Resident #56 stated the resident had a concern about a certified nursing assistant (CNA) who worked nights at the facility. The resident stated on the day before Christmas Eve (12/23/2022), early in the morning, CNA #7 came in to change the resident and pushed the resident off the bed. Resident #56 stated CNA #7 was changing the resident's (incontinence) brief because the resident had a bowel movement, and the CNA pushed the resident on his/her side to clean the resident. The resident said the CNA grabbed the resident's right wrist area and was pulling on it and pushing the resident over to his/her left side. Resident #56 stated he/she was hanging onto the grab bar on the left side of the bed with his/her left hand, but the CNA kept pushing the resident. The resident said the CNA kept saying loudly, Roll, roll, roll over, while pushing on the resident's back side. The resident told the CNA that the resident could not roll any further because the resident was already on the edge of the bed. The resident stated the CNA pushed the resident one more time and the resident's legs fell off the bed. The resident stated he/she hung onto the grab bar and the left side of the bed with both hands; however, the resident's legs and feet were on the floor. Resident #56 yelled at the CNA and told her that she pushed the resident off the bed. CNA #7 ran out and yelled for help and a nurse came in and started taking care of the resident. The resident stated the nurse got the resident back in bed utilizing a mechanical lift. Resident #56 stated his/her legs hurt a lot and there was blood all over. The resident told the nurse that the CNA defiantly pushed the resident off the bed. According to Resident #56, the resident was transferred to the hospital for treatment of the legs. On 12/27/2022 at 11:50 AM, an observation of Resident #56 revealed multiple areas of discoloration to the resident's thumb on the left hand and the second toe on the left foot was discolored from top to bottom and was purple in color. Further observation revealed slight swelling was noted to both legs and there was a large 4 inch by (x) 4-inch adhesive bandage to each lower leg. Resident #56 stated he/she had skin tears where the adhesive bandages were located. A review of a facility Event report for Resident #56, dated 12/23/2022 at 4:15 AM, indicated the resident fell from bed while a staff member was changing the resident's incontinence brief. The report indicated staff rolled the resident too far and the resident fell out of bed. The report indicated the resident sustained a large skin tear to each leg and an abrasion to the left upper thigh. According to the report, the staff called 911. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a Nurse Note, dated 12/23/2022 at 4:15 AM, revealed Licensed Practical Nurse (LPN) #3 documented that a CNA called her to Resident #56's room. Per the note, the resident and the resident's roommate were also yelling out for help. When LPN #3 entered the room, Resident #56's lower body was on the floor, while the resident was holding onto the handrail to keep his/her upper body from hitting the floor. Resident #56 indicated the resident did not hit his/her head. The note revealed there was feces, urine, and blood on the floor. According to the note, the resident's bed was elevated. The nurse lowered Resident #56's bed and the resident was able to continue to hold onto the bed while the nurse lowered the resident's upper body to the floor. The nurse then positioned the resident on his/her side and conducted an assessment. Resident #56 sustained an abrasion to the left upper leg, a two-inch skin tear to the left lower leg, and a two-inch skin tear to the right lower leg with a tendon exposed. According to the note, the right leg skin tear approximated from top to bottom [and] the middle had tendon showing. The nurse's note indicated the nurse practitioner stated the resident would have to be sent to the hospital for staples. Further review of the nurse's note revealed the CNA stated she was providing care and the resident rolled out of bed. However, the resident and roommate disagreed with the CNA's account of the encounter. The nurse documented that Resident #56 stated the CNA kept pushing the resident. A review of Resident #56's hospital emergency room (ER) record, dated 12/23/2022, revealed the resident was treated for a fall and a laceration to the leg. A review of the resident's computerized tomography (CT; provided more details than an x-ray) scan report, dated 12/23/2022, revealed there was edema (swelling) in the soft tissue of the left upper leg. The CT scan report of the right leg, dated 12/23/2022, revealed there was an Apparent skin defect and bandaging overlying the anterior shin with Minimal associated subcutaneous induration [minimal involvement beneath or under all layers of the skin]. During an interview conducted on 12/28/2022 at 2:23 PM with CNA #7 via telephone, she stated that during the early morning on 12/23/2022 she had to change Resident #56's incontinence brief twice. She stated the first time the resident had loose stool and the CNA had to change the resident in the bed. She stated everything went well and there were no problems. The CNA stated the second time, approximately one hour later, the resident turned on the light and stated he/she had another bowel movement. Resident #56 had loose, diarrhea stool and the CNA asked the resident to turn toward the window. CNA #7 stated the resident grabbed the grab bar on the left side of the bed and started to turn. She stated she saw that the resident had feces on the back side of the right arm and elbow. She stated she hung onto the resident's arm at the wrist to hold the arm up while she cleaned the elbow and back of arm. She stated she asked the resident to roll over and picked up the resident's right leg and put it on top of the left leg so the resident could turn over. Resident #56 was then on his/her left side, and the CNA began cleaning feces from the resident's buttocks and back. The CNA stated she then rolled up all the dirty sheets and tucked them under the resident and started putting on the clean sheet. She stated she was not pushing the resident and did not have her hands on the resident. CNA #7 stated she was using both of her hands to put the sheet on the bed and tuck it under the resident. The CNA stated she was almost ready to tell the resident to roll back so the CNA could go to the other side of the bed when the resident rolled off the bed. According to CNA #7, the bottom half of the resident's body was on the floor and the resident continued to hold onto the grab bar on the left side of the bed. The CNA stated she was scared and ran from the room to the hallway to yell for help. She stated the nurse came and assisted the resident. CNA #7 stated the resident had skin tears to both lower legs and there was a lot of blood and urine on the floor. The CNA stated the resident was yelling for help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview conducted on 12/28/2022 at 2:43 PM, LPN #3 stated that on the night of 12/23/2022 at approximately 4:30 AM, she heard CNA #7 calling down the hall for help. The nurse stated she went to Resident #56's room, and the resident was on the floor on the left side of the bed between the bed and the window. The resident was hanging onto the small grab bar on the left side of the bed with both hands and the resident's face was toward the floor. The rest of the resident's body was hanging off the bed and his/her legs and feet were on the floor. She stated she ran over to the resident and the resident was lying in blood, urine, and feces that was all over the floor. The nurse stated the resident kept repeating, She pushed me off the bed. She pushed me off the bed. LPN #3 stated she sent CNA #7 out of the room to get a mechanical lift because they had to get the resident off the floor. Resident #56 and the roommate were upset and yelling at the CNA. LPN #3 further stated that Resident #56's bed was in the high position because the CNA was changing the resident and the LPN lowered the bed. According to LPN #3, the resident's bed was unusually high, and believed it was about the height of the CNA's chest. After the LPN lowered the bed, she helped the resident let go of the grab bar, lowered the resident to the floor, and turned the resident over to fully assess the resident. She stated the CNA then came into the room and they lifted the resident back into bed with the mechanical lift. LPN #3 then did a head-to-toe assessment. LPN #3 indicated Resident #56 had large skin tears on both lower legs. The LPN stated the left skin tear was a couple of inches long and could be put together (approximated), but the skin tear on the right lower leg looked like the tendon was showing. Both skin tears were bleeding heavily. The resident also had a left knee abrasion and was complaining of pain. The nurse stated the resident told her, The CNA pushed me out of the bed. The resident said the CNA kept saying loudly, Roll, roll, roll! The resident told the CNA the resident was as far over as they could be and was already on the edge of the bed. The resident told the LPN that the CNA gave one more push and the resident rolled off the bed. The nurse stated she reported the incident to the Director of Nursing (DON) and the DON came into the facility that morning. During an interview conducted on 12/27/2022 at 1:14 PM with LPN #8, she stated she was aware of the fall Resident #56 experienced on the morning of 12/23/2022. She came on duty the morning of 12/24/2022 and the resident came back from the hospital. She stated when caring for Resident #56, the resident told her that CNA #7 pushed the resident off the bed when she was changing the resident's incontinence brief. The resident told her that the CNA was pushing the resident over onto his/her side but kept pushing even though the resident was already on the edge of the bed on his/her left side. The resident told her the CNA was yelling loudly, Roll, roll, roll as she was pushing the resident over on the left side of the bed, and then with one last push, the resident rolled off the bed. The resident told the CNA that the resident could not roll over anymore because he/she was on the side of the bed. The nurse stated the resident sustained skin tears to both lower legs, a bruised second toe of the left foot, an abrasion on the left knee, and bruising to the left thumb. During an interview conducted on 12/28/2022 at 5:12 PM, the DON stated staff notified him when he came in early on the morning of 12/23/2022 of Resident #56's fall with a report of what happened and the injuries the resident sustained. He stated the resident was transferred to the hospital just minutes before he came in. The DON stated the nurses described the incident to him and he talked to CNA #7 before she went home. The DON stated after he heard what happened from the nurse and talked with the CNA he went back to his office and wrote up an associate corrective action form. He stated he gave the form to the CNA's supervisor, LPN #4, to give to the CNA later. The DON stated the CNA needed to take more care with moving a resident and to pay attention to positioning and patient movement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of an Associate Corrective Action Form, dated 12/23/2022, indicated CNA #7 was assisting a resident in bed and moved the resident away from her, causing her to lose control of movement. The resident fell to the floor from the bed and sustained injury to the lower extremities (skin tears which required a hospital transfer for evaluation). The corrective action plan for CNA #7 was to take more care when moving residents, pay attention to positioning and patient movement, and ask for assistance from other CNAs when moving a resident who was bedbound or who had mobility defects. The form indicated with larger residents it was necessary to have a second person stand on the opposite side of the bed to assist with movement. Per the form, the resident should be moved close to the CNA and only moved when communication was completed, and the resident verbalized understanding. The form indicated the CNA should also remember to lower the bed to the lowest position when finished moving a resident. During an interview conducted on 12/30/2022 at 8:35 AM, LPN #9, the Resident Assessment Instrument (RAI) Coordinator, revealed he believed the root cause of Resident #56's fall was due to the CNA failing to position the resident away from the side of the bed before rolling the resident over and the CNA failing to ask for assistance with the resident's care. During an interview conducted on 12/28/2022 at 5:47 PM, the Administrator (ADM) stated she was not notified of the resident's fall/incident until Tuesday 12/27/2022 when she came into the facility. She stated she thought the incident was closed. A follow up interview with the Administrator on 12/30/2022 at 9:54 AM revealed CNA #7 had not worked in the facility since the night of the fall/incident and was suspended on 12/28/2022 pending investigation.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34575 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure sufficient staffing to meet the daily needs of six (Resident #17, #41, #56, #47, #25, and #45) of six residents reviewed for activities of daily living. Specifically, the facility failed to ensure there were enough staff to provide restorative nursing care, showers, and fingernail care. Findings included: On 12/29/2022 at 7:57 AM the Staffing Coordinator (SD) was asked to provide a policy on staffing; however, the facility did not have a staffing policy. A review of the Facility Assessment Tool revealed the facility needed six certified nursing assistants (CNAs) on dayshift based on the resident population and their needs for care and support to ensure there were sufficient staff to meet the needs of residents. The facility assessment further defined this need as a CNA to patient ratio of one CNA per 12 residents. A review of the Facility Two Week Staffing Grid for the dates of the survey, 12/27/2022, 12/28/2022, and 12/29/2022, revealed four CNAs were scheduled on dayshift to meet the needs of the residents. Observations of staffing on the floor for each of these days confirmed there were four CNAs working on the floor during dayshift. A review of the facility Resident Census and Condition of Residents revealed the resident census on 12/28/2022 was 65, which was approximately 16 residents for each of the four CNAs. 1. A. During an interview on 12/27/2022 at 9:31 AM, Resident #17 stated there was not sufficient staff to conduct restorative services for the resident that was supposed to be initiated when therapy ended. The resident stated a goal was for the resident to get stronger and potentially return home, which would involve being able to walk. However, Resident #17 stated staff only sometimes assisted the resident with walking. A follow-up interview with Resident #17 on 12/29/2022 at 9:05 AM revealed staff had not offered restorative services for at least three weeks. The resident stated the last time a staff member assisted him/her with walking was when CNA #10 assisted the resident approximately three weeks ago. On 12/28/2022 at 2:45 PM, CNA #10 stated she filled in to do restorative care when CNA #5 was not at the facility. CNA #10 further stated she had only provided restorative care to Resident #17 one time and that was about three weeks ago. CNA #10 stated restorative care was not being provided because there were not enough staff. 1. B. During an interview on 12/28/2022 at 11:45 AM, Resident #41 stated the resident was placed on a restorative program for range of motion (ROM) exercises and assistance with self-propelling a wheelchair. Resident #41 stated that staff had not helped the resident get out of bed and into a wheelchair for a number of weeks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. C. During an interview on 12/29/2022 at 11:50 AM, Resident #56 stated staff had not conducted any restorative exercises with the resident because the facility was short staffed. Resident #56 stated he/she could not remember the last time an aide had assisted the resident with sitting on the side of the bed and the resident did not get out of the bed now. An interview with CNA #5, who was also a restorative nurse aide, on 12/28/2022 at 2:42 PM revealed she had not provided restorative services for residents in two to three weeks. An interview with the Assistant Director of Nursing (ADON) on 12/28/2022 at 2:48 PM revealed she had run the restorative program for approximately two years. She stated there were two CNAs, CNA #5 and CNA #10, who were supposed to provide restorative nursing services. The ADON stated when five or six CNAs were working, the staff could provide restorative services for residents. However, due to staffing, the facility did not have a dedicated CNA to provide restorative nursing services. 2. During an interview on 12/27/2022 at 9:31 AM, Resident #17 stated there was not sufficient staff to provide a shower and the resident could not remember the last time the staff had assisted with a shower. The resident further stated that he/she had not received a shower for almost three weeks, and the resident was supposed to get a shower on Tuesdays, Thursdays, and Saturdays, A review of Resident #17's Resident ADL Documentation between 09/01/2022 and 12/23/2022 revealed Resident #17 had not received a shower three times per week as requested. The last date Resident #17 received a shower was on 12/09/2022, which was approximately 18 days without a shower. During an interview on 12/28/2022 at 11:23 AM, CNA #5 stated there were usually only four CNAs working at the facility, occasionally 5. CNA #5 further stated the residents were supposed to receive a shower three times each week based on their room numbers. Odd numbered rooms were showered Tuesday, Thursday, and Saturday and even numbered rooms on Monday, Wednesday, and Friday. During an interview on 12/28/2022 at 12:05 PM Licensed Practical Nurse (LPN) #4 stated there were one to two CNAs less than required. The LPN stated residents did not get baths when there were less than five CNAs. LPN #4 stated staffing was impacting the needs of the residents. 3. A. An observation on 12/27/2022 at 10:56 AM revealed Resident #47 was in the resident's room, sitting up in a wheelchair beside the bed. The resident's nails were noted to be one-quarter to one-half inches long. The resident did not respond to questions asked about their nails. On 12/29/2022 at 1:50 PM, Resident #47's fingernails were observed with the Director of Nursing (DON), and it was noted that four of the resident's 10 fingernails were more than one-quarter inch long and the other six nails appeared to be chewed. 3. B. An observation on 12/27/2022 at 11:51 AM revealed Resident #25 was in the resident's room sitting up in a wheelchair beside the bed. The resident's nails were noted to be long, untrimmed, jagged, and sharp. The resident stated in an interview that the resident needed help with their nails but did not get help and their nails were sharp and long. On 12/29/2022 at 1:52 PM, Resident #25's fingernails were observed with the Director of Nursing (DON), and it was noted all 10 fingernails were one-quarter to one-half inches long and some were slightly jagged. The resident indicated that they would like their nails trimmed. (continued on next page)

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	115353	A. Building B. Wing	12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehabilitation	101 Old Talbotton Rd Thomaston, GA 30286

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. C. An observation on 12/27/2022 at 12:14 PM revealed Resident #45 was in the resident's room, sitting up in a wheelchair beside the bed. The resident's nails were noted to be long, untrimmed, and jagged. There was a black substance noted under several of the resident's nails. The resident was unable to be interviewed about their nails due to cognitive impairment. On 12/29/2022 at 1:56 PM, Resident #45's fingernails were observed with the Director of Nursing (DON), and it was noted all 10 fingernails were at least one-quarter inch long, with a black substance under each nail. During an interview conducted on 12/28/2022 at 12:34 PM, Licensed Practical Nurse (LPN) #8 stated CNAs were supposed to provide nail care on shower days or whenever they saw that the resident's nails were long, jagged, or dirty. She stated they were to use nail clippers and emery board to trim residents' nails and use a nail stick to clean under the nails if they were dirty. The nurse stated there had been days when they only had two to three CNAs staffed and they had not been able to provide residents with nail care. During an interview conducted on 12/28/2022 at 1:03 PM, CNA #5 stated she had not been able to do the resident's nails all the time because the staffing had been short. During an interview conducted on 12/28/2022 at 12:39 PM, CNA #11 stated when they were short-staffed it was hard to get to everything. During an interview on 12/28/2022 at 10:55 AM, CNA #12 stated staffing usually consisted of two nurses and three or four CNAs, occasionally there were five CNAs. CNA #12 stated staff tried to split the hallways to provide care and they helped each other complete tasks. During an interview on 12/29/2022 at 7:57 AM the Staffing Coordinator (SC) stated the staffing on dayshift was supposed to be seven CNAs; however, the facility had been unable to sustain five CNAs for the past few months. The SC further stated currently the facility was staffed with three to four CNAs on the day shift and there were only five total full-time dayshift CNAs at the facility. The SC stated the staff were worn out. During an interview on 12/29/2022 at 9:49 AM, the Human Resources Director (HRD) stated there were not enough CNAs on dayshift. The facility staffing model required six CNAs on dayshift, but the facility only had five full time dayshift CNAs employed to cover the needs. The HRD was unable to state how many CNAs the facility would need to hire to meet the required staffing model but did have four current open positions for dayshift CNAs, which had been open since August 2022. During an interview on 12/29/2022 at 3:29 PM the Administrator stated the facility should be staffed to meet the residents' needs. Despite attempts to augment staffing, the Administrator stated the facility had been unable to increase CNA staff.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34575 Based on observation, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to maintain accurately documented medical records for three (Resident #17, Resident #41, and Resident #56) of six residents reviewed for activities of daily living (ADL) care. The medical record for each resident indicated the resident received restorative nursing care services for 15 minutes every day, 7 days a week; however, the facility failed to provide restorative nursing services. Findings included: A review of the facility policy titled, Clinical Documentation, dated 12/04/2021 revealed, It is the intent that progress clinical documentation should be maintained for each patient. The policy indicated, Clinical documentation reflects the patient's progress and response to his/her care plan, medications, diet, etc. Further review revealed, Clinical Documentation is recorded and signed by the individual responsible for monitoring the patient's progress (i.e., Activities, Dietary, Social Services, Nursing). A review of the facility policy titled, Restorative, dated 12/04/2021, revealed Documentation of minutes of care provided will be documented in EMR [resident's electronic medical record] by staff providing restorative services. 1. A review of a Face Sheet indicated Resident #17 had diagnoses that included a displaced fracture of the lateral left tibia (a bone in the lower leg), hemarthrosis of the left knee, pain in the left knee, and generalized muscle weakness. The quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The resident required extensive assistance of one person for bed mobility and transfers and limited assistance of one person for walking in the room and on the unit. Resident #17 required limited assistance to walk in the room and corridor. The MDS further indicated the resident was not being steady when moving from a seated to standing position, walking, moving on and off the toilet, nor a surface-to-surface transfer. Review of Resident #17's Restorative Care Plan, initiated on 09/22/2022, revealed a plan for staff to assist the resident with transfers from the wheelchair to the commode fifteen minutes per day, seven days per week. The resident also had a plan with interventions for staff to assist the resident one time per day, six days per week with walking up to 50 feet utilizing a rolling walker. Review of Resident #17's Nursing Restorative Care Program documentation revealed the Assistant Director of Nursing (ADON) documented that the resident had participated in a restorative program for walking every day from 09/24/2022 through 12/27/2022. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/27/2022 at 9:31 AM, Resident #17 stated there was a goal for the resident to get stronger and potentially return home; however, the resident stated staff sometimes assisted the resident with walking and did not think it was often enough. Resident #17 was observed seated in a wheelchair beside his/her bed on 12/27/2022 at 11:22 AM, 12/27/2022 at 3:24 PM, and 12/28/2022 at 10:53 AM. The resident was not observed up walking with staff members. During an interview on 12/29/2022 at 9:05 AM, Resident #17 stated staff had not offered restorative services for at least three weeks. The resident stated the last time a staff member assisted the resident with walking was almost three weeks ago when Certified Nursing Assistant (CNA) #10 assisted the resident. On 12/28/2022 at 2:45 PM, CNA #10 stated she filled in and provided restorative care when CNA #5 was not at the facility. CNA #10 stated she had only provided restorative care to Resident #17 one time, which was approximately three weeks ago. 2. A review of a Face Sheet indicated Resident #41 had diagnoses that included diabetes with diabetic neuropathic arthropathy and polyneuropathy, morbid obesity, and a below the knee amputation of the left leg. The quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The resident required extensive assistance of one person for bed mobility, dressing, toilet use, and personal hygiene. According to the MDS, Resident #41 had not walked during the seven-day assessment period. Further review of the MDS revealed the resident had received restorative nursing services for active range of motion (ROM) in the last seven calendar days. A review of Resident #41's Nursing Restorative Care Program revealed a program was initiated for the resident on 09/13/2022 for active full body ROM one time per day, six days per week. Further review of the program revealed staff were required to assist with wheelchair mobility 15 minutes per day, six days per week. The goal was for the resident to maintain the ability to propel a wheelchair 100 feet. According to the program documentation, the Assistant Director of Nursing (ADON) documented that the resident had participated in a restorative program for wheelchair mobility and ROM daily (seven days per week) for 15 minutes from 09/13/2022 through 12/27/2022. Resident #41 was observed on 12/27/2022 at 9:00 AM; 12/27/2022 at 12:30 PM; 12/27/2022 at 3:29 PM; 12/28/2022 at 8:15 AM; and 12/28/2022 at 11:45 AM in bed. Resident #41 was not observed during any of these observations to be propelling a wheelchair nor performing range of motion exercises. During an interview on 12/28/2022 at 11:45 AM, Resident #41 stated the resident was placed on a restorative program for ROM and self-propelling the wheelchair. However, the resident stated an aide would only have the resident move his/her arms around and straighten his/her leg every couple of days. Resident #41 further stated that the staff had not helped the resident out of bed and into a wheelchair for a number of weeks. In the past, the resident would get up and self-propel a wheelchair to visit a relative in another room but now the relative came to Resident #41's room and the resident stayed in bed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of a Face Sheet indicated Resident #56 had diagnoses that included diabetes, chronic respiratory failure, difficulty in walking, and muscle weakness. The significant change Minimum Data Set (MDS), dated [DATE], revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The resident required extensive assistance of one person for bed mobility, and dressing. The resident was dependent on two people for transfers and totally dependent on one person for toilet use and personal hygiene. According to the MDS, Resident #56 did not walk during the previous seven days. The MDS further revealed Resident #56 received a restorative program of passive range of motion (ROM) during the previous seven days. Review of Resident #56's Nursing Restorative Care Program documentation revealed the resident's program included full body ROM exercises one time a day, five days a week. The program also included assistance with bed mobility that included sitting on the edge of the bed one time a day, five times per week for 10 minutes to maintain function and sitting balance. According to the documentation, the Assistant Director of Nursing (ADON) documented restorative services were provided for the resident every day (seven days per week) from 10/15/2022 through 12/27/2022. During an interview with Resident #56 on 12/29/2022 at 11:50 AM, Resident #56 revealed staff were not assisting with exercises. The resident stated he/she could not remember the last time a restorative aide worked with the resident, maybe a couple of months ago. During an interview on 12/28/2022 at 2:42 PM, CNA #5, the restorative aide, stated she reported to the ADON when restorative services were provided and was not responsible for documenting restorative care. According to CNA #5, she had not provided/reported to the ADON any restorative care for residents in two to three weeks. She stated the last time she provided services for Resident #17 was maybe on 12/13/2022. In an interview on 12/28/2022 at 2:48 PM the ADON stated she oversaw the restorative nursing program and there were two CNAs who were considered the restorative aides, CNA #10, and CNA #5. However, the ADON stated there were times every staff member had to provide restorative services to their residents. The ADON stated she documented all restorative services in each resident's medical record and wrote a note if the residents refused. The ADON stated she verified restorative care was being provided by observing residents being assisted with walking. The ADON stated Resident #17 participated sometimes, but often refused. Although the resident had not been walking, staff were attempting to assist the resident with walking and they were doing range of motion exercises with the resident, which the ADON stated she thought was adequate and was counted as the restorative care. The ADON was unable to provide any documented evidence of Resident #17 refusing to be assisted with walking. A follow-up interview with the ADON on 12/29/2022 at 2:22 PM revealed she had been too trusting of staff and assumed restorative care was being provided. The ADON stated the aides told her they got all their work completed and she assumed that included restorative services. The ADON stated she was involved in too many things to be able to ask about every resident who had a restorative program. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Licensed Practical Nurse (LPN) #9, the Resident Assessment Instrument (RAI) Coordinator, on 12/28/2022 at 3:09 PM, revealed if 15 minutes of restorative services was documented, he had no reason to question the validity of the documentation. LPN #9 stated that restorative was a service that must be present/provided and documented in order to include the service on a resident's MDS. He stated if 15 minutes of restorative services was documented, it should mean the service was provided. On 12/29/2022 at 3:29 PM the Administrator stated it was her expectation that restorative services be provided as documented.