| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 165426 | A. BUILDING _____ B. WING _____ | 02/02/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PEARL VALLEY REHABILITATION AND NURSING AT PERRY, | 2625 IOWA STREET PERRY, IA 50220 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>Amended on 4/13/2017, following the IDR decision.<br>Correction date_____<br><br>The following deficiencies result from the facility's annual health survey 1/30 - 2/2/17<br><br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 226 SS=D | 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. | F 226 | F226<br>Staff A completed the Mandatory 2 Hour Dependent Adult Abuse Training on 11-23-16.<br>Upon review of other employees' files, all other employees are current with this training. The Administrator will check the status of employee 2 Hr Mandatory Adult Abuse Training on a random basis. The Administrator will address any issues during the QA meetings. This represents with facilities credible allegation of compliance dated 2-3-17. | 2/3/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Douglas D. Ward — TITLE: Administrator — (X6) DATE: 02/24/2017

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.

POC accepted 4/12/17 SSmunson

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| F 226 | Continued From page 1<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on employee file review, facility policy review and staff interview the facility failed to ensure 1 of 5 sampled employees completed an approved mandatory reporter training within six months of their hire date (Staff A). The facility reported a census of 16 residents.<br><br>Findings include:<br><br>1. Review of the new hire list provided by the facility and Staff A's personnel file revealed a hire date of 4/22/16. Staff A's employee file contained a completed Dependent Adult Abuse for Mandatory Reporters certificate dated 11/23/16.<br><br>The facility's Abuse Prevention, Identification, Investigation, and Reporting Policy, dated 12/18/16, revealed each employee shall be required to complete 2 hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment.<br><br>During interview on 2/1/17 at 10:27 a.m., the Administrator verified that Staff A's mandatory reporter was not completed within six months of hire. | F 226 | | |
| F 311 SS=D | 483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS | F 311 | | 2/9/17 |

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| F 311 | Continued From page 2<br>(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility failed to have a restorative program implemented for 3 of 7 current residents reviewed (Residents #2, #3 and #6). The facility reported a census of 16 residents.<br><br>Findings include:<br><br>1. Resident #2's Minimum Data Set (MDS) assessment dated 12/17/16 identified diagnoses that included Parkinson's disease, Non-Alzheimer's dementia and depression. According to the MDS the resident scored 4 out of 15 on the Brief Interview for Mental Status (BIMS) testing indicating severe cognitive and memory impairment. The MDS revealed the resident required the assistance of one staff for bed mobility, transfers, walking in room, walking in corridor, dressing, toilet use, personal hygiene and bathing. The MDS indicated no physical or occupational therapy and no passive or active range of motion restorative exercises performed during the last 7 days of the assessment's lookback period.<br><br>Resident #2's care plan dated 12/15/16 revealed the resident at risk of not having activities of daily living (ADLs) needs met due to cognitive impairments/dementia. Interventions included the resident is an assist of one staff for showers, bed mobility, transfers, ambulation, dressing and grooming. | F 311 | F311<br>Staff C, as well as other Nursing staff have been re-educated regarding the importance of performing Restorative Nursing Programs for appropriate residents. PRN Nursing staff, or staff on PTO/Vacation will review the Restorative Nursing Program information prior to their next scheduled shift. The facility has requested Therapy to screen Residents #2, #3, and #6. PT began working with Resident #2 on 1-25-17 to 2-20-17. PT worked with Resident #3 from 12-28-16 to 1-25-17. PT screened Resident #3 on 2-3-17 and determined PT or a Restorative Program was not recommended d/t Resident #3 is able to transfer with CGA and ambulate up to 100ft with CGA. OT performed Part B Therapy with Resident #3 from 1-11-17 to 2-23-17. Resident #6 has received OT Part B | |

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| F 311 | Continued From page 3<br><br>The resident's clinical record contained no information regarding provision of a restorative program.<br><br>2. The MDS assessment dated 12/5/16 identified diagnoses for Resident #3 that included heart failure and hypertension. According to the MDS the resident scored a 5 out of 15 on the BIMS test, indicating severe memory and cognitive impairment. The resident required the extensive assist of one staff for bed mobility, transfers, walking in the room, walking in the corridor, dressing, personal hygiene and bathing. The MDS indicated no physical or occupational therapy and no passive or active range of motion restorative exercise performed during the last 7 days of the assessment's lookback period.<br><br>The resident's care plan dated 12/8/16 revealed the risk of not having his/her ADLs met related to decreased independence. Interventions included the assistance of one for dressing, grooming, transfers and toileting.<br><br>The resident's clinical record contained no information regarding provision of a restorative program.<br><br>3. The MDS assessment dated 12/13/16 identified Resident #6 had diagnoses that included diabetes mellitus, quadriplegia and osteoarthritis. The MDS documented the BIMS score of 15 out of 15, indicating intact memory and cognition. The MDS documented the resident had functional limitation in range of motion to both of their upper and lower extremities. The MDS documented the resident had total dependence on two staff for bed | F 311 | Therapy from 1-11-17 to present. PT screened resident on 2-3-17 though did not pick Resident #6 up on Part B Therapy, or refer this resident to a Restorative Nursing Program. The facility has requested that the contracted therapists systematically review residents during the Quarterly MDS Assessment Process, or sooner as deemed necessary, to determine if the resident would benefit from Part B Therapy, any necessity to revise a Functional Maintenance Program, and/or, implement a Restorative Nursing Program for a particular resident.<br>The DON, or their designee, will address any issues during the QA meetings. This represents our credible allegation of compliance dated 2-9-17. | |

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| F 311 | Continued From page 4<br>mobility, transfers, dressing, hygiene and toileting. The MDS indicated no physical or occupational therapy, and no passive or active range of motion restorative exercises performed during 7 days of the assessment's lookback period.<br><br>The care plan dated 9/14/16, and revised 12/8/16, identified the resident at risk of not having ADL needs met due to paralysis and unable to perform ADL's. The care plan directed staff to:<br>a. Use a Hoyer and two staff assist for transfers;<br>b. Provide extensive assistance for ADLs;<br>c. Staff to propel Broda wheelchair for mobility.<br><br>Review of the Occupational Therapy (OT) note dated 1/11/17 revealed a referral to therapy for upper extremity strengthening exercises and wheelchair positioning, due to the resident had decreased functional strength and reduced activity tolerance. The OT note indicated the resident entered the facility in June, 2015.<br><br>The resident's clinical record contained no information regarding a resident restorative program.<br><br>In an interview 2/1/17, at 7:40 a.m., the Director of Nursing (DON) reported the facility had no restorative program or restorative aide. The DON reported no restorative program in place since she started working at the facility in May of 2016. She thought the CNAs (certified nursing assistants) could be trained to do range of motion though. The DON thought some residents were on a walk to dine program.<br><br>In an interview 2/1/17, at 1:30 p.m., Staff C, CNA | F 311 | | |

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| F 311 | Continued From page 5<br>reported 5 residents at the facility had a walk to dine program, otherwise the facility had no restorative services in place.<br><br>In an interview 2/2/17, at 11:40 a.m., the Therapy Director reported the facility had no restorative program or maintenance program in the past 1 1/2 years. The Therapy Director reported it was unknown why there wasn't a program, but thought it was important for residents to participate in a restorative program to prevent a decline in functional ADLs. | F 311 | | |
| F 315 SS=D | 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>(e) Incontinence.<br>(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and | F 315 | F315<br>Nursing staff members B and C, as well as other Nursing staff, have reviewed the Incontinence Care Protocol. PRN Nursing staff, or Nursing staff on PTO/Vacation will review the Incontinence Care Protocol prior to their next scheduled shift. Nursing staff members have been informed of the importance of providing proper incontinence care for Resident #3 and #4, as well as all residents. The DON, or their designee, will perform random incontinence care audits. Any ongoing concerns will be addressed by the QA Committee. This represents our credible allegation of compliance dated 2-9-17 | 2/9/17 |

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| F 315 | Continued From page 6<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, observation, staff interview and facility policy review, the facility failed to provide incontinence care that minimized the chance for urinary tract infections for 2 of 3 incontinent residents reviewed (Residents #4 and #3). The facility reported a census of 16 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 11/3/16 recorded Resident #4 had diagnoses that included diabetes mellitus, muscle weakness, anxiety disorder and depression. The MDS documented the resident required the assistance of two staff for transfers and the assistance of one staff with toilet use and personal hygiene activities. The MDS documented the resident had occasional bowel and bladder incontinence.<br><br>The resident's Care Plan, updated on 11/2/16, indicated the resident had chronic urinary tract infections. The care plan provided directives for staff to provide incontinence care as needed. | F 315 | | |

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| F 315 | Continued From page 7<br><br>Observation on 1/31/17 at 7:20 a.m. revealed Staff B, CNA (certified nursing assistant) and Staff C, CNA used an EZ stand and stood Resident #4 up by the commode. After Staff B cleansed the resident's periarea, Staff B took a wet washcloth and cleansed the resident's left (L) hip with the washcloth in an upward motion, then downward across the (L) buttock, then upward again between the resident's buttocks. Staff B used the same washcloth and did not change the surface of the cloth between swipes. Staff B took another washcloth and cleansed the resident's right (R) hip wiping upward across the hip, then downward across the (R) buttock, then upward between the buttocks without changing the surface of the cloth.<br><br>The facility's policy titled Incontinence Care Protocol dated 10/13/11 instructed staff to gently separate labia and wash down one side, then the other making sure to wash front to back and turn the surface with each wipe and dry. Wash buttock and both sides of upper thighs be sure to dry the skin. Wash the anal area, front to back using facility choice of solution and cloths/wipes.<br><br>2. The MDS assessment dated 12/5/16 identified diagnoses for Resident #3 that included heart failure and hypertension. According to the MDS the resident scored a 5 out of 15 on the BIMS test, indicating severe memory and cognitive impairment. The resident required the assistance of one staff with personal hygiene and toilet use and experienced frequent urinary incontinence.<br><br>The resident's Care Plan dated 12/8/16 revealed the resident at risk for genitourinary (GU) dysfunction related to decreased mobility, chronic | F 315 | | |

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| F 315 | Continued From page 8<br>renal insufficiency and a history of urinary tract infections (UTIs). Another problem identified the risk of not having activities of daily living (ADLs) met related to decreased independence. The interventions instructed staff to assist resident as needed with incontinent care.<br><br>Observation on 1/31/17 at 8:08 a.m. revealed the resident seated at the edge of the bed. Staff B and Staff C entered the resident's room and walked the resident to the bathroom. Observation revealed a soiled chux (liner) on the resident's bed and a urine odor in the room. Once the resident used the toilet, the aides assisted the resident to stand. Staff B obtained a wet wash cloth and cleansed the resident's groin area. Staff B then changed the surface of the wash cloth and cleansed front to back of the resident's perineal area with one swipe. Staff B changed the surface of the wash cloth, cleansed the resident's hips and coccyx area in a circular motion and with the same surface of the wash cloth, reached from the back and wiped the middle front to back.<br><br>In an interview on 2/1/16 at 11:18 a.m., the Director of Nursing (DON), expected staff to change the surface of the wash cloth with each swipe. | F 315 | | |
| F 318 SS=G | 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>(c) Mobility.<br><br>(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. | F 318 | | 2/9/17 |

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| F 318 | Continued From page 9<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interviews, the facility failed to provide restorative activities or ensure routine range of motion exercises were performed in order to prevent the development of motion declines (Resident #4). The sample consisted of 7 residents and the facility reported a census of 16 residents.<br><br>Findings include:<br><br>1. Resident #4 had a MDS with a reference date of 2/4/16. The MDS documented the resident had no functional limitations in range of motion to the upper or lower extremities. The MDS documented the resident required extensive assistance of two staff persons for hygiene and toileting, and independent for eating. The MDS indicated the resident had an unsteady balance during transfers and ambulation unless staff stabilized the resident.<br><br>Resident #4 had a MDS (Minimum Data Set) assessment, with a reference date of 11/3/16. The MDS identified the resident had diagnoses that included diabetes mellitus, muscle weakness, peripheral vascular disease, anxiety disorder, and depression. The MDS documented the resident scored 6 out of 15 on the brief interview for mental status. A score of 6 represented a severe cognitive impairment. The MDS documented the resident required extensive | F 318 | Staff members B, C, D, as well as other Nursing staff have been re-educated regarding the importance of performing Restorative Nursing Programs for appropriate residents. PRN Nursing staff, or staff on PTO/Vacation will review the Restorative Nursing Program information prior to their next scheduled shift. The facility has requested a Therapy screen Resident #4. PT screened resident # 4 on 2-3-17 though did not pick Resident #4 up on Part B Therapy, or refer this resident to a Functional Maintenance Program or a Restorative Nursing Program d/t, "Resident is at max potential and self-limiting, with MD reporting her declines are unavoidable. Resident was on PT 3 times in 2016 with no improvements made". OT screened resident #4 on 2-8-17 and picked up Resident #4 on Part B Therapy r/t wheelchair positioning and mobility. The facility has requested that the contracted therapists systematically review residents Quarterly during the MDS Assessment Process, or sooner as deemed necessary, to determine if | |

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| F 318 | Continued From page 10<br>assistance of two staff persons for transfers, totally dependent for hygiene and toileting, and required assistance to set up for meals. The MDS documented the resident had functional limitations in range of motion to the lower extremities (hip, knee, ankle, foot). The MDS indicated no physical or occupational therapy, and no passive or active range of motion restorative exercises or ambulation performed during 7 days of the MDS referenced assessment period. The MDS indicated the resident had one fall since the prior assessment completed.<br><br>On 2/19/16, the care plan interventions for staff included:<br>a. Provide assistance as needed for ambulation and transfers<br>b. Use walker for mobility<br><br>On 8/15/16, the care plan interventions for staff included the following:<br>a. Use two assist and walker for transfers and ambulation<br>b. Use wheelchair for mobility<br><br>The care plan dated 11/3/15, and updated on 8/15/16 and 11/2/16, indicated the resident had a fall risk related to weakness and decreased independence.<br><br>The therapy referral form dated 8/9/16, revealed the resident had declined in ambulation and transfers, required two staff for assistance, and had decreased strength and a tendency to lean backward when he/she stood.<br><br>On 8/16/16, the physical therapist (PT) screened the resident and documented the resident had poor balance and strength. On 9/7/16, the PT | F 318 | the resident would benefit from Part B Therapy, any necessity to revise a Functional Maintenance Program, and/or, implement a Restorative Nursing Program for a particular resident. The DON, or their designee, will address any issues during the QA meetings. This represents our credible allegation of compliance dated 2-9-17. Submission of this Plan of Correction shall not be considered an admission as to any of the findings of the citation and thus, shall not be used against facility in any such challenge. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PEARL VALLEY REHABILITATION AND NURSING AT PERRY, | 2625 IOWA STREET PERRY, IA 50220 |

| (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 |
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documented the resident used a front wheeled walker and ambulated 8 feet and then another 4 feet with contact guard assistance (CGA). The resident required CGA of one staff when he/she stood from the walker. On 9/21/16, the PT notes identified the resident had safely transferred from a supine to a sitting position with moderate assistance, required contact guard assistance when he/she stood up or sat down in a wheelchair, and required moderate assistance when transferred from a recliner. The PT recommended the resident attend a facility exercise program in order to maintain strength in the upper and lower extremities.

The Occupational Therapy (OT) progress notes and discharge summary dated 10/6/16 revealed the resident safely dressed the upper body with moderate to maximum assistance, and required maximum assistance for lower body dressing. The OT documented the resident safely transferred with moderate to maximum assistance when moved from a chair to the commode.

A fax communication to the physician on 8/14/16 showed the resident had complained of leg weakness, and a CNA had lowered the resident to the floor. The intervention implemented included two staff needed when transferred the resident, until PT evaluated the resident.

A fax communication to the physician on 10/31/16 indicated the resident had posturing, a hard time sitting up straight in the wheelchair, increased lethargy, and increased weakness when transferred.

A fax communication to the physician on 1/6/17,

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| F 318 | Continued From page 12<br>revealed an OT evaluation requested for strengthening and wheelchair positioning.<br><br>The nurse's notes documented the following:<br>On 8/14/16 at 9:07 a.m., a CNA lowered the resident to the floor.<br><br>On 8/14/16 at 8:00 p.m., the resident had normal range of motion and required assistance of 2 staff for transfers.<br><br>On 10/28/16 at 4:55 p.m., the resident slouched at the dinner table and had difficulty sitting up straight in a wheelchair. The nurse helped the resident eat supper. The resident transferred to a recliner with 2 staff assist and an EZ stand, but had no weight bearing when transferred.<br><br>On 12/23/16, the resident required 2 staff persons assistance for most ADL's (activities of daily living skills), assistance of 1 staff person to eat, and 2 staff persons assistance and an EZ stand (mechanical lift which helps the resident stand if able to bear weight) when transferred. The resident tended to slouch in the wheelchair, and staff encouraged the resident to sit up correctly. On 12/24/16, staff encouraged the resident to sit upright. The resident sat up briefly but then the resident leaned.<br><br>On 1/6/17, at 1:30 p.m., a new order received for an OT evaluation and treatment.<br><br>On 1/6/17, 6p-6a, staff used a Hoyer lift to transfer the resident into bed.<br><br>On 1/25/17, 6p-6a, the resident had the inability to move legs and no independence in bed mobility. The resident grabbed the side rail in | F 318 | | |

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| F 318 | Continued From page 13<br>order to help hold self when turned but not able to reach and turn self. The resident used a Hoyer lift for all transfers, could not ambulate without staff assistance, and unable to propel the wheelchair. The staff had to move the wheelchair for the resident.<br><br>On 1/29/17, the resident required stand by assistance and the assistance of 1 staff to hold silverware and take bites of food during mealtime. The nurse documented the resident had a rough time feeding self and had difficulty holding sandwiches or silverware in his/her hands. Staff had difficulty feeding the resident because the resident had his/her head down a lot.<br><br>The monthly ADL care sheets dated 8/2016 to 12/2016, revealed the resident performed a walk to dine only 2 days in 5 months.<br>A review of the 1/2017, Activity Calendar identified the resident participated 0 of 8 days when group morning stretch activities offered. The medical record lacked any other restorative exercise activities completed.<br><br>During observation on 1/30/17, at 12:30 p.m., Staff C, CNA sat next to the resident by the dining room table and assisted the resident with eating. Staff C provided verbal cues to the resident to take a bite of food.<br><br>On 1/31/17, at 7:20 a.m., Staff B, CNA, and Staff C, used an EZ stand and transferred the resident to a commode.<br><br>On 1/31/17, at 8:00 a.m., the resident complained of a runny nose. Staff E, Licensed Practical Nurse (LPN), handed the resident a Kleenex. Resident #4 had difficulty holding the Kleenex | F 318 | | |

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and blowing nose. Staff E took the Kleenex and held the Kleenex under the resident's nares as the resident blew his/her nose.

On 2/2/17, at 8:25 a.m., Staff B, CNA, sat next to the resident by the dining room table. Staff B held a glass of juice near the resident's mouth, and held a straw for the resident as the resident drank the juice. Staff B then picked up a fork and fed the resident.

In an interview on 2/1/17, at 7:40 a.m., the Director of Nursing (DON) reported no restorative program or restorative aide at the facility. The DON reported no restorative program had been in place since she started working at the facility in May, 2016.

In an interview on 2/1/17, at 12:40 p.m., Staff D, Occupational Therapy Assistant (OTA), reported when a resident discharged from therapy, the therapist normally made recommendations for a maintenance program, but the facility had no maintenance or restorative program or staff who completed restorative activity (RA). Staff D reported they had received referrals for residents who had been in therapy, then discharged, and later referred again because the resident had an increase in weakness or a decline in function. Staff D reported Resident #4 had been referred to therapy 8/18-9/19/16, after the resident had a fall at the facility. Staff D reported when the resident discharged from therapy, he/she would have recommended a maintenance program if a maintenance program option had been available at the facility.

In an interview on 2/1/17, at 1:35 p.m., Staff C, CNA, reported Resident #4 had definitely had a

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| F 318 | Continued From page 15<br>decline in his/her level of function over the past several months. Staff C reported Resident #4 use to walk to the dining room and propelled the wheelchair in 9/2016, but since 10/2016, the resident no longer walked and no longer able to proper wheelchair. Staff C stated the resident also had fed self, but now required assistance with feeding. Staff C stated they used an EZ stand during the day and a Hoyer lift (mechanical sling lift) in the evening when they transferred the resident because the resident had increased weakness.<br><br>In an interview 2/1/17 at 2:20 p.m., a family member reported the resident no longer stood or walked due to increased weakness and staff recently used a Hoyer lift for transfers.<br><br>In an interview 2/2/17, at 11:40 a.m., the Therapy Director reported the facility had no restorative program or maintenance program in the past 1 1/2 years. The Therapy Director reported it was unknown why there wasn't a program, but thought it was important for residents to participate in a restorative program to prevent a decline in functional ADL's, and prevent contractures. The Therapy Director reported Resident #4 was referred to therapy three times in the past year due to decreased balance and difficulty when transferred to/from a commode. | F 318 | | |