STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/8/2022 through 3/10/2022. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/08/2022 through 03/10/2022. Two complaints were investigated during the survey. Complaint VA00053497 was substantiated with deficient practice. Complaint VA00050504 was substantiated without deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of fifteen (15) current resident reviews and two (2) closed record reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		3/30/22

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

Electronically Signed | 03/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan (CCP) for one of 17 residents in the survey sample, Resident #31. Findings include: Resident #31 was admitted to the facility originally on 02/22/21. Diagnoses for Resident #31 included, but were not limited to: atrial fibrillation, CHF (congestive heart failure), high blood pressure, diabetes mellitus, anxiety, depression, history of a stroke with left side hemiparesis/hemiplegia, and left hand contracture. The most recent MDS (minimum data set) was an annual assessment dated 01/10/22. This MDS assessed the resident with a cognitive score	F 657	1.) The careplan for Resident #31 has been updated to indicate the use of her hand splint. 2.) A 100% audit was completed on all other residents with braces/splints to ensure brace/splint use is indicated on their comprehensive plan of care. 3.) An inservice was conducted by the RDCS(Regional Director of Clinical Services) for the MDS Coordinator on developing comprehensive care plans that include braces/splints. 4.) DON or designee will review the resident device list and audit the careplan to ensure that the resident has a comprehensive plan of care for braces/splints monthly x3. Results of these audits will be discussed at QAPI meetings monthly for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2	F 657		

of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from at least one staff person for most all ADL's (activities of daily living).

On 03/08/22 at 2:47 p.m., Resident #31 was observed in her room, sitting in her wheelchair. Resident #31 was asked what happened to her left hand (left hand was contracted). Resident #31 stated, "I have a dead hand." Resident #31 took her right hand and attempted to open the left hand by pulling and prying the finger of the left hand back. Resident #31 was asked if she had a splint or brace for the left hand to help with the contracture. Resident #31 stated that she did not have a brace or splint.

On 03/08/22 at 3:45 p.m., Resident #31 was again observed without any type of brace or splint in place to the left hand.

Resident #31's current CCP was reviewed and documented, "...Focus: potential for skin breakdown due to limited mobility...Interventions: ...L (left) cock up splint as tolerated QHS (every night) as tolerated...resident will choose to wear splint during the day at times...(Date initiated: 02/23/21)...(Revision: 06/11/21)...treatments as ordered..."

On 03/09/22 at 03:46 p.m., OT (occupational therapy) was interviewed regarding Resident # 31. The OT stated that Resident #31 has a resting splint and a palm roll splint and that both of those should be in the resident's room. The OT stated that the palm roll splint/brace is more relaxed and Resident #31 wears that during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 3	F 657		

day and then there is a rigid black brace/splint with finger extension that the resident should wear at night. The OT stated that Resident #31 was seen in January 2022 for the left hand, but had also been seen for the left hand when Resident #31 was originally admitted (February 2021). The OT provided documentation regarding the resident's evaluation, treatment and discharge summary. The OT stated that she instructed staff that the blue splint/brace was to be worn during the day and the black splint/brace at night. The OT was asked, how she would know if Resident #31 was actually receiving the recommended treatment and services. The OT stated, "I wouldn't unless I walk down there and look." The OT was made aware that Resident #31 had not had a splint/brace on when observed during the last two days and that Resident #31 had stated that she did not have a brace/splint for that hand. The OT stated that staff are not allowed to put anything on the walls as far as instruction and that she verbally educated nursing staff. The OT was asked if recommendations were on the physician's order set. The OT stated that she didn't think so, that information is given to nursing once the recommendation is done. The OT stated that she wouldn't know if Resident #31 had on the splint/brace unless she physically went down there to see if the resident had it on or not.

The resident's OT evaluation and plan of treatment dated 12/30/21 documented,"...apply forearm splint...patient and staff will participate in splint wearing schedule to increase wear time...patient has resting hand splint with palm roll...could accommodate a more open resting hand splint..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 4 A therapy note dated 01/10/22 documented, "...staff training on splint schedules and education on donning with patient participation...discharge planning. Orders placed with nursing..." The OT discharge summary documented, "...Discharge 01/10/22 ...patient has worn left resting hand splint with rigid form, with thenar abduction and finger extension...increasing to overnight with no signs/symptoms of redness/soreness...staff have been educated on plan and goals. Orders placed with nursing for wear schedule...resting hand splint with palm roll..." On 03/10/22 at 9:30 a.m., RN (registered nurse) #3 was interviewed regarding Resident #31's left hand brace/splint and the incorrect information regarding the brace on the CCP. RN #3 stated that she will review physician's orders, talk with staff, talk with different disciplines, talk with the residents, and update the care plan accordingly. RN #3 stated that information must have been missed. On 03/10/22 at 10:50 a.m., the DON (director of nursing) and the administrator were made aware in a meeting with the survey team that Resident #31's CCP was not updated to reflect the resident's current status and the resident's current OT treatment recommendations. No further information and/or documentation was presented prior to the exit conference.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		3/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 5 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure assistive devices were implemented for the prevention of decreased range of motion (ROM) for one of 17 residents in the survey sample, Resident #31. Findings include: Resident #31 was admitted to the facility originally on 02/22/21. Diagnoses for Resident #31 included, but were not limited to: atrial fibrillation, CHF (congestive heart failure), high blood pressure, diabetes mellitus, anxiety, depression, history of a stroke with left side hemiparesis/hemiplegia, and left hand contracture. The most recent MDS (minimum data set) was an annual assessment dated 01/10/22. This	F 688	1.) Splint was applied to Resident #31 at the time of the survey. 2.) A 100% audit of all other residents with braces/splints to visually validate that residents are wearing braces/splints as ordered. 3.) Therapy staff will be inserviced by the Director of Rehab or designee on completing therapy to nursing communication forms for new splint/brace with recommended wearing times. 4.) DON or designee will make observation rounds weekly for thirty days then monthly for 60 days to ensure that residents are wearing braces/splints as indicated. Results of these audits will be discussed at QAPI meetings monthly for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 6	F 688		

MDS assessed the resident with a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from at least one staff person for most all ADL's (activities of daily living).

On 03/08/22 at 2:47 p.m., Resident #31 was observed in her room, sitting in her wheelchair. Resident #31 was asked what happened to her left hand (left hand was contracted). Resident #31 stated, "I have a dead hand." Resident #31 took her right hand and attempted to open the left hand by pulling and prying the finger of the left hand back. Resident #31 was asked if she had a splint or brace for the left hand to help with the contracture. Resident #31 stated that she did not have a brace or splint.

On 03/08/22 at 3:45 p.m., Resident #31 was again observed without any type of brace or splint in place to the left hand.

Resident #31's physician's orders were reviewed. There were no physician's orders regarding a splint or brace for the resident's left hand.

The MARs/TARs (medication administration records/treatment administration records) were reviewed and did not reveal any type of treatments and/or interventions for Resident #31's left hand.

Resident #31's current CCP was reviewed and documented, "...Focus: potential for skin breakdown due to limited mobility...Interventions: ...L (left) cock up splint as tolerated QHS (every night) as tolerated...resident will choose to wear

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 7	F 688		

splint during the day at times...(Date initiated: 02/23/21)...(Revision: 06/11/21)...treatments as ordered..."

On 03/09/22 at 3:12 PM, licensed practical nurse (LPN) #2 was interviewed regarding Resident #31's left hand. LPN #2 stated that she didn't know right off what was wrong with the resident's hand and that she would have to look that information up. LPN #2 was asked if Resident #31 wore a splint or brace to the left hand. LPN #2 stated that she was not sure and that she would have to look that up. LPN #2 stated that she doesn't normally work on that hall and although is familiar with Resident #31, did not know that information.

On 03/09/22 at 03:46 p.m., OT (occupational therapy) was interviewed regarding Resident # 31. The OT stated that Resident #31 has a resting splint and a palm roll splint and that both of those should be in the resident's room. The OT stated that the palm roll splint/brace is more relaxed and Resident #31 wears that during the day and then there is a rigid black brace/splint with finger extension that the resident should wear at night. The OT stated that Resident #31 was seen in January 2022 for the left hand, but had also been seen for the left hand when Resident #31 was originally admitted (February 2021). The OT provided documentation regarding the resident's evaluation, treatment and discharge summary. The OT stated that she instructed staff that the blue splint/brace was to be worn during the day and the black splint/brace at night. The OT was asked, how she would know if Resident #31 was actually receiving the recommended treatment and services. The OT stated, "I wouldn't unless I walk down there and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 8	F 688		

look." The OT was made aware that Resident #31 had not had a splint/brace on when observed during the last two days and that Resident #31 had stated that she did not have a brace/splint for that hand. The OT stated that staff are not allowed to put anything on the walls as far as instruction and that she verbally educated nursing staff. The OT was asked if recommendations were on the physician's order set. The OT stated that she didn't think so, that information is given to nursing once the recommendation is done. The OT stated that she wouldn't know if Resident #31 had on the splint/brace unless she physically went down there to see if the resident had it on or not.

The resident's OT evaluation and plan of treatment dated 12/30/21 documented,"...apply forearm splint...patient and staff will participate in splint wearing schedule to increase wear time...patient has resting hand splint with palm roll...could accommodate a more open resting hand splint..."

Therapy notes documented the following:

01/05/22, "...fitted with resting hand splint on left hand..."

01/06/22, "...patient was still wearing night time resting hand splint in late AM, splint had shifted distally..."

01/07/22, "...Patient still had rigid splint on in late AM, splint doffed and wrist support with palm roll donned. Staff education on wear schedule...refitted with rigid resting hand splint with instructions to remove in the morning..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 9	F 688		

01/10/22, "...staff training on splint schedules and education on donning with patient participation...discharge planning. Orders placed with nursing..."

Resident #31's OT discharge summary documented, "...Discharge 01/10/22 ...patient has worn left resting hand splint with rigid form, with thenar abduction and finger extension...increasing to overnight with no signs/symptoms of redness/soreness...staff have been educated on plan and goals. Orders placed with nursing for wear schedule...resting hand splint with palm roll..."

Resident #31's nursing and progress notes were reviewed from January 2022 through present (03/10/22). No documentation was found indicating that Resident #31 refused the use of the recommended treatment interventions by OT for her left hand.

On 03/10/22 at 7:30 a.m., Resident #31 was observed in bed with the blue splint/brace (resting hand splint with palm roll).

On 03/10/22 at 9:15 a.m., RN (registered nurse) #4 (working with Resident #31) was interviewed and asked about the resident requiring or wearing a brace/splint to the left hand. RN #4 stated that she did not have knowledge and would have to see if that had been initiated.

On 03/10/22 at 9:25 a.m., CNA (certified nursing assistant) #8 stated that the CNAs and nurses will put on a brace/split if they have one and that they get the information in report.

On 03/10/22 at 10:00 a.m., CNA #6 (working with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 10	F 688		

Resident #31) stated that she was told the splint is for night time for Resident #31 and that the resident uses a rolled cloth/towel during the day. CNA #6 stated they find the information out in their documentation on the computer.

On 03/10/22 at 10:15 a.m., the OT was interviewed again. Resident #31 was observed with the OT present. Resident #31 had the blue splint/brace (resting palm roll) applied. The OT stated that is for day use and the rigid/black one is for night. The OT was again made aware that Resident #31 had been observed multiple times throughout the survey without a brace/splint applied. The morning of 03/10/22 at 7:30 a.m. was the first observation with Resident #31 wearing the brace/splint.

On 03/10/22 at 10:50 a.m., the DON (director of nursing) and the administrator were made aware of the above information in a meeting with the survey team. The DON stated that it is not a physician's order and they will get information from OT for trials and recommendations.

No further information and/or documentation was presented prior to the exit conference.