STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 02/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interviews the facility failed to submit the 24 hour and 5 day report to the state agency and complete an investigation for 1 of 1 sampled residents (resident #1) with an injury of unknown origin. Findings included: A review of the facilities "Abuse Investigation and Reporting" policy dated July 2017 revealed in part "An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than:" a. 2 hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. 24 hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. Resident #1 was admitted to the facility on 4-2-10	F 607	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. 1. Facility identified that the reason the deficiency occurred was related to the Director of Nursing having a misunderstanding of the regulation. That the facility is required to submit injury of unknown origin per state guidelines. Resident #1 was assessed to assure no injuries and subsequently reported per	3/14/18

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

Electronically Signed | 03/10/2018

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F 607	Continued From page 1 with multiple diagnoses that included hemiplegia and hemiparesis of the right side following a stroke, aphasia and adult failure to thrive. The resident was noted to be cognitively impaired needing total assistance with one staff member for bed mobility, dressing, toileting and personal hygiene. During the medical record review it was noted that the resident was receiving Hospice services. An interview with the family member occurred on 2-21-18 at 3:00pm. She stated that she found the bruise on the resident's forehead on 2-3-18. The complainant described the area as purple with a black mark near the resident's hairline and that she felt it was a bruise caused by the resident hitting her head against the enabler bar. She went on to state that she informed the nurse on shift as well as Hospice. The incident records were reviewed for the time frame of the incident 2-3-18 which revealed that there was no incident report completed at that time. There was an incident report completed 2-20-18 for the incident on 2-3-18 which stated that an "old bruising area" was noted to resident #1's forehead. A review of the nursing notes for 2-3-18 revealed that there was no documentation or assessment completed for the report made by the granddaughter that there was a bruise on the residents forehead. There was a nursing note made on 2-4-18 listed as a "late entry" stating that the granddaughter was concerned about an area on the residents forehead and that the nurse did not observe any swelling but did see "a little" discoloration that	F 607	regulations. Deficiency occurred related to staff knowledge of regulation as well as policy and procedure. 2. Procedure for implementing an acceptable plan of correction includes head to toe assessments of all residents to assure no injury of unknown injury, Director of Nursing, Assistant Director of Nursing and Unit Managers to complete assessments by 3/14/18. Regional Director of Clinical Operations in-serviced Director of Nursing on 2/21/18 regarding regulation, policy and procedure and requirements of being compliant. Director of Nursing will assure that All Staff have been in-serviced on abuse, reporting and injuries of unknown origin and policy and procedures by 3/14/18. The abuse and reporting process/policy and procedure will be incorporated in the annual training and new hire process. 3. Monitoring process to assure POC is effective and facility remains in compliance is that any injury of unknown origin is reported immediately to Director of Nursing (this was inclusive as part of in-servicing). Clinical team will discuss daily any injuries and assure compliant practice. Unit Managers will review daily documentation to assure any injuries have been addressed appropriately. Weekly "At Risk" meeting will involve the team reviewing any type of injury and assure compliant practice and positive impact on resident's quality of life. Facility has assured staff have policy and procedure readily available.	

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F 607	Continued From page 2 "looks like a vein". During an interview with the nurse (nurse #3) on 2-21-18 at 1:17pm revealed she was the nurse that the granddaughter reported the bruise to resident #1's forehead. Nurse #3 stated she believed it was a bruise but did not know where it came from. She stated she reported the area to her unit manager. An interview with the Administrator occurred on 2-21-18 at 4:15pm. The Administrator stated she did not feel that this was a reportable incident but if it was then she would expect that a report would be made with in the 24 hour time frame as required.	F 607	4. The Director of Nursing and Assistant Director of Nursing are responsible for implementing this POC and consistent monitoring. The results will be reviewed and analyzed at the centers monthly Quality assurance and process improvement meeting for 3 months with a subsequent plan of correction as needed.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		3/14/18

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F 609	Continued From page 3 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, complainant interview and resident observation the facility failed to report a bruise of unknown origin to a residents forehead within the 24 hour time frame and complete the 5 day report for 1 of 1 residents (resident #1). Findings included: Resident #1 was admitted to the facility on 4-2-10 with multiple diagnoses which included hemiplegia and hemiparesis to the right side following a stroke, aphasia, adult failure to thrive and contracture of unspecified joint. The Minimum Data Set (MDS) dated 1-4-18 revealed that the resident was severely cognitively impaired. Resident #1 was coded as needing total assistance with one person for bed mobility, dressing, eating, toileting and personal hygiene. The resident was also coded for tube feedings as well as a stage 4 pressure ulcer. During a review of resident #1's care plan dated 12-27-17 it revealed a goal of: Resident will have intact skin free of redness, blisters or discoloration and the resident pressure ulcer will show signs of healing and remain free of	F 609	1. Facility identified that the reason the deficiency occurred was related to the Director of Nursing having a misunderstanding of the regulation and policy and procedure as well as nursing staff not reporting injury of unknown origin to Director of Nursing. That the facility is required to submit injury of unknown origin per state guidelines. Resident #1 was assessed to assure no injuries and subsequently reported per regulations. 2. Procedure for implementing an acceptable plan of correction includes head to toe assessments of all residents to assure no injury of unknown injury, Director of Nursing, Assistant Director of Nursing and Unit Managers to complete assessments by 3/14/18. Regional Director of Clinical Operations in-serviced Director of Nursing on 2/21/18 regarding regulation and reporting criteria. Director of Nursing will assure that All Staff have been in-serviced on abuse, reporting and injuries of unknown origin by 3/14/18. The abuse and reporting process/policy and procedure will be incorporated in the annual training and new hire process.	

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F 609	Continued From page 4 infection: padding to enabler bar (Added to the care plan on 2-5-18), admin meds as ordered, admin treatment as ordered, monitor dressing to ensure it is intact, monitor nutritional status, resident requires supplemental protein and vitamins, treat pain per orders. A review of the nursing notes dated 2-4-18 revealed that resident #1's granddaughter was concerned about an area on the resident's forehead. The nurse documented that there was no swelling but a little discoloration that looked like a vein. The incident report dated 2-20-18 for the incident on 2-3-18 revealed that the nurse was called to resident #1's room by the granddaughter and the nurse observed "old bruising area" to the resident's forehead. An interview with the Hospice nurse occurred on 2-21-18 at 12:19pm who stated she had seen a bruise on resident #1's forehead on 2-6-18 and that she questioned the nurse as to what happened but stated the nurse could not answer her and that she did not know what caused the bruise. The Hospice nurse stated the bruise started at the hair line of the forehead and came down into a "V" shape to the middle of her forehead. The Director of Nursing (DON) was interviewed on 2-21-18 at 12:40pm. She stated she saw the area on resident #1's forehead on 2-5-18 and that it was greenish/yellowish in color and felt that it was a vein. During the conversation the DON stated she felt resident #1 received this "discoloration" from the enabler bar "she will lean her head against that bar so we padded the bar"	F 609	3. Monitoring process to assure POC is effective and facility remains in compliance is that any injury of unknown origin is reported immediately to Director of Nursing (this was inclusive as part of in-servicing). Clinical team will discuss daily any injuries and assure compliant practice. Unit Managers will review daily documentation to assure any injuries have been addressed appropriately. Weekly "At Risk" meeting will involve the team reviewing any type of injury and assure compliant practice and positive impact on resident's quality of life. Facility has assured staff have policy and procedure readily available. 4. The Director of Nursing and Assistant Director of Nursing are responsible for implementing this POC and consistent monitoring. The results (Incident logs, daily stand up notes, weekly risk meeting notes) will be reviewed and analyzed at the centers monthly Quality assurance and process improvement meeting for 3 months with a subsequent plan of correction as needed.	

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F 609	Continued From page 5	F 609		

and indicated that the facility padded the enabler bar on 2-5-18. The DON also stated that the unit manager was responsible for completing the incident report and documenting her assessment but "she forgot to do it".

During an interview with the nurse (nurse #3) on 2-21-18 at 1:17pm revealed she was the nurse that the granddaughter reported the bruise to resident #1's forehead. Nurse #3 stated she believed it was a bruise but did not know where it came from. She stated she reported the area to her unit manager and assessed the resident for pain and denied that the resident complained of pain to her forehead.

An observation of the resident was completed on 2-21-18 at 1:30pm. The resident was noted to be laying on her right side with no signs or symptoms of distress. The resident's forehead was examined and a green circular shape was noted to extend from her hairline to the middle of her forehead. An attempt was made to ask the resident if the area on her forehead hurt but the resident was not able to answer the question she was noted to just smile.

The unit manager (Unit Manager #5) was interviewed on 2-21-18 at 1:40pm who stated she first saw the area on resident #1's forehead on 2-5-18 and that she believed it was a bruise. She revealed that she felt it came from the resident hitting her head on the enabler bar that is attached to her bed. The unit manager stated she reported the incident while she was in the clinical meeting that Monday morning but that she had forgotten to complete an incident report at that time.

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F 609	Continued From page 6 An interview with the family member occurred on 2-21-18 at 3:00pm. She stated that she visits her grandmother every day and that she found the bruise on the resident's forehead on 2-3-18. The complainant described the area as purple with a black mark near the resident's hairline and that she felt it was a bruise caused by the resident hitting her head against the enabler bar. She went on to state that she informed the nurse on shift as well as Hospice. During the investigation an attempt was made to contact the weekend supervisor on 3 different occasions but was not able to reach her. An interview with the Administrator occurred on 2-21-18 at 4:15pm. The Administrator stated she did not feel that this was a reportable incident but if it was then she would expect that a report would be made with in the 24 hour time frame as required.	F 609		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 637		3/14/18

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F 637	Continued From page 7 by: Based on record review and staff interviews the facility failed to complete the Minimum Data Set (MDS) related to a significant change within the 14 day time frame for 1 of 1 residents (resident #1). Findings included: Resident #1 was admitted to the facility on 4-2-10 with multiple diagnoses which included hemiplegia and hemiparesis of the right side following a stroke, aphasia, adult failure to thrive and contracture of unspecified joint. The quarterly Minimum Data Set (MDS) dated 1-4-18 revealed that resident #1 was severely cognitively impaired. Resident #1 was coded as needing total assistance with one person for bed mobility, transfers did not occur and total assistance with one person was needed for dressing, eating, toileting and personal hygiene. The MDS did reveal a code for tube feeding as well as a stage 4 pressure ulcer with measurements of 7.5 centimeters longx11.8 centimeters widex2.3 centimeters deep. The care plan dated 12-27-17 revealed a goal that resident #1 will have intact skin free of redness, blisters or discoloration and that the residents pressure ulcer will show signs of healing and remain free of infection. The interventions for this goal were as follows; administer medication as ordered, administer treatments as ordered, monitor dressing to ensure it is intact, monitor nutritional status, supplemental protein and vitamins as ordered and treat pain per orders. An intervention was added 1-25-18 to pad enabler bar. A goal was	F 637	1.Resident #1's medical record was noted that the resident was placed on Hospice services starting 1-25-18, further review of the record revealed that there was a significant change MDS started but not completed as of 2-20-18.Resident #1's Significant change assessment was completed on 2/21/2018 and transmitted and accepted on 2/26/2018.The MDS nurse misinterpreted the timeframe for completion of significant change assessments which is what caused the deficiency. 2.An audit was performed by the IDT team(interdisciplinary Team) members on the current Hospice resident population to insure the mds assessment was completed in the correct timeframe.No other records were identified in this audit. 3.The regional mds consultant re-educated the IDT team responsible for scheduling significant change assessments(resident assessment instrument)process for mds accuracy. Education completed by 3/14/18. 4.The MDS team and Director of Nursing will implement POC. This information will be included in the employee orientation program for newly hired IDT members. The Director of nursing,and the IDT team will monitor 20 new mds assessments and significant change MDS weekly x 4 weeks, then monthly x 3 months to ensure ongoing compliance in the accuracy of scheduling assessments.	

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F 637	Continued From page 8 added 1-25-18 that resident #1 will have comfort maintained with the following interventions; adjust provisions of activities of daily living to compensate for the residents changing abilities, encourage support of family and friends, observe for signs and symptoms of pain and work cooperatively with the Hospice team. During a review of resident #1's medical record it was noted that the resident was placed on Hospice services starting 1-25-18. A further review of the record revealed that there was a significant change MDS started but not completed as of 2-20-18. An interview with the MDS nurse (MDS #1) occurred on 2-20-18 at 3:15pm who stated she had 14 days after the change in condition was determined to complete the significant change MDS. She also stated that she decided to do a significant change due to resident #1 being placed on Hospice services. MDS #1 stated she was made aware of the change to Hospice services on 1-25-18 but that she had 14 days from the ARD date to complete the MDS. The Administrator was interviewed on 2-21-18 at 4:20pm and stated that her expectation was that the MDS be completed on time.	F 637		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		3/14/18

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F 688	Continued From page 9 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide services that were ordered by the physician to treat contractures for 2 of 3 residents (Resident #6 and Resident #2) that were reviewed for limited range of motion (ROM.) Findings Included: 1. Resident #6 was admitted to the facility on 5/20/11 and diagnoses included contractures, chronic pain syndrome and persistent vegetative state. An annual minimum data set (MDS) for Resident #6 dated 1/20/18 identified he had limited ROM to upper and lower extremities bilaterally, was totally dependent for activities of daily living (ADL ' s), had not received any therapy or restorative nursing during the look back period and had severely impaired cognition. A care plan for Resident #6 dated 2/3/18 stated he had an alteration in musculoskeletal status related to contractures of multiple joints.	F 688	1.The deficient practice occurred as the facility failed to provide services that were ordered by the physician to treat contractures for 2 of 3 residents (Resident #6 and Resident #2) that were reviewed for limited range of motion (ROM.) The failure occurred due to lack of consistent communication between nursing, therapy and accountability of nursing practice. Corrective action for resident #6 were therapy assessment and new devices ordered by 3/7/18. Resident #2 no longer resides at facility. 2. All residents and all new admissions will be screened by therapy services for contracture management by 3/14/18. The Director of Nursing and Assistant Director of Nursing are responsible for implementing/maintaining an acceptable POC. 3.The Director of Nursing, Assistant director of nursing and Staff development coordinator will in-service all nursing staff	

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F 688	Continued From page 10 Interventions included to give analgesics as ordered, position resident to prevent contractures, provide range of motion (ROM) and monitor for non-verbal signs of pain during ROM, rolled gauze to bilateral hands daily, clean hands before application and therapy to monitor for increase in contractures as indicated. Review of the February 2018 physician orders for Resident #6 revealed an order to roll gauze to both hands daily, wash hands with soap and water, pat dry, insert roll of gauze in both hands daily from 7:00 am to 2:59 pm. Review of a physician ' s progress note dated 2/7/18 for Resident #6 stated with worsening contractures in upper extremities reduce Baclofen (a medication for spasticity) 20 milligrams (mg) from four times daily to three times daily and order Physical Therapy (PT) / Occupational Therapy (OT) to work with patient. Review of the telephone orders for Resident #6 revealed an order dated 2/7/18 for PT / OT to work with the patient. A review of the medical record for Resident #6 from 2/7/18 through 2/21/18 revealed no PT / OT evaluations or treatment. A review of the February 2018 treatment administration record (TAR) for Resident #6 revealed a treatment order for rolled gauze to both hands daily, wash hands with soap and water, pat dry and insert a roll of gauze in both hands from 7:00 am to 2:59 pm. The treatment record was checked as being completed on 2/15, 2/16, 2/20 and 2/21. The rest of the days were blank.	F 688	and require a return demonstration as to the cleaning of the skin prior to the area where the splint is to be applied, the skin integrity of the area where the splint is to be applied, the application of the splint related to the doctors orders and the removal of the splint in the correct removal time. The in-service will also include the importance of accurate documentation on the application of splints. Completed by 3/14/18. 4.The Director of Nursing, and Assistant Director of Nursing are responsible for implementation of POC. The Director of Nursing, Assistant Director of Nursing and Staff development coordinator will observe and audit 20 residents per week, x 4 weeks, then 20 residents per month x 3 months. Data results will be reviewed and analyzed at the centers monthly Quality assurance and process improvement meeting for 3 months with a subsequent plan of correction as needed.	

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	345092	A. BUILDING _____ B. WING _____	C 02/21/2018

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Observations of Resident #6 on 2/20/18 at 9:10 am, 2/20/18 at 11:30 am and 2/22/18 at 1:36 pm revealed he was lying in bed with both hands visible and in a fist like position. Resident #5 ' s hands did not contain any rolled gauze or any other splint like device on all 3 observations.

An interview on 2/21/18 at 1:47 pm with Nursing Assistant (NA) #2 revealed she had worked with Resident #6. She stated the facility had assignment sheets for each resident that told them what type of care each resident needed. The care card for Resident #6 was reviewed with NA #2 and there was nothing identified regarding placing gauze wraps inside resident ' s hands. NA #2 stated the information would be on the nurse ' s computer and the NAs probably wouldn ' t have that information.

An interview on 2/21/18 at 1:55 pm with NA #3 revealed she was the NA for Resident #6 today. She stated he required total care and she would try to "stretch" him out sometimes because his upper arms would get stiff. NA #3 added she wasn ' t sure if he was supposed to have anything placed in his hands, but she believed she had seen something rolled up in his hands before. She stated she wasn ' t sure if that was done by therapy.

An interview on 2/21/18 at 2:03 pm with Nurse #2 revealed she was the nurse for Resident #6 today. She stated he did have contractures of his hands, but she was not aware of any special treatments or orders for his hands. Nurse #2 added she had seen other residents that had contractures have orders for rolled up wash clothes placed in their palms, but she didn ' t

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believe Resident #6 had any orders for this.

An interview on 2/21/18 at 2:38 pm with the Certified Occupational Therapy Assistant (COTA) revealed if the physician ordered therapy an evaluation should be completed.

A phone interview on 2/21/18 at 3:08 pm with the Rehab Manager revealed this was the first time she heard about a therapy evaluation order for Resident #6. She stated usually when a physician ordered a therapy evaluation they would get a copy of the order or sent a "Hey Therapy" notification. The rehab manager added they had not received anything for Resident #6 and it was her expectation that therapy evaluations would be completed within 24 hours of the physician ' s order.

An interview on 2/21/18 at 4:05 pm with the Administrator revealed she expected residents to receive services as ordered by their physician ' s.

2. Resident #2 was admitted to the facility on 4/7/17 and diagnoses included contractures of multiple sites, abnormal posture and traumatic brain injury. The resident was not in the facility during the time of the investigation.

A quarterly minimum data set (MDS) for Resident #2 dated 10/19/17 identified he had limited range of motion (ROM) bilaterally in upper and lower extremities, had not received any therapy or restorative nursing services during the look back period and had severely impaired cognition.

A care plan with a review date of 10/23/17 for Resident #2 stated he had potential for decline in present level of ROM related to muscle spasms

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and contractures to bilateral upper and lower extremities. Interventions included to monitor for increased pain with ROM and notify physician. Monitor for changes in ROM and notify therapy as needed. Therapy to evaluate and treat as needed. Provide ROM daily during care tasks to include bathing, dressing and toileting. On restorative nursing program for ROM / contracture management.

A review of the January 2018 physician orders for Resident #2 revealed an order with an origination date of 4/10/17 to wash left hand with soap and water, dry well, apply ½ roll of kerlix (a woven gauze material) every day for protection to contracture of the hand.

Review of the January 2018 treatment administration record (TAR) for Resident #2 identified a treatment order to wash left hand with soap and water, dry well, apply ½ roll of kerlix every day for protection to contracture of the hand. The treatment order was blank for 1/1/18, 1/2/18, 1/6/18, 1/7/18, 1/9/18, 1/13/18, 1/14/18, 1/16/18 and 1/18/18.

Review of a physician ' s progress note for Resident #2 dated 1/14/18 stated the resident had been seen for Botox injections to treat contractures, but that had not worked well for him.

An interview on 2/21/18 at 2:17 pm with NA #1 revealed he worked with Resident #2 on first shift. NA #1 stated he had never placed any kind of splint or rolled up towel in the resident ' s hand. He added some residents had this done by the restorative aides, but this resident didn ' t.

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F 688	Continued From page 14 An interview on 2/21/18 at 2:23 pm with Nurse #1 revealed he had been the nurse for Resident #2. He stated the resident had contractures of his legs and his arms were very rigid. Nurse #1 stated he was not aware of any splints or devices the resident was supposed to use for his contractures. An interview on 2/21/18 at 3:30 pm with MDS nurse #2 revealed that Resident #2 had not received any restorative services during the last few months. An interview on 2/21/18 at 4:05 pm with the Administrator revealed she expected residents to receive services as ordered by their physician ' s.	F 688		