STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. BUILDING ______ B. WING ______	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARNETT WOODS NURSING AND REHABILITATION CENTER	**604 LUCAS ROAD DUNN, NC 28334**

(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 recertification survey was conducted on 05/28/24 through 05/31/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TKLY11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 05/28/24 through 05/31/24. Event ID#TKLY11	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer residents with newly evident mental health diagnoses for Preadmission Screening and Resident Review (PASRR) level II	F 644	F644 Coordination of PASRR and Assessments On 6/14/24 the administrator submitted an	6/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/18/2024

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.

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F 644	Continued From page 1 screen for 2 of 5 sampled residents reviewed for PASRR (Resident #44 and Resident #63). Findings included: 1. Resident #44 was admitted to the facility on 11/28/2019 with diagnoses that did not include any mental health diagnoses. The North Carolina PASRR level I screen dated 11/28/2019 revealed no mental health diagnoses. The PASRR level II determination notification dated 11/28/2019 revealed no further PASRR screening was required unless a significant change occurred with the individual's status which suggests a diagnosis of mental illness. The diagnosis report revealed depression was added as a diagnosis on 02/14/2024. The annual Minimum Data Set (MDS) dated 07/26/2023 had Resident #44 coded as alert and oriented and was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS listed diagnoses including anxiety disorder, depression (other than bipolar), bipolar disorder, and psychotic disorder (other than schizophrenia). There were no moods or behaviors documented. The care plan dated 05/06/2024 had a focus area of a problematic way resident acts characterized by ineffective coping. There was no evidence a referral was made to PASRR when the new mental health diagnoses were identified for Resident #44.	F 644	evaluation of Pre-Admissions Screening and Resident Review (PASRR) for resident #44. Determination is pending. On 6/13/24 the administrator submitted an evaluation of PASRR for resident #63. Determination is pending. On 5/30/24, the Administrator, Director of Nursing (DON), and Administrative Licensed Practical Nurse (LPN) initiated an audit of diagnosis for all residents with a Level I PASRR. This audit is to identify any resident with a newly added Level II PASRR qualifying diagnosis to ensure resident assessed for need to re-submit PASRR for evaluation. The Administrator, Social Worker, Admissions Director or Accounts Receivable (AR) Bookkeeper will address all concerns identified during the audit to include submission of Level II PASRR evaluation/re-evaluation and education staff. The audit will be completed by 6/28/24. On 5/29/24 the Administrator initiated an in-service regarding Level II PASRRs with the Admissions Director, Accounts Receivable (AR) bookkeeper, Social Worker, Minimum Data Set Nurse (MDS), Director of Nursing with emphasis on referral for evaluation/re-evaluation of PASRR following changes in mental health status or newly Level II qualifying diagnosis. In-service will be completed by 6/28/24. After 6/28/24 any admission director, social worker, MDS nurse or DON who has not worked or completed the in-service will complete upon the next	

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Continued From page 2

An interview with the Director of Nursing (DON) was conducted on 05/29/24 at 3:40 PM. The DON stated PASRRs were completed by the Admissions Director and Accounts Receivable. She reported they were both currently out from work. She indicated Resident #44 did have a new mental health diagnosis after the 11/28/2019 PASRR determination letter. The DON also stated she was not familiar with the PASRR process, and she did not know why they did not complete the referral for a screening when there was a new mental health diagnosis. The DON also stated there would be education completed to ensure this issue was not be repeated.

An interview with the Administrator was conducted on 05/29/2024 at 3:59 PM. The Administrator stated Resident #44 did have new mental health diagnoses and a new referral for a PASRR screening should have been completed when the diagnoses were identified. The Administrator indicated it may have been due to confusion or oversite, but the staff would be educated on the PASRR process.

2. Resident #63 was admitted to the facility on 04/25/2023 with diagnoses that included Parkinson's disease, and anxiety disorder.

The North Carolina Department of Health of Human Services (NCDHHS) halted PASRR level II determination notification dated 05/04/2023 indicated no further PASRR screening was required unless a significant change occurred with the individual's mental status which suggested a psychiatric disorder that was not

F 644

scheduled work shift. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-service during orientation regarding PASRRs.

The administrative nurse will audit all newly added Level II PASRR qualifying diagnosis to ensure resident assessed for need to re-submit PASRR for evaluation weekly x 4 weeks then monthly x 1 month utilizing the PASRR Audit Tool. This audit is to ensure any newly written PASRR qualifying diagnosis is reviewed to determine the need for re-submission of PASRR information. The Social worker, Administrator, AR bookkeeper or admissions director will address all concerns identified during the audit to include completing a new PASRR review. The Director of Nursing (DON) will review and initial the PASRR Audit Tool weekly for 4 weeks then monthly for 1 month for completion and ensure all areas of concern were addressed.

The Director of Nursing will forward the results of the PASRR Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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F 644	Continued From page 3	F 644		

dementia.

Review of the diagnoses report revealed Resident #63 had a new diagnosis of psychotic disorder dated 11/08/2023.

The annual Minimum Data Set (MDS) dated 04/05/2024 indicated Resident #63 was not currently considered by the state level II PASRR process to have serious mental illness and/ or intellectual disability or a related condition. The MDS indicated the resident had behavioral symptoms of rejection of care. It indicated the diagnoses of anxiety disorder and psychotic disorder. The MDS had Resident #63 coded as severely cognitively impaired.

The care plan dated 07/06/2023 and updated 04/25/2024 had a focus of a problematic way resident acts characterized by ineffective coping. The resident demonstrates verbal/physical aggression or agitation, combativeness related to cognitive impairment.

There was no evidence a referral was made to PASRR when the new mental health diagnosis was identified for Resident #63.

An interview with the Director of Nursing (DON) was conducted on 05/29/24 at 3:40 PM. The DON stated PASRRs were completed by the Admissions Director and Accounts Receivable staff. She stated they were both on leave and unavailable for an interview. The DON acknowledged that Resident #63 had a new mental illness diagnosis of psychotic disorder on 11/08/2023 and was not referred for PASRR screening. The DON also stated she was not familiar with the PASRR process, and she did not

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F 644	Continued From page 4 know the reason the new diagnosis was not screened. The DON indicated that there would be PASRR education completed to ensure this issue did not repeat itself. An interview with the Administrator was conducted on 05/29/2024 at 3:59 PM. The Administrator stated Resident #63 had a new mental Illness that should have been screened when identified on 11/08/2023. She added that the staff would be educated on the PASRR process.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		6/28/24

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F 645	Continued From page 5	F 645		

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an

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F 645	Continued From page 6 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to apply for a level II Preadmission Screening and Resident Review (PASRR) screening for 2 of 5 residents reviewed for PASRR level II screenings.(Resident #63 and Resident #71) Findings included: 1.Resident #63 was admitted to the facility on 04/25/2023 with diagnoses that included Parkinson's disease and anxiety disorder. Review of the diagnoses report revealed Resident #63 had a diagnosis of anxiety disorder dated 04/25/2023. The North Carolina Preadmission Screening Resident Review (NC PASRR) level I screen dated 05/04/2023 did not include the diagnosis of anxiety disorder. The North Carolina Department of Health of Human Services (NCDHHS) halted PASRR level II determination notification dated 05/04/2023 indicated no further level I screen was required unless a significant change occurred with the individual's mental status which suggested a psychiatric disorder that was not dementia. The annual Minimum Data Set (MDS) dated 04/05/2024 indicated Resident #63 was not currently considered by the state level II PASRR process to have a serious mental illness and/or	F 645	F645 PASRR Screening On 6/14/24 the administrator submitted an evaluation of Pre-Admissions Screening and Resident Review (PASRR) for resident #71. Determination is pending. On 6/13/24 the administrator submitted an evaluation of PASRR for resident #63. Determination is pending. On 5/30/24 the Administrator, Director of Nursing (DON), and Administrative Licensed Practical Nurse (LPN) initiated an audit of diagnosis for all residents with a Level I PASRR. This audit is to identify any resident with a newly added Level II PASRR qualifying diagnosis to ensure resident assessed for need to re-submit PASRR for evaluation. The Administrator, Social Worker, Admissions Director or AR Bookkeeper will address all concerns identified during the audit to include submission of Level II PASRR evaluation/re-evaluation and education staff. The audit will be completed by 6/28/24. On 5/29/24, the Administrator initiated an in-service regarding Level II PASRRs with the Admission Director, AR bookkeeper, Social Worker, Minimum Data Set Nurse (MDS), Director of Nursing with emphasis on referral for evaluation/re-evaluation of	

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F 645

Continued From page 7

intellectual disability or a related condition. The MDS indicated the resident had behavioral symptoms of rejection of care and a diagnosis of anxiety disorder. The MDS had Resident #63 coded as severely cognitively impaired.

The care plan dated 04/25/2024 had a focus of a problematic way resident acts characterized by ineffective coping. The resident demonstrates verbal/physical aggression or agitation and combativeness related to cognitive impairment.

An interview with the Director of Nursing (DON) was conducted on 05/29/24 at 3:40 PM. The DON stated PASRRs were completed by the Admissions Director and Accounts Receivable staff. She stated they were both on leave and unavailable for an interview. The DON acknowledged that Resident #63 had a mental illness diagnosis that was not included in the screening form to determine the PASRR level II before the resident's admission to the facility on 04/25/23. The DON also stated she was not familiar with the PASRR process, and she did not know why they did not complete the screening accurately before the resident was admitted to the facility. The DON indicated that there would be PASRR education completed to ensure this issue did not repeat itself.

An interview with the Administrator was conducted on 05/29/2024 at 3:59 PM. The Administrator stated Resident #63 had a mental illness that should have been screened before the resident's admission on 04/25/2023. The Administrator indicated that the anxiety diagnosis may have been missed due to confusion. She added that the staff would be educated on the PASRR process.

F 645

PASRR following changes in mental health status or newly Level II qualifying diagnosis. In-service will be completed by 6/28/24. After 6/28/24 any admission director, social worker, MDS nurse or DON who has not worked or completed the in-service will complete upon the next scheduled work shift. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-service during orientation regarding PASRRs.

The Administrative Nurse will audit all newly added Level II PASRR qualifying diagnosis to ensure resident assessed for need to re-submit PASRR for evaluation weekly x 4 weeks then monthly x 1 month utilizing the PASRR Audit Tool. This audit is to ensure any newly written PASRR qualifying diagnosis is reviewed to determine the need for re-submission of PASRR information. The Administrator, AR bookkeeper, Admissions director, or social worker will address all concerns identified during the audit to include completing a new PASRR review. The Director of Nursing (DON) will review the PASRR Audit Tool weekly for 4 weeks then monthly for 1 month for completion and ensure all areas of concern are addressed.

The Administrative Nurse will audit all newly admitted residents weekly x 4 weeks then monthly x 1 month utilizing the PASRR Audit Tool. This audit is to ensure the facility submitted a review for a Level II PASRR determination for all residents

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F 645	Continued From page 8 2. Resident #71 was admitted to the facility on 02/16/2024 with diagnoses that included psychotic disorder (onset 02/16/2024). The North Carolina PASRR level I screen dated 02/16/2024 revealed no mental health diagnoses. The PASRR level II determination notification dated 02/16/2024 revealed no further PASRR screening was required unless a significant change occurrred with the individual's status which suggested a diagnosis of mental illness. The admission Minimum Data Set (MDS) dated 02/23/2024 had Resident #71 coded as moderately cognitively impaired and was not considered by the state for a PASRR level II to have a serious mental illness. The care plan dated 05/06/2024 had a focus of inappropriate behavior and resistive to treatment and care. An interview with the Director of Nursing (DON) was conducted on 05/29/24 at 3:40 PM. The DON stated PASRRs were completed by the Admissions Director and Accounts Receivable. They were both out from work currently. She indicated Resident #71 did have a mental health diagnosis during the time the screening was completed. The DON also stated she was not familiar with the PASRR process, and she did not know why they did not include the diagnosis in the screening. The DON also stated there would be education completed to ensure this issue did not repeat itself.	F 645	admitted with a level II PASRR qualifying diagnosis. The Administrator, AR bookkeeper, Admissions director, or social worker will address all concerns identified during the audit to include submission of Level II PASRR evaluation/re-evaluation and education staff. The audit will be completed by 6/28/24. The Director of Nursing (DON) will review the PASRR Audit Tool weekly for 4 weeks then monthly for 1 month for completion and ensure all areas of concern are addressed. The Director of Nursing will forward the results of the PASRR Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 645	Continued From page 9 An interview with the Administrator was conducted on 05/29/2024 at 3:59 PM. The Administrator stated Resident #71 did have a mental health diagnosis of psychotic disorder and the diagnosis should have been included with the screening. The Administrator reported this may have been due to confusion or oversite but the staff would be educated on the PASRR process.	F 645		
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 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, record review, staff, family and resident interviews the facility failed to provide a restorative maintenance program to prevent further decrease in range of motion/mobility for 1 of 3 residents reviewed for range of motion (Resident #64).	F 688	F688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) 5/30/24 therapy staff assessed resident # 64 for changes in range of motion (ROM) to bilateral lower extremities.	6/28/24

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F 688	Continued From page 10 Findings included: Resident #64 was admitted into the facility on 5/10/23 with diagnoses of cerebrovascular accident and epilepsy. A review of Resident #64's most recent quarterly Minimum Data Set dated 5/2/24 included he was severely cognitively impaired, had no refusal of care, had behavioral symptoms directed towards others on 4-6 day. He was dependent on staff for all his activities of daily living including bed mobility. He had functional limitation of range of motion on both sides in both upper and lower extremities. A review of Resident #64's comprehensive care plan initiated 5/17/23 included a focus of activities of daily living/ personal care with interventions of chair/bed-to-chair transfer: mechanical lift, lower body dressing: dependent, oral hygiene: dependent, personal hygiene: dependent, putting on/taking off footwear: dependent, roll left and right: dependent, shower/bathe self: dependent, toileting hygiene: dependent, tub/shower transfer: dependent., upper body dressing: dependent, bed mobility: totally dependent, ensure proper placement/position when turning. An additional focus initiated 7/3/23 of requires assistance for transferring from one surface to another related to: generalized muscle weakness, physical limitations with interventions including transfers: provide two persons with mechanical aid, resident cannot weight bear and mechanical lift. An observation was made on 5/30/24 of Resident #64's legs revealed the left leg appeared contracted at the knee at approximately a	F 688	On 6/5/24 the Administrator, Director of Nursing, Administrative RN, MDS Nurse, Activity Director and Social Worker initiated an audit of all residents for changes in ROM and/or new/worsening contractures to ensure the resident was assessed, the physician notified for further recommendations, therapy referral initiated, and care plan updated for new interventions when indicated. The Therapy Director and Director of Nursing will address all concerns identified during the audit. The audit will be completed by 6/28/24. On 5/29/24 the Staff Development Coordinator initiated an in-service with all nurses regarding Changes in Mobility with emphasis on notification of the physician of any resident with changes in mobility or new/worsening of contractures to ensure interventions to include but not limited to ROM, therapy referral or use of splints are initiated when indicated. In-service will be completed by 6/28/24. After 6/28/24, any nurse who has not worked or completed the in-service will complete upon the next scheduled work shift. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-service during orientation regarding Changes in Mobility. The Administrative Nurse will monitor all residents weekly x 4 weeks then monthly x 1 month using a resident census. This audit is to identify any resident with changes in ROM and/or new/worsening	

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	345478	A. BUILDING ______ B. WING ______	05/31/2024

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F 688	Continued From page 11 45-degree angle and the right leg appeared contracted at the knee at approximately a 30-degree angle. When Resident #64 was turned and repositioned by Nurse Aide #1 and the Wound Care Nurse there was no noted change in the positioning of the legs and range of motion was not performed. A telephone interview was conducted on 5/28/24 at 1:00 PM with Resident #64's representative who stated that Resident #64 had some contractures in his lower legs specifically at the knee when he was admitted into the facility however it appeared to him that they had gotten worse. He stated Resident #64 was not receiving therapy to prevent the contractures from getting worse and was not out of bed on a regular basis. An interview was conducted on 5/30/24 at 9:59 AM with the Therapy Director who indicated that Resident #64 had therapy for a few days after he was admitted into the facility, he was then discharged to the hospital and discharged from physical therapy 6/11/23. He was not picked back up for therapy upon his return to the facility 6/19/23. An interview was conducted on 5/30/24 at 11:30 AM. Nurse #1 indicated that Resident #64 only got out of bed when the room was deep cleaned every 4-5 months otherwise, he refused to get out of bed. An interview was conducted on 5/30/24 at 11:45 AM with Resident #64's roommate Resident #51 who was cognitively intact. He revealed that the only time Resident #64 got out of bed was when the room was deep cleaned, about every 4-5 months. He stated that he had never heard the	F 688	contractures to ensure the resident was assessed, the physician notified for further recommendations, therapy referral initiated, and care plan updated for new interventions when indicated. The Administrative Nurse, Director or Nursing or Therapy Director will address all concerns identified during the audit to include assessment of the resident, notification of the physician for further recommendations, therapy referral when indicated, and updating care plan for new interventions. The Director of Nursing (DON) will review the audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 688	Continued From page 12 staff ask Resident #64 if he wanted to get up or heard them attempt to get him out of bed. However, the staff had come in and turned and repositioned Resident #64 frequently but denied ever seeing range of motion being provided. An interview was conducted on 5/30/24 at 11:55 AM with Nurse Aide #1 who indicated that she had never transferred Resident #64 out of bed, nor had she assisted with a transfer for Resident #64. She said that she had never performed range of motion on Resident #64. She added that she was normally assigned to Resident #64's hall when she worked. An interview was conducted on 5/30/24 at 12:58 PM with the Activity Director revealed that Resident #64 had not attend activities, but she provided 1 on 1 activities in his room that included playing music, tactile stimulation, reading etc. 1-2 times a week. She stated that Resident #64 was always in bed when the activities were performed. A telephone interview was conducted on 5/31/24 at 9:00 AM with the Physical Therapist who indicated that she had attempted to obtain measurements of the degree of the knee joint limitation for Resident #64 on 5/30/24 for comparison to the measurements obtained from his prior therapy records but was unable due to severe spasming of Resident #64's legs. She further indicated that she could not definitively say the contractures were worse without those measurements. She stated that physical therapy was going to pick him up to see if soft splints at the knee would help prevent breakdown in the area. She further stated that she was unsure why they had not picked him up upon his return to the	F 688		

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F 688	Continued From page 13 facility and that a discharge plan had not been developed due to the discharge being unexpected so, the nursing assistants had not been educated on how to perform range of motion, how often to perform range of motion, and what joints to perform range of motion on for Resident #64. An interview was conducted on 5/31/24 at 10:30 AM with Nurse Aide #2 who revealed that she had transferred Resident #64 out of bed when the room was being deep cleaned and that she had performed range of motion on his legs at times but had never received education for providing range of motion to Resident #64. An interview with the Administrator on 5/31/24 at 11:00 AM indicated that she had always seen Resident #64 in bed and could not recall if she had ever seen him out of bed. She also indicated that residents should not stay in bed all the time but assisted out of bed on a regular basis, unless the resident refused. She stated that therapy would have to be involved to determine what type of transfer and mobility device would be needed for Resident #64 to get out of bed and that education would be given to the staff to get residents out of bed on a routine basis. She also indicated that she was unaware if range of motion was being provided or not.	F 688		