STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105389	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST , SARASOTA, Florida, 34237

(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
F0000	INITIAL COMMENTS An unannounced recertification survey with complaint number 2025009723 was conducted on through at Birchwood Health and Rehabilitation Center, a nursing home in Sarasota, Florida. Birchwood Health and Rehabilitation Center is not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long-Term Care Facilities. The following is the description of the noncompliance.	F0000		/2025
F0688 SS = E	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 and interview, the facility failed to provide appropriate treatment and services to prevent the decline in range of motion for 1 (Resident #31) of 2 residents reviewed with limited range of motion. The findings included:	F0688	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. F688 Increase/Prevent Decrease in ROM/Mobility (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On , Resident # 31 was assessed by a licensed nurse. No concerns were noted related to the alleged deficient practice. On , the order was clarified with MD to indicate donning and doffing of , as well as performing PROM. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On Audit was completed by Director of Nursing/designee on residents who had orders for , /braces to ensure order indicated donning and	/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0688 SS = E	Continued from page 1 Review of the facility's policy and procedure titled, "Standards and Guidelines: ADL (Activities of Daily Living) Care and Services" with a revised date of revealed, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . . . /brace. . ." On at 10:50 a.m., Resident #31 was observed with right / (permanently flexed towards the palm). Resident #31 was not able to answer interview questions. Review of the clinical record for Resident #31 revealed an admission date of . Diagnoses included of one side of the body) and on one side of the body} following ( ) affecting right dominant side and age-related decline. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of revealed Resident #31's skills for daily decision making were severely . Resident #31 was rarely/never understood. Resident #31 had functional limitation in range of motion of the upper and lower extremities on one side and was dependent on staff for activities of daily living. The MDS noted Resident #31 did not receive passive/ active range of motion or or brace assistance for at least 15 minutes in the last 7 calendar days. The care plan initiated on noted Resident #31 required assistance with ADL care related to multiple factors including , decreased mobility, history of ( ) with right , , aphasia (language that affects a person's ability to communicate). The goal was for the resident to maintain and/or improve current level of function. The interventions initiated on and revised on included passive range of motion and /brace application. Encourage and assist resident to participate with donning and doffing of right /brace. Apply in PM (afternoon) after PROM (passive range of motion) performed and remove in AM (morning) followed by PROM (passive range of motion) as tolerated. The care plan specified the resident may remove device per preference. Review of the physician's orders revealed an order dated for, "PROM and /Brace application:	F0688	Continued from page 1 doffing equipment. Any issues identified were immediately corrected. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; By , Current Nurses and staff will be educated on the components of F688 with an emphasis on documenting the donning and doffing of a /brace and following the comprehensive resident centered care plan and Prevention of decrease in ROM/Mobility by the DON/Designee. Newly hired licensed nurses/ Staff will be educated on the components of F688 with an emphasis on documenting the donning and doffing of a /brace and following the comprehensive resident centered care plan and prevention of decrease in ROM/Mobility by the Director of Nursing/Designee at orientation as a part of the systematic changes. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee to conduct audits of 5 residents with physician orders for a /brace 2x a week for 4 weeks, then 1x a week for 4 weeks and then monthly for 1 month to ensure that the physician order includes documentation of donning and doffing /brace. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

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F0688 SS = E	Continued from page 2 Encourage and assist resident to participate with donning and doffing of right , /brace. Apply , in PM after PROM performed and remove in AM followed by PROM as tolerated. Review of the Certified Nursing Assistant (CNA) Kardex (provides instructions for care) revealed, "ADLs/Restorative Care. PROM and , /brace application: Encourage and assist resident to participate with donning and doffing of right , /brace. Apply , /brace in PM after PROM performed and remove in AM followed by PROM as tolerated. Monitor skin surfaces under devise and notify physician of abnormal findings. The resident may remove device per preference." On at 1:10 p.m., in an interview CNA Staff F said Resident #31's right and were . He said Resident #31 was receiving Rehabilitation , , about months ago. CNA Staff F said he was trained on PROM and , care for Resident #31. The CNA said Resident #31 did not have anything in place for the right at this time. Staff F said Resident #31 has a lot of , when he moves his . On at 1:15 p.m., Licensed Practical Nurse (LPN) Staff A said she was not aware of any , , device for Resident #31's right . On at 4:21 p.m., in an interview LPN Staff A said CNAs check the Kardex every day to find out about their residents. She said the nurses were responsible for making sure the CNAs are following the Kardex. On at 4:25 p.m. in an interview LPN Staff G said PROM and , , devices are reviewed at care plan meetings. LPN Staff G said the nurses are responsible for PROM and , /brace application documentation on the Treatment Administration Record (TAR). Review of the TAR from through failed to reveal documentation of PROM or that the , was applied to Resident #31's right as ordered. On at 9:21 a.m., in an interview the Director of Nursing (DON) verified Resident #31 had an order dated for passive range of motion and , application to the right . She verified the lack of documentation Resident #31 received the range of motion or the , was applied to the resident's right as ordered.	F0688		
F0727 SS = D	RN 8 Hrs/7 days/Wk, Full Time DON	F0727	F727-RN 8 Hrs/7 days/wk	/2025

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F0727 SS = D	Continued from page 3 CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after , a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to ensure a Registered Nurse (RN) provided services for 8 consecutive hours for 2 of 14 days of staffing reviewed (and). The findings included: Review of the facility provided form " state Minimum Nursing Staff for Long Term Care Facilities" for through revealed on and the facility below the required 8 consecutive hours worked for Registered Nursed.	F0727	Continued from page 3 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Administrator completed a comprehensive review of RN hours for the previous 2 weeks and found that there were 8 consecutive hours of RN coverage. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On , Audit was completed by Administrator/designee of Staffing hours for past 2 weeks to ensure that Staffing requirements are met, including 8 consecutive RN hours every day of the week day. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; By /205, the Staffing coordinator, Administrator and Human Resources and Director of Nursing will be educated on the components of F727 with an emphasis on 8 consecutive hours seven days a week of RN hours per day and schedule requirements by the Regional Vice President of Operations/Designee. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Administrator/Designee to conduct audits of staffing report 5x a week for 4 weeks, then 2x a week for 4 weeks and then monthly for 1 month to ensure that Staffing requirements are met and that there are 8 consecutive RN hours every day of the week. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

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F0727 SS = D	Continued from page 4 The form noted: On , the number of Registered Nurse hours worked was 7.87 hours. On , the number of Registered Nurse hours worked was 5.42 hours. On at 12:58 p.m., in an interview Labor Coordinator Staff D said the facility has a Registered Nurse 8 hours a day and provided Registered Nurse Staff E's time sheet for , , and . Review of Registered Nurse Staff E's time sheets revealed on RN Staff E clocked in at 2:47 p.m., and clocked out on at 7:06 a.m. The total number of hours worked on from 12:00 a.m. to 7:06 a.m. were 7 hours and 6 minutes. On , RN Staff E clocked in at 5:35 p.m. and clocked out on at 7:37 a.m. The total number of RN hours worked on was 6 hours and 25 minutes. On at 1:56 p.m., in an interview Labor Coordinator Staff D said no other RN worked on and . She confirmed there were no call offs for those days. She said it was a mistake. On at 3:50 p.m., in an interview the Nursing Home Administrator verified the number of RN hours worked on and below the required 8 consecutive hours. He said he needed to speak to the scheduler and come up with a plan. He said they needed to change the way they do scheduling to accommodate the rates to meet the resident's needs.	F0727		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing,	F0755	F755-Pharmacy Services/Procedures/Pharmacist/Records (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On the expired , and , gel were removed from the medication carts. Audit was conducted of remaining medication carts with no other concerns were noted related to the alleged deficient practice. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;	/2025

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F0755 SS = D	Continued from page 5 and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and records review the facility failed to ensure expired medications were removed from 2 (Colonial 1 and Heritage) of 4 medication carts reviewed for medication storage. The findings included: Review of facility "Standards and Guidelines: Medication Administration" policy (last revised) states "the expiration/beyond use date on the medication label is checked prior to administering". On at 9:00 a.m., observation of the "Colonial 1" medication cart revealed one bottle of , with an expiration date of . "Photographic evidence obtained." On at 9:28 a.m., observation of the "Heritage" medication cart revealed one bottle of , gel 0.5 milligram per milliliter for Resident #4. The packaging specified, "Do not use after ". "Photographic evidence obtained." On in an interview the Director of Nursing said there should not be expired medications in the medication carts. She said they check the medication	F0755	Continued from page 5 On Audit was completed by Director of Nursing/designee on all medication carts and medication rooms to ensure there were no outdated or expired medications. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; By , Current Licensed Nurses will be educated on the components of F755 with an emphasis on monitoring medications for expiration dates and appropriate medication storage by the DON/Designee. Newly hired licensed Nurses will be educated on the components of F755 with an emphasis on monitoring medications for expiration dates and appropriate medication storage by the DON/Designee at orientation as a part of the systematic changes. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee to conduct audits of medication carts and medication a week for 4 weeks, then 1x a week for 4 weeks and then monthly for 1 month to ensure that there are no expired or outdated medications present and medications are stored properly. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

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F0755 SS = D	Continued from page 6 carts on Sundays and will have to work on following through with the medication carts checks.	F0755		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a medication error rate below 5%. The facility medication error rate was 8% out of 25 opportunities. Review of facility "Standards and Guidelines: Medication Administration" policy (last revised) states "medications are administered in accordance with prescriber orders, including any required time limit". The policy further states "if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns". Review of facility "Standards and Guidelines: Physician Orders" policy (last revised) states "Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated". On at 9:15 a.m., Licensed Practical Nurse (LPN) Staff A was observed administering 6 different medications to Resident #22, including: One tablet of , ER (Extended release 24 Hour), 25 milligrams. One tablet of M20 (Extended Release). LPN Staff A crushed both extended release medications,	F0759	F759-Free of Medication Error Rate of 5% or More (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On , Staff A was educated regarding medication administration and the "Do not Crush" list on medication cart. On , Resident # 22 was assessed by a licensed nurse with no negative findings. MD was notified of medication error with orders received to change the form of the 2 identified medications. started treatment on . (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On Audit was completed by Director of Nursing/designee on current residents to identify if medications needed to be crushed. Any identified meds were changed to the appropriate form. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; By , Current Licensed Nurses will be educated on the components of F759 with an emphasis on being aware of what medications can be crushed and which medications can not be crushed as well as overall medication administration practices by the DON/Designee. Newly hired licensed Nurses will be educated on the components of F759 with an emphasis on being aware of what medications can be crushed and which medications can not be crushed as well as overall medication administration practices by the DON/Designee at orientation as a part of the systematic changes.	/2025

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F0759 SS = D	Continued from page 7 mixed them in pudding and administered them to the resident. Review of the physician's orders revealed the following instructions, " , crush or dilute medications as needed unless contraindicated." According to Drugs.com, extended-release tablet crushing is contraindicated and "crushing may lead to the medicine being released too early". On at 10:02 a.m., the Consultant Pharmacist was asked about the "may crush or dilute medications as needed unless contraindicated" for the 2 medications. The Consultant Pharmacist said "they are crushing them? Yes, they should not be doing that". The Consultant Pharmacist said that would be a contraindication. On at 10:24 a.m., the Director of Nursing said they are not allowed to crush extended-release tablets. When informed the , and extended-release tablets were crushed, she said neither of the medications should be crushed. She said they should have got different orders. She said, "sometimes we can get a capsule or liquid or a tablet we can give more often". She said those two medications should not have been crushed.	F0759	Continued from page 7 (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee to conduct observations of medication administration 3x a week for 4 weeks, then 1x a week for 4 weeks and then monthly for 1 month to ensure that licensed Nurses are administering medications properly. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12640961	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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N0000	INITIAL COMMENTS An unannounced recertification survey with complaint number 2025009723 was conducted on through at Birchwood Health and Rehabilitation Center, a nursing home in Sarasota, Florida. The following is the description of the deficiencies.	N0000		/2025
N0201 SS = E	Right to Adequate and Appropriate Health Care CFR(s): 400.022(1)(l), FS (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to provide appropriate treatment and services to prevent the decline in range of motion for 1 (Resident #31) of 2 residents reviewed with limited range of motion. The findings included: Review of the facility's policy and procedure titled, "Standards and Guidelines: ADL (Activities of Daily Living) Care and Services" with a revised date of revealed, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . . . /brace. . ." On at 10:50 a.m., Resident #31 was observed with right / (permanently flexed towards the palm). Resident #31 was not able to	N0201	F688 Increase/Prevent Decrease in ROM/Mobility (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On , Resident # 31 was assessed by a licensed nurse. No concerns were noted related to the alleged deficient practice. On , the , order was clarified with MD to indicate donning and doffing of , as well as performing PROM. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On Audit was completed by Director of Nursing/designee on residents who had orders for , /braces to ensure order indicated donning and doffing equipment. Any issues identified were immediately corrected. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; By , Current Nurses and , , staff will be	/2025

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

Florida State Department of Health

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N0201 SS = E	Continued from page 1 answer interview questions. Review of the clinical record for Resident #31 revealed an admission date of . Diagnoses included , , (, of one side of the body) and , (on one side of the body) following ( ) affecting right dominant side and age-related decline. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of revealed Resident #31's skills for daily decision making were severely . Resident #31 was rarely/never understood. Resident #31 had functional limitation in range of motion of the upper and lower extremities on one side and was dependent on staff for activities of daily living. The MDS noted Resident #31 did not receive passive/ active range of motion or or brace assistance for at least 15 minutes in the last 7 calendar days. The care plan initiated on noted Resident #31 required assistance with ADL care related to multiple factors including , decreased mobility, history of ( ) with right , aphasia (language that affects a person's ability to communicate). The goal was for the resident to maintain and/or improve current level of function. The interventions initiated on and revised on included passive range of motion and /brace application. Encourage and assist resident to participate with donning and doffing of right /brace. Apply in PM (afternoon) after PROM (passive range of motion) performed and remove in AM (morning) followed by PROM (passive range of motion) as tolerated. The care plan specified the resident may remove device per preference. Review of the physician's orders revealed an order dated for, "PROM and /Brace application: Encourage and assist resident to participate with donning and doffing of right /brace. Apply in PM after PROM performed and remove in AM followed by PROM as tolerated. Review of the Certified Nursing Assistant (CNA) Kardex (provides instructions for care) revealed, "ADLs/Restorative Care. PROM and /brace application: Encourage and assist resident to participate with donning and doffing of right /brace. Apply /brace in PM after PROM performed and remove in AM followed by PROM as tolerated. Monitor skin surfaces under devise and notify physician of abnormal findings. The resident may	N0201	Continued from page 1 educated on the components of F688 with an emphasis on documenting the donning and doffing of a /brace and following the comprehensive resident centered care plan and Prevention of decrease in ROM/Mobility by the DON/Designee. Newly hired licensed nurses/ , Staff will be educated on the components of F688 with an emphasis on documenting the donning and doffing of a /brace and following the comprehensive resident centered care plan and prevention of decrease in ROM/Mobility by the Director of Nursing/Designee at orientation as a part of the systematic changes. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee to conduct audits of 5 residents with physician orders for a /brace 2x a week for 4 weeks, then 1x a week for 4 weeks and then monthly for 1 month to ensure that the physician order includes documentation of donning and doffing /brace. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12640961	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N0201 SS = E	Continued from page 2 remove device per preference." On at 1:10 p.m., in an interview CNA Staff F said Resident #31's right and were . He said Resident #31 was receiving Rehabilitation , about months ago. CNA Staff F said he was trained on PROM and care for Resident #31. The CNA said Resident #31 did not have anything in place for the right at this time. Staff F said Resident #31 has a lot of when he moves his . On at 1:15 p.m., Licensed Practical Nurse (LPN) Staff A said she was not aware of any device for Resident #31's right . On at 4:21 p.m., in an interview LPN Staff A said CNAs check the Kardex every day to find out about their residents. She said the nurses were responsible for making sure the CNAs are following the Kardex. On at 4:25 p.m. in an interview LPN Staff G said PROM and devices are reviewed at care plan meetings. LPN Staff G said the nurses are responsible for PROM and /brace application documentation on the Treatment Administration Record (TAR). Review of the TAR from through failed to reveal documentation of PROM or that the was applied to Resident #31's right as ordered. On at 9:21 a.m., in an interview the Director of Nursing (DON) verified Resident #31 had an order dated for passive range of motion and , application to the right . She verified the lack of documentation Resident #31 received the range of motion or the was applied to the resident's right as ordered. Class III	N0201		