Nursing Home Surveyor Training Resource
Range of Motion at F 317 and F318
June, 2007

These tags are cited when the surveyor confirms that a resident required(es) services to maintain or improve range of motion and did not receive those services. If the resident had no loss in range of motion at the time of admission and then experienced a loss because the facility did not implement the necessary services, then F317 would be cited. If the resident already had a loss of range of motion and the facility did not consistently implement the necessary services to prevent further loss or improve the range of motion when indicated, F318 would be cited.

Facilities are instructed to code the MDS at G4A for a loss of "functional" range of motion. The regulations do not use the word functional and this has sometimes created confusion. A surveyor may not be able to use the MDS alone to show a decline or improvement in range of motion because the MDS coding only refers to a "functional" loss. When being tested, if the resident is unable to assist with range of motion at all, the body part has to be coded as limited regardless of the presence of actual physical contractures. Because of this coding requirement, an interview needs to be conducted with staff familiar with the resident to determine the actual presence of physical contractures and their estimated duration of its existence.

Investigation:

Observations of resident to determine presence of joint limitations:

- ♦ Observe the resident during care and during the daily routine to see if there are any limitations in range of motion. Document the specific observation or observations of the ADLs, therapy, etc., that led the surveyor to this conclusion. If no losses noted, no deficient practice exists. No need for further review. If loss is observed, continue investigation.

- ♦ Observe the resident to determine what services, if any, are being provided to maintain, prevent, or improve the resident's range of motion. Can include splints, positioning aides, ROM exercises, PT/OT, etc. If discontinued from OT/PT, determine if instruction was given to nursing staff or rehab nursing staff and continue follow up range of motion exercises. (Verify by record review and/or interview.)

  If discontinued from OT/PT, verify there was no instruction given to have nursing staff or rehab nursing staff follow up with range exercises. (Verify by record review and/or interview.)

- ♦ Observe the resident for conditions that might put the resident at risk for developing a

decrease in range of motion (restraints, immobility, disease, dx, etc.).

Interviews:

- Interview the resident who has joint limitations, if cognitively alert, about what services are being provided (such as ROM exercises, splints, therapies, etc.).

- If you did not observe services being provided, interview at both the direct care level and the charge nurse level as to when and if this service is to be implemented.

- If surveyor not able to observe these services or if staff or the resident indicated the services were provided when surveyors was not present, directly interview the person responsible to complete the services. Either ask to be present when the services are being provided or ask the person who conducted the services to verbally identify the steps they implemented including the number of repetitions as well as when it was completed. Confirm this information by interviewing the resident or family if possible. Also confirm to determine the care plan being followed. If not following the care plan, can cite at F282.

- If the resident or family is refusing services, interview the resident or family to determine if they are aware of the risks of failure to accept the care. (If the resident is refusing, was there evidence found in the record to confirm reason for refusal and alternatives offered to overcome refusal. If not cite F155.)

- If range of motion services should be provided and are not found on the care plan, interview the charge nurse as to why not on the care plan. Cite F279 if not developed; cite F280 for failure to revise the care plan when it was confirmed by the resident's functional change.

- Interview the charge nurse to determine if they are aware of when the limitation in range of motion occurred. Ask when the change was noted and what was thought to be the cause.

- If surveyor notes through observation, that the degree of limitation affects the resident's ability to complete an ADL task, interview direct care staff who have been there for 4-6 months and have worked with this resident, to determine if they noted this change and when it occurred.

Record review:

- For a resident who is observed with contractures, review the record to determine if interventions are on the care plan. Cite F279 if services are not on the care plan.

- When contractures are observed, review the most recent RAI and determine if the

facility acknowledged in the RAPS that the limitation was present. If not, attempt to determine by interview with direct care staff when the loss was noted to have occurred. Also confirm whether there was any documented functional loss evident at the time of completion of the RAI.

- If the resident entered the facility without a limitation in range of motion then subsequently developed a limitation in range of motion and there were no interventions or inconsistent implementation of interventions confirmed by interview, cite F317. Otherwise continue with determination if F318 should be cited.

- If the record documents the presence of contractures, find the reason for development through further record review and interview. Could be harm if evidence of loss and no plan. Start determining avoidable vs. unavoidable through interview with direct care staff and RN Case Manger.

- If the facility did not provide interventions to prevent the loss of ROM, is there a documented decision not to proceed to care plan based upon valid decision of resident or POA. If not, consider F155.

- Compare similarity of scores on MDS in Section G, physical functioning and structural problems items g, h, i and j with those listed under Section 4 "Functional limitations in range" with those done over the past 6-9 months. Do these areas indicate a score that surveyor observations confirmed? If not, interview MDS nurse to determine how arrived at scores. Does facility follow the testing requirements identified in the MDS for these areas, if not cite inaccurate assessment, F278. If the scores show evidence of progressive loss, was there a medical reason, or decision documented why the loss could not be overcome through range of motion.

- Review the record to determine if interventions were consistently documented as completed. Review, at minimum, the last 2-3 months of its implementation. Is it documented as having been implemented as designed? If not, this can not be the sole reason for citing a deficient practice. It needs to be confirmed by interview with the person or persons responsible for implementing this service that the service was not performed as designed. Remember, a resident may refuse care but this should be an "informed refusal." The surveyor should then be certain to confirm that the resident and/or decision maker was provided with the risks/benefits of their decision and this information is documented in the record. Also the facility must document the alternatives that were attempted to overcome the reason for the resident's refusal over a reasonable span of time. If not, cite F155.