Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 15, 2023

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: CCN: 245585
Cycle Start Date: July 5, 2023

Dear Administrator:

On August 4, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2023

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Re: Reinspection Results
Event ID: 2K8412

Dear Administrator:

On August 4, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 5, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Electronically delivered
July 18, 2023

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: CCN: 245585
Cycle Start Date: July 5, 2023

Dear Administrator:

On July 5, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 5, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 5, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 18, 2023

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Re: State Nursing Home Licensing Orders
Event ID: 2K8411

Dear Administrator:

The above facility was surveyed on July 5, 2023 through July 5, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING ______ B. WING ______	C 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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 000	INITIAL COMMENTS On 7/5/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H55853341C (MN00087638). H55853363C (MN00089835). AND The following complaints were reviewed. H55853362C (MN00083189) with a deficiency issued at (F677). H55853340C (MN00093052) with a deficiency issued at (F676 and F686). H55853440C (MN00084000) with a deficiency issued at (F677 and F686). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of	F 676		7/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 07/24/2023

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 676	Continued From page 1 daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement therapy recommendations and routinely provide ambulation services to maintain function for 2 of 3 residents (R1 and R3) reviewed for ambulation.	F 676	F 676 Activities Daily Living (ADLs)/Maintain Abilities (D) Immediate Corrective Action: A process for documenting ambulation per therapy recommendations was established and entered into the medical record for R1 and	

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F 676	Continued From page 2 Findings include: R1 R1's quarterly Minimum Data Set (MDS) dated 6/20/23, identified R1 was cognitively intact and had diagnoses which included cancer, coronary artery disease, diabetes mellitus. Indicated R1 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting, personal hygiene and walking with assistance of one facility staff. Identified R1 was not steady moving from a seated to standing position and moving on and off toilet however was able to stabilize without human assistance. R1 had no functional limitations with range of motion (ROM), utilized a wheel chair and had received physical therapy (PT) services from 3/6/23 to 4/17/23. R1's significant change Care Area Assessment (CAA) dated 3/20/23, identified R1 required limited assistance with ADL's and was at risk for further decline in ADL's, falls, contractures, isolation, complications with immobility, pressure ulcers, muscle atrophy, and incontinence. To proceed with plan of care to prevent and minimize risk. R1's care plan undated, revealed R1 had actual deficits with ADL's related to current medical, cognitive and physical status. The care plan indicated R1 was independent with ambulating in her room, hallway, to/from meals with front wheeled walker (FWW). R1 would utilize call light for assistance if not feeling well and would ask to ambulate with FWW. R1 would require one staff assistance for safety while ambulating and staff were to ask and remind R1 about walking. The	F 676	R3. Corrective Action/Others: Other residents with therapy recommendations for ambulation will be reviewed to ensure the recommendations are accurately reflected in the resident's medical record, and that a system for documentation is established allowing staff to document accordingly. Prevent Recurrence: The policies titled "Restorative Program" and "Activities of Daily Living" were reviewed and remain current. Nursing staff will be educated on the policy and documentation expectations for residents with ambulation programs. Date of Alleged Compliance: 7/31/2023 Ongoing Monitoring: Random visual and documentation audits will be conducted to ensure dependent residents receive assistance with ambulation in accordance with individualized care planned interventions and therapy recommendations. Three audits will be conducted as follows: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: DON/Designee	

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F 676	Continued From page 3	F 676		

care plan identified staff were to follow PT recommendations as able or accepted.

R1's Physical Therapy Discharge Summary dated 4/14/23, identified R1 had met goals to maximum potential at that time. R1 was appropriate to ambulate with FWW verses the four wheeled walker (4WW) at the time due to reduced safety with the 4WW. Recommendations were for staff to assist R1 at all times with hallway ambulation and identified R1 tolerated up to 150 feet in a single bought on good days. The discharge plan revealed R1 had ambulated up to 150 feet with her FWW at the time of discharge from skilled therapy services.

During an interview on 7/5/23 at 10:46 a.m., R1 stated she attempted to do things for herself most of the time and would call staff when she required assistance with cares. R1 indicated she had not been receiving the assistance she needed with walking. She stated would go out into the hallway to ask for assistance with walking and was not certain they had enough staff to help. R1 indicated staff would inform her they would return later to assist her with walking and stated they never returned. R1 indicated she used to attend PT and had since graduated to restorative therapy. R1 stated her 4WW went too fast and she was informed by staff to use her FWW instead when walking. In a follow up interview at 3:31 p.m., R1 confirmed she had not been offered to be walked by staff today and stated that was frequently the case. R1 indicated staff were expected to be walking her daily and stated they only offered once in a while.

During an observations on 7/5/23 at 9:36 a.m., R1 was seated in her wheel chair and wheeled

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F 676	Continued From page 4	F 676		

herself independently into the sun room at the end of the 400 wing where other residents were present. R1 was actively participating in looking at pictures in the coloring books.

- at 10:23 a.m. R1 continued to be in activity in the sun room while her and other residents listened to audio books.

- at 10:46 a.m. R1 was seated in her wheel chair in her room, while she was looking at her coloring books. R1 indicated staff had just finished assisting her to the bathroom. R1's walker was located up against her bedroom wall by her door.

- at 11:35 a.m. R1 remained in her wheel chair and in her room. R1's walker was located up against her bedroom wall by the door.

- at 11:46 a.m. R1 was seated in her wheel chair out in the commons area and actively participating in playing trivia.

- at 11:52 a.m. R1 wheeled herself via wheel chair independently into the dining room area for lunch, while passing by several staff members in the commons area.

- at 12:58 p.m. R1 wheeled herself via wheel chair out of the dining room area and back to her room independently.

- at 3:31 p.m. R1 was seated in her wheel chair in her room visiting with her grandson. R1's walker was located up against her bedroom wall by the door.

- at 3:45 R1 remained the same.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 676	Continued From page 5 During observations through out the day, staff were not observed to ask/offer or assist R1 with ambulation. During an interview on 7/5/23 at 12:27 p.m., the occupational therapist (OT) indicated R1 had been receiving PT services and was discharged on 4/17/2023. The OT stated when R1 was discharged from PT she was placed on the walking list to be walked two to three times a day with one staff assistance, distance as tolerated and with wheel chair following behind. The OT indicated R1 was to use her FWW versus her 4WW due to reduced safety with walker and assistance of one staff in hallways with ambulation at all times. R1 was able to ambulate 150 feet in a single instance on good days. The OT indicated the nursing staff were responsible for ensuring R1's daily walking program was completed and was not certain how nursing staff were tracking the program. The OT stated she expected staff to follow the recommendations made by PT and to ask/offer R1 to walk and if she refused, staff should have documented the refusals. The OT indicated she was currently working with registered nurse (RN)-A on a system to track the walking program. During an interview on 7/5/23 at 3:22 p.m., nursing assistant (NA)-B confirmed R1 was currently on a walking program and she had not offered or asked R1 to ambulate that day. NA-B indicated R1 was able to walk usually half way to the dining room at times when offered. NA-B stated R1 was supposed to be walked three times a day for 30 min and staff were expected to report to the nurse any refusals. NA-B indicated R1 was pretty good about walking when asked and hardly ever refused when offered.	F 676		

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F 676	Continued From page 6	F 676		

Continued From page 6

During an interview on 7/5/23 at 3:35 p.m., NA-C indicated R1 propelled herself independently in her wheel chair to maneuver around the facility. NA-C stated she was not aware R1 was currently on a walking program. NA-C indicated R1 did not walk very often and NA-C confirmed she had not asked or offered to ambulate R1 that day.

During an interview on 7/5/23 at 4:48 p.m., RN-A confirmed R1 was currently on a walking program and had been recently discharged from therapy. RN-A indicated PT recommended staff were to walk R1 two to three times a day to keep up her strength. RN-A stated she would expect staff to walk the residents, to offer encouragement when they refused and to follow PT recommendations. RN-A indicated the facility currently did not have a way of tracking the facility walking program.

R3

R3's significant change Minimum Data Set (MDS) dated 5/3/23, identified R3 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, dementia, and arthritis. Indicated R3 required extensive assistance of two staff with transfers and walking in room and corridor. Identified R3's physical therapy ended on 4/25/23, and R3 did not have a restorative nursing program.

R3's significant change Care Area Assessment (CAA) dated 5/4/23, identified R3 had Alzheimer's disease and required extensive assistance with activities of daily living (ADLs).

R3's care plan, undated, identified R3 had complications with deficits with ADLs related to

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F 676	Continued From page 7	F 676		

dementia, weakness and left foot ulcer. R3's care plan directed staff to ambulate with assistance of one and follow with wheelchair per therapy. R3's care plan directed staff to walk to and from three meals each day, approximately 150 feet.

R3's Physical Therapy Discharge Summary dated 4/6/23 to 4/25/23, included discharge recommendations to ambulate R3 with assistance of one staff to/from meals three x/day with the use of front wheeled walker (FWW), staff to walk along side R3 with wheelchair to follow.

R3's medical record lacked documentation R3 had been walked to meals, as recommended by therapy since 4/25/23.

During an observation on 7/5/23 at 10:16 a.m., R3 was seated in her wheelchair in the doorway to her room. R3 propelled herself in her wheelchair down the hallway to the common area near the nurses desk, where R3 stopped and remained. At 11:06 a.m., R3 was noted in the common area near the dining room at the exercise activity program. At 11:53 a.m. R3 went to the dining room for lunch. At 12:36 p.m. R3 propelled herself in her wheelchair out of the dining room to an empty room in the 600 hallway where she remained. At 12:57 p.m. trained medication aide (TMA)-A wheeled R3 down the hallway to a nearby bathroom where TMA-A and registered nurse (RN)-A provided R3 with toileting assistance.

During an interview on 7/5/23 at 3:26 p.m., RN-A confirmed the facility had a list of residents who were supposed to be walked, which included R3. RN-A indicated they had been working with

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therapy to develop a system to assure walking was completed as therapy recommended.

During interview on 7/5/23 at 3:33 p.m., occupational therapist (OT)-A confirmed the facility had a list of residents who required walking, and the nursing department was responsible to assure the residents were being walked. OT-A reviewed R3's electronic medical record and confirmed staff were expected to walk to meals since 4/25/23. OT-A stated it was important for R3 to be walked to maintain her leg strength, her transferring ability, for her cardiovascular health, and to increase blood flow for healing of her foot ulcer. In addition, OT-A stated it was good for R3 to walk to decrease her anxiety, as R3 had a desire for movement.

During an interview on 7/5/23 at 1:33 p.m., nursing assistant (NA)-A stated R3 was on a walking schedule, and her usual practice was to attempt to walk R3 to at least one meal per day. NA-A confirmed she had not assisted R3 to walk that day.

During an interview on 7/5/23 at 1:42 p.m., NA-B stated R3 walked well, and she had walked with R3 in the past, however had not assisted her to walk today.

During an interview on 7/5/23 at 1:47 p.m., NA-C indicated she was responsible for R3's cares that day. NA-C stated R3 was to be walked to meals and confirmed she had not assisted her with walking that day. At 2:57 p.m. during a follow up interview, NA-C indicated she had not asked for assistance with R3 to complete her cares, including walking to meals.

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During a telephone interview on 7/5/23 at 5:11 p.m., family member (FM)-A stated it bothered him that R3 was always in her wheelchair. FM-A indicated when R3 was discharged from therapy, he was informed R3 was able to walk with her walker, however felt R3 was not being assisted with walking as needed. FM-A stated he felt the facility should at least walk R3 daily so R3 would not lose her ability to walk.

During an interview on 7/5/23 at 4:16 p.m., director of nursing (DON) stated the facility was working on creating new group sheets, to include information regarding residents who needed to be walked. DON confirmed she was not aware if the facility had a system to track when residents were walked to assure it was completed and stated they had discussed the need to document it in the resident's medical record. DON indicated she was not aware R3 and R1 were not being walked as care planned. DON stated she expected staff to follow resident care plans, to walk residents per therapy recommendations, and encourage and educate them as needed if they refused. DON indicated walking residents was important to help keep their muscle and bone strength, endurance, balance, and ability to continue to walk. DON stated she expected staff to ask for assistance if they could not complete resident's cares.

The facility policy titled Restorative Program revised May 2020, identified while in the facility, all residents were supported to maintain or attain their highest level of functioning. The policy further identified all residents were assessed upon admission and at each care plan meeting for possible inclusion in restorative programs, which were individualized to meet the resident

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F 676	Continued From page 10 needs. Restorative programs included training and skills practice in ambulation. The facility policy titled Activities of Daily Living-ADL revised May 2020, identified the resident's abilities in ADLs did not diminish unless circumstances of the individual's clinical condition demonstrated that diminution was unavoidable, which included: mobility: transfer and ambulation, including walking.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine shaving for 1 of 3 residents (R3) who was dependent on staff for assistance with grooming and personal hygiene. In addition, the facility failed to provide timely toileting assistance and incontinence care for 1 of 3 residents (R3) who was dependent on staff for assistance with activities of daily living (ADLs). Findings include: R3's significant change Minimum Data Set (MDS) dated 5/3/23, identified R3 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, dementia and arthritis. Indicated R3 required extensive assistance with toilet use, and personal hygiene. Identified R3 was frequently incontinent of bowel	F 677	F 677 ADL Care for Dependent Residents (D) Immediate Corrective Action: R3 was assisted with toileting and shaving. The medical record and Kardex for R3 were reviewed to ensure ADL tasks for shaving and toileting assistance were accurately documented and remained current. Corrective Action/Others: Other residents that require assistance with toileting and shaving will be reviewed to ensure their medical records accurately reflect the type and level of assistance needed to complete the ADL tasks. Prevent Recurrence: The policies for “Activities of Daily Living” and “Bowel/Bladder Management” were reviewed and remain current. Nursing staff will be educated on the policies.	7/31/23

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and bladder and was not on a toileting program.

R3's significant change Care Area Assessment (CAA) dated 5/4/23, identified R3 had Alzheimer's disease and required extensive assistance with ADLs. Indicated R3 had urinary incontinence and required extensive assistance with toilet use.

R3's care plan, undated, identified R3 had complications with deficits with ADLs related to dementia, weakness and sore left foot. R3's care plan identified R3 required physical assistance of one staff with hygiene. Indicated one person physical assist for all toileting, incontinence cares with incontinent episode, toilet upon arising, between meals, at bedtime (HS) and as needed, and to check and change every two hours at night and PRN (as needed).

R3's Bladder Data Collection Tool dated 5/3/23, identified R3 was not continent of bladder and had impaired mobility, dependent transfer and severe cognitive impairment. Indicated R3 had functional urinary incontinence with scheduled incontinence care.

R3's Bowel Data Collection Tool dated 5/3/23, identified R3 was not continent of bowel and had presence of fecal staining. Indicated staff were to provide scheduled incontinence care and comfort and to not alter R3's toilet program.

During an observation which started on 7/5/23, at 10:16 a.m. R3 sat in her wheelchair in the doorway of her room and propelled herself down the hallway to the common area near the nurses' station. R3 had four to six black and white coarse facial hairs approximately six millimeters (mm) long on the right side of her mouth, a few black

F 677

Date of Alleged Compliance: 7/31/2023
Ongoing Monitoring: Random visual audits will be conducted to ensure dependent residents receive assistance with shaving and toileting in accordance with individualized care planned interventions. Three audits will be conducted as follows:

- 5x/week for 2 weeks
- 3x/week for 2 weeks
- 2x/week for 2 weeks
- Weekly x 4 weeks

A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.
Monitored By: DON/Designee

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and white facial hairs approximately six mm long on the left side of her mouth and one wispy white hair three to four centimeters long on the left edge of her mouth. R3 remained seated in her wheelchair in the hallway outside the common area. At 11:06 a.m. R3 propelled herself to the common area outside the dining room and was observed in the common area near the dining room during the exercise activity program until 11:53 a.m. R3 entered the dining room in her wheelchair for lunch. At 12:36 p.m., R3 propelled herself out of the dining room to the end of the 600 hallway to an empty room and sat. R3 was not observed to be offered to be toileted or shaved by staff nor was she observed to independently toilet or shave herself during this time. At 12:57 p.m., surveyor intervened two hours and forty one minutes after R3 was first observed in her wheelchair by informing trained medication aid (TMA)-A R3 required assistance. TMA-A assisted R3 to the bathroom nearby with assistance of registered nurse (RN)-A. TMA-A and RN-A transferred R3 to the toilet using a gait belt. R3's brief was moderately saturated with urine. R3's buttocks and perineal area were noted to be slightly red with a few wrinkled areas present. TMA-A and RN-A cleansed R3's perineal area, applied a new brief and adjusted her clothing. At 1:07 p.m. TMA-A confirmed she had not assisted R3 with any cares prior to that time.

During an interview on 7/5/23 at 1:33 p.m., nursing assistant (NA)-A stated R3 required assistance with cares in the morning and staff were expected to take R3 to the bathroom every two hours. NA-A confirmed she had not assisted R3 with toileting or shaving tasks that day.

During an interview on 7/5/23 at 1:42 p.m., NA-B

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F 677	Continued From page 13 indicated R3 required assistance with ADLs from one to two staff, depending on her mood. NA-B stated her usual practice was to shave residents when facial hair was visible. NA-B confirmed she had not assisted R3 with cares that day as she was assigned to the other side of the facility. During an interview on 7/5/23 at 1:47 p.m., NA-C indicated she was responsible for R3's cares, however confirmed she had not assisted her with morning cares as R3 was already up in her wheelchair when she arrived for her shift. NA-C stated she had not assisted R3 with cares that day as she was busy with other residents and identified R3 had last been toileted at 6:30 a.m. NA-C confirmed R3 had a few facial hairs and stated she had last assisted R3 to remove facial hairs with shaving last Friday or Monday and had shaved R3's chin however had not shaved around R3's mouth. NA-C stated staff were expected to shave R3's facial hair whenever it was visible. NA-C stated she had not asked other staff for assistance with toileting or shaving R3 that day. During an interview on 7/5/23 at 1:54 p.m., licensed practical nurse (LPN)-A confirmed she had not assisted R3 with any cares that day. R3 was not observed to be offered toileting or incontinence cares for two hours and forty one minutes, and nursing staff verified by interview R3 had not been assisted with toileting and incontinence cares for six hours and 27 minutes since 6:30 a.m. During an observation and interview on 7/5/23 at 3:26 p.m., RN-A confirmed R3 had facial hairs present when RN-A observed R3 in her	F 677		

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F 677	Continued From page 14	F 677		

wheelchair in her room. RN-A indicated she expected staff to assist R3 with removing facial hair on R3's bath day and whenever facial hairs were visible. RN-A stated she was unaware R3 had facial hair present prior to that observation. RN-A confirmed she had not been informed R3 had not been toileted as care planned and stated she expected R3 to be toileted every two hours. RN-A confirmed R3's brief was moderately saturated with urine. RN-A indicated it was important to toilet residents as care planned for dignity, comfort and to prevent skin breakdown.

During an interview on 7/5/23 at 4:16 p.m., director of nursing (DON) indicated she was unaware R3 had facial hair present and was not toileted as care planned. DON stated she expected staff to complete all cares following resident care plans, which included toileting, incontinence cares, and removing facial hair. DON indicated she expected staff to remove facial hair during morning cares. DON stated it was important for residents to have facial hair removed to promote dignity and to assure they looked their best. DON indicated she expected staff to provide routine toileting and incontinence cares to promote dignity, prevent skin breakdown, prevent urinary infections and to promote good hygiene and cleanliness. DON stated she would expect staff to ask for assistance if they were unable to complete cares timely.

During a telephone interview on 7/5/23 at 5:11 p.m., family member (FM)-A stated sometimes they discovered R3 had not been brought to the bathroom or been changed. FM-A indicated he was not aware if R3's facial hairs bothered her now due to the effects of her dementia, however believed staff should have assisted her by

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F 677	Continued From page 15 removing her facial hair to promote dignity. The facility policy titled Activities of Daily Living-ADL revised May 2020, identified the resident's abilities in ADLs would not diminish unless circumstances of the individual's clinical condition demonstrated that diminution was unavoidable, which included: hygiene: bathing, dressing, grooming and oral care, and elimination: toileting. The facility policy titled Bowel And Bladder Management revised 4/2020, identified there was a system to ensure that each resident with bowel and bladder incontinence would receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible. The policy indicated a resident who was incontinent of bladder would receive appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		7/31/23

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide routine repositioning intervention for 1 of 3 residents (R3) who was at risk for pressure ulcers.

Findings Include:

R3's significant change Minimum Data Set (MDS) dated 5/3/23, identified R3 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, dementia and arthritis. Indicated R3 required extensive assistance with bed mobility, transfers, and toilet use. Identified R3 was at risk for pressure ulcers, and had one unhealed stage three pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) that was present upon admission.

R3's significant change Care Area Assessment (CAA) dated 5/4/23, identified R3 had Alzheimer's disease and required extensive assistance with activities of daily living (ADLs). Indicated R3 had potential for pressure ulcer due to need for extensive assistance with bed mobility and further complicated by frequently incontinent of urine and bowel. Identified R3 currently had a pressure ulcer and was at risk for skin breakdown and to proceed to plan of care with goal to maintain skin integrity.

R3's Braden Scale Screening Tool (a standardized assessment tool used to assess a resident's risk of pressure injuries) dated 4/12/23, identified R3 had a score of 16, which indicated

F 686

F 686 Treatment and Services Prevent/Heal Pressure Ulcers (D)
Immediate Corrective Action: R3 was assisted with repositioning and R3’s medical record and Kardex were reviewed to ensure they accurately reflected the type and level of assistance needed to prevent and/or heal pressure ulcers.
Corrective Action/Others: Other residents that are at risk for pressure ulcer development will be reviewed to ensure appropriate interventions are care planned accordingly, based on individual risk factors, to mitigate the risk of skin breakdown and promote wound healing.
Prevent Recurrence: The policy titled “Pressure Ulcer/Skin Integrity” was reviewed and remains current. Staff will be educated on the policy.
Date of Alleged Compliance: 7/31/2023
Ongoing Monitoring: Random visual audits will be conducted to ensure repositioning interventions are implemented based on individualized resident-centered care plans to prevent and/or heal pressure ulcers. Three audits will be conducted as follows:
- 5x/week for 2 weeks
- 3x/week for 2 weeks
- 2x/week for 2 weeks
- Weekly x 4 weeks

A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.
Monitored by: DON/Designee

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R3 had a mild risk of developing a pressure ulcer.

R3's care plan, undated, identified R3 had complications of deficits with ADLs related to dementia, weakness and a left foot ulcer. Indicated R3 required one person physical assist with bed mobility, transfers, toilet use and hygiene. Identified R3 had actual complications with impaired skin integrity related to current pressure wound on left lateral arch of foot, stage three. R3 was at risk for impaired skin integrity related to incontinence and dementia. R3's care plan instructed staff to reposition R3 every two hours in bed and chair and PRN (as needed).

During observation which started on 7/5/23, at 10:16 a.m. R3 sat in her wheelchair in the doorway of her room and propelled herself down the hallway to the common area near the nurses' station. At 11:06 a.m. R3 propelled herself to the common area outside the dining room. R3 attended the exercise activity program in the common area near the dining room until 11:53 a.m., at which time R3 went to the dining room in her wheelchair for lunch. At 12:36 p.m., R3 propelled herself out of the dining room to the end of the 600 hallway to an empty room and sat. R3 was not observed to be offered to be repositioned by staff nor was she observed to independently reposition herself during that time. At 12:57 p.m., surveyor intervened two hours and forty one minutes after R3 was first observed in her wheelchair by informing trained medication aid (TMA)-A R3 required assistance. TMA-A assisted R3 to the bathroom nearby with assistance of registered nurse (RN)-A. TMA-A and RN-A transferred R3 to the toilet using a gait belt. R3's brief was moderately saturated with urine. R3's buttocks and perineal area were noted to be

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slightly red with a few wrinkled areas present. TMA-A and RN-A cleansed R3's perineal area, applied a new brief and adjusted her clothing. At 1:07 p.m. TMA-A confirmed she had not assisted R3 with any cares prior to that time.

During an interview on 7/5/23 at 1:33 p.m., nursing assistant (NA)-A stated R3 required assistance with cares in the morning and staff were expected to reposition and toilet R3 every two hours. NA-A confirmed she had not assisted R3 with repositioning that day.

During an interview on 7/5/23 at 1:42 p.m., NA-B indicated R3 required assistance with ADLs from one to two staff, depending on her mood. NA-B confirmed she had not assisted R3 with repositioning that day as she was assigned to the other side of the facility.

During an interview on 7/5/23 at 1:47 p.m., NA-C indicated she was responsible for R3's cares that day however she had not assisted her with morning cares as R3 was already up when she arrived for her shift. NA-C confirmed she had not assisted R3 with repositioning that day due to being busy caring for other residents and indicated R3 had last been repositioned at 6:30 a.m. NA-C confirmed she had not requested assistance from other staff when she was not able to complete R3's repositioning tasks every two hours as identified in her care plan.

During an interview on 7/5/23 at 1:54 p.m., licensed practical nurse (LPN)-A confirmed she had not assisted R3 with repositioning cares that day.

R3 was not observed to be repositioned for two

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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 686	Continued From page 19	F 686		

hours and forty one minutes, and nursing staff verified by interview R3 had not been assisted with repositioning for six hours and 27 minutes since she had last been repositioned at 6:30 a.m.

During an interview on 7/5/23 at 3:26 p.m., RN-A indicated she had not been informed R3 had not been repositioned and had not been asked to assist with R3's cares. RN-A indicated she expected R3 to be repositioned every two hours. RN-A stated she felt R3 could reposition herself a little and would at times stand up while in her wheelchair and walk by herself. RN-A confirmed R3 had a pressure ulcer on her left foot however indicated R3 had no other areas of skin breakdown at that time.

During an interview on 7/5/23 at 4:16 p.m., director of nursing (DON) confirmed R3 was at risk for skin breakdown, due to wheelchair use, incontinence, and inability to reposition herself. DON stated she believed R3 was able to reposition herself a little on her own. DON stated she expected staff to complete all cares following resident care plans. DON stated she would expect staff to ask for assistance if they were unable to complete cares timely.

The facility policy titled Pressure Injury/Skin Integrity/Wound Management revised 11/16, identified a system was in place for the prevention, identification, treatment, and documentation of pressure injuries and non-pressure wounds. The policy identified upon admission an assessment would be made to identify specific factors that may increase the risk of pressure injury development or affect healing of a pressure injury. The policy instructed appropriate turning and repositioning schedules

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F 686	Continued From page 20 would also be put in place per assessment and a care plan would be initiated.	F 686		

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	00669	A. BUILDING: ______ B. WING ______	C 07/05/2023

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 7/5/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H55853341C (MN00087638). H55853363C (MN00089835). AND The following complaints were reviewed. H55853362C (MN00083189) with a licensing order issued at (0920), H55853340C (MN00093052) with a licensing order issued at (0915 and 0905), H55853440C (MN00084000) with a licensing order issued at (0920 and 0905). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine repositioning intervention for 1 of 3 residents (R3) who was at risk for pressure ulcers. Findings Include: R3's significant change Minimum Data Set (MDS)	2 905	Immediate Corrective Action: R3 was assisted with repositioning and R3's medical record and Kardex were reviewed to ensure they accurately reflected the type and level of assistance needed to prevent and/or heal pressure ulcers. Corrective Action/Others: Other residents that are at risk for pressure ulcer	7/31/23

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2 905	Continued From page 3 dated 5/3/23, identified R3 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, dementia and arthritis. Indicated R3 required extensive assistance with bed mobility, transfers, and toilet use. Identified R3 was at risk for pressure ulcers, and had one unhealed stage three pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) that was present upon admission. R3's significant change Care Area Assessment (CAA) dated 5/4/23, identified R3 had Alzheimer's disease and required extensive assistance with activities of daily living (ADLs). Indicated R3 had potential for pressure ulcer due to need for extensive assistance with bed mobility and further complicated by frequently incontinent of urine and bowel. Identified R3 currently had a pressure ulcer and was at risk for skin breakdown and to proceed to plan of care with goal to maintain skin integrity. R3's Braden Scale Screening Tool (a standardized assessment tool used to assess a resident's risk of pressure injuries) dated 4/12/23, identified R3 had a score of 16, which indicated R3 had a mild risk of developing a pressure ulcer. R3's care plan, undated, identified R3 had complications of deficits with ADLs related to dementia, weakness and a left foot ulcer. Indicated R3 required one person physical assist with bed mobility, transfers, toilet use and hygiene. Identified R3 had actual complications with impaired skin integrity related to current pressure wound on left lateral arch of foot, stage three. R3 was at risk for impaired skin integrity related to incontinence and dementia. R3's care	2 905	development will be reviewed to ensure appropriate interventions are care planned accordingly, based on individual risk factors, to mitigate the risk of skin breakdown and promote wound healing. Prevent Recurrence: The policy titled "Pressure Ulcer/Skin Integrity" was reviewed and remains current. Staff will be educated on the policy. Date of Alleged Compliance: 7/31/2023 Ongoing Monitoring: Random visual audits will be conducted to ensure repositioning interventions are implemented based on individualized resident-centered care plans to prevent and/or heal pressure ulcers. Three audits will be conducted as follows: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	

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2 905	Continued From page 4	2 905		

plan instructed staff to reposition R3 every two hours in bed and chair and PRN (as needed).

During observation which started on 7/5/23, at 10:16 a.m. R3 sat in her wheelchair in the doorway of her room and propelled herself down the hallway to the common area near the nurses' station. At 11:06 a.m. R3 propelled herself to the common area outside the dining room. R3 attended the exercise activity program in the common area near the dining room until 11:53 a.m., at which time R3 went to the dining room in her wheelchair for lunch. At 12:36 p.m., R3 propelled herself out of the dining room to the end of the 600 hallway to an empty room and sat. R3 was not observed to be offered to be repositioned by staff nor was she observed to independently reposition herself during that time. At 12:57 p.m., surveyor intervened two hours and forty one minutes after R3 was first observed in her wheelchair by informing trained medication aid (TMA)-A R3 required assistance. TMA-A assisted R3 to the bathroom nearby with assistance of registered nurse (RN)-A. TMA-A and RN-A transferred R3 to the toilet using a gait belt. R3's brief was moderately saturated with urine. R3's buttocks and perineal area were noted to be slightly red with a few wrinkled areas present. TMA-A and RN-A cleansed R3's perineal area, applied a new brief and adjusted her clothing. At 1:07 p.m. TMA-A confirmed she had not assisted R3 with any cares prior to that time.

During an interview on 7/5/23 at 1:33 p.m., nursing assistant (NA)-A stated R3 required assistance with cares in the morning and staff were expected to reposition and toilet R3 every two hours. NA-A confirmed she had not assisted R3 with repositioning that day.

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2 905	Continued From page 5	2 905		

During an interview on 7/5/23 at 1:42 p.m., NA-B indicated R3 required assistance with ADLs from one to two staff, depending on her mood. NA-B confirmed she had not assisted R3 with repositioning that day as she was assigned to the other side of the facility.

During an interview on 7/5/23 at 1:47 p.m., NA-C indicated she was responsible for R3's cares that day however she had not assisted her with morning cares as R3 was already up when she arrived for her shift. NA-C confirmed she had not assisted R3 with repositioning that day due to being busy caring for other residents and indicated R3 had last been repositioned at 6:30 a.m. NA-C confirmed she had not requested assistance from other staff when she was not able to complete R3's repositioning tasks every two hours as identified in her care plan.

During an interview on 7/5/23 at 1:54 p.m., licensed practical nurse (LPN)-A confirmed she had not assisted R3 with repositioning cares that day.

R3 was not observed to be repositioned for two hours and forty one minutes, and nursing staff verified by interview R3 had not been assisted with repositioning for six hours and 27 minutes since she had last been repositioned at 6:30 a.m.

During an interview on 7/5/23 at 3:26 p.m., RN-A indicated she had not been informed R3 had not been repositioned and had not been asked to assist with R3's cares. RN-A indicated she expected R3 to be repositioned every two hours. RN-A stated she felt R3 could reposition herself a little and would at times stand up while in her wheelchair and walk by herself. RN-A confirmed R3 had a pressure ulcer on her left foot however

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2 905	Continued From page 6	2 905		

indicated R3 had no other areas of skin breakdown at that time.

During an interview on 7/5/23 at 4:16 p.m., director of nursing (DON) confirmed R3 was at risk for skin breakdown, due to wheelchair use, incontinence, and inability to reposition herself. DON stated she believed R3 was able to reposition herself a little on her own. DON stated she expected staff to complete all cares following resident care plans. DON stated she would expect staff to ask for assistance if they were unable to complete cares timely.

The facility policy titled Pressure Injury/Skin Integrity/Wound Management revised 11/16, identified a system was in place for the prevention, identification, treatment, and documentation of pressure injuries and non-pressure wounds. The policy identified upon admission an assessment would be made to identify specific factors that may increase the risk of pressure injury development or affect healing of a pressure injury. The policy instructed appropriate turning and repositioning schedules would also be put in place per assessment and a care plan would be initiated.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could train all staff on ensuring each resident received turning and repositioning assistance according to their assessed need. The DON or designee could then perform observational audits to determine compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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2 915	Continued From page 7	2 915		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine shaving for 1 of 3 residents (R3) who was dependent on staff for assistance with grooming and personal hygiene. In addition, the facility failed to provide timely toileting assistance and incontinence care for 1 of 3 residents (R3) who was dependent on staff for assistance with activities of daily living (ADLs). Findings include: R3's significant change Minimum Data Set (MDS) dated 5/3/23, identified R3 had significant cognitive impairment and diagnoses which	2 915	Immediate Corrective Action: R3 was assisted with toileting and shaving. The medical record and Kardex for R3 were reviewed to ensure ADL tasks for shaving and toileting assistance were accurately documented and remained current. Corrective Action/Others: Other residents that require assistance with toileting and shaving will be reviewed to ensure their medical records accurately reflect the type and level of assistance needed to complete the ADL tasks. Prevent Recurrence: The policies for “Activities of Daily Living” and “Bowel/Bladder Management” were	7/31/23

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2 915	Continued From page 8 included: Alzheimer's disease, dementia and arthritis. Indicated R3 required extensive assistance with toilet use, and personal hygiene. Identified R3 was frequently incontinent of bowel and bladder and was not on a toileting program. R3's significant change Care Area Assessment (CAA) dated 5/4/23, identified R3 had Alzheimer's disease and required extensive assistance with ADLs. Indicated R3 had urinary incontinence and required extensive assistance with toilet use. R3's care plan, undated, identified R3 had complications with deficits with ADLs related to dementia, weakness and sore left foot. R3's care plan identified R3 required physical assistance of one staff with hygiene. Indicated one person physical assist for all toileting, incontinence cares with incontinent episode, toilet upon arising, between meals, at bedtime (HS) and as needed, and to check and change every two hours at night and PRN (as needed). R3's Bladder Data Collection Tool dated 5/3/23, identified R3 was not continent of bladder and had impaired mobility, dependent transfer and severe cognitive impairment. Indicated R3 had functional urinary incontinence with scheduled incontinence care. R3's Bowel Data Collection Tool dated 5/3/23, identified R3 was not continent of bowel and had presence of fecal staining. Indicated staff were to provide scheduled incontinence care and comfort and to not alter R3's toilet program. During an observation which started on 7/5/23, at 10:16 a.m. R3 sat in her wheelchair in the doorway of her room and propelled herself down the hallway to the common area near the nurses'	2 915	reviewed and remain current. Nursing staff will be educated on the policies. Date of Alleged Compliance: 7/31/2023 Ongoing Monitoring: Random visual audits will be conducted to ensure dependent residents receive assistance with shaving and toileting in accordance with individualized care planned interventions. Three audits will be conducted as follows: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: DON/Designee	

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2 915	Continued From page 9	2 915		

station. R3 had four to six black and white coarse facial hairs approximately six millimeters (mm) long on the right side of her mouth, a few black and white facial hairs approximately six mm long on the left side of her mouth and one wispy white hair three to four centimeters long on the left edge of her mouth. R3 remained seated in her wheelchair in the hallway outside the common area. At 11:06 a.m. R3 propelled herself to the common area outside the dining room and was observed in the common area near the dining room during the exercise activity program until 11:53 a.m. R3 entered the dining room in her wheelchair for lunch. At 12:36 p.m., R3 propelled herself out of the dining room to the end of the 600 hallway to an empty room and sat. R3 was not observed to be offered to be toileted or shaved by staff nor was she observed to independently toilet or shave herself during this time. At 12:57 p.m., surveyor intervened two hours and forty one minutes after R3 was first observed in her wheelchair by informing trained medication aid (TMA)-A R3 required assistance. TMA-A assisted R3 to the bathroom nearby with assistance of registered nurse (RN)-A. TMA-A and RN-A transferred R3 to the toilet using a gait belt. R3's brief was moderately saturated with urine. R3's buttocks and perineal area were noted to be slightly red with a few wrinkled areas present. TMA-A and RN-A cleansed R3's perineal area, applied a new brief and adjusted her clothing. At 1:07 p.m. TMA-A confirmed she had not assisted R3 with any cares prior to that time.

During an interview on 7/5/23 at 1:33 p.m., nursing assistant (NA)-A stated R3 required assistance with cares in the morning and staff were expected to take R3 to the bathroom every two hours. NA-A confirmed she had not assisted R3 with toileting or shaving tasks that day.

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2 915	Continued From page 10	2 915		

During an interview on 7/5/23 at 1:42 p.m., NA-B indicated R3 required assistance with ADLs from one to two staff, depending on her mood. NA-B stated her usual practice was to shave residents when facial hair was visible. NA-B confirmed she had not assisted R3 with cares that day as she was assigned to the other side of the facility.

During an interview on 7/5/23 at 1:47 p.m., NA-C indicated she was responsible for R3's cares, however confirmed she had not assisted her with morning cares as R3 was already up in her wheelchair when she arrived for her shift. NA-C stated she had not assisted R3 with cares that day as she was busy with other residents and identified R3 had last been toileted at 6:30 a.m. NA-C confirmed R3 had a few facial hairs and stated she had last assisted R3 to remove facial hairs with shaving last Friday or Monday and had shaved R3's chin however had not shaved around R3's mouth. NA-C stated staff were expected to shave R3's facial hair whenever it was visible. NA-C stated she had not asked other staff for assistance with toileting or shaving R3 that day.

During an interview on 7/5/23 at 1:54 p.m., licensed practical nurse (LPN)-A confirmed she had not assisted R3 with any cares that day.

R3 was not observed to be offered toileting or incontinence cares for two hours and forty one minutes, and nursing staff verified by interview R3 had not been assisted with toileting and incontinence cares for six hours and 27 minutes since 6:30 a.m.

During an observation and interview on 7/5/23 at 3:26 p.m., RN-A confirmed R3 had facial hairs

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present when RN-A observed R3 in her wheelchair in her room. RN-A indicated she expected staff to assist R3 with removing facial hair on R3's bath day and whenever facial hairs were visible. RN-A stated she was unaware R3 had facial hair present prior to that observation. RN-A confirmed she had not been informed R3 had not been toileted as care planned and stated she expected R3 to be toileted every two hours. RN-A confirmed R3's brief was moderately saturated with urine. RN-A indicated it was important to toilet residents as care planned for dignity, comfort and to prevent skin breakdown.

During an interview on 7/5/23 at 4:16 p.m., director of nursing (DON) indicated she was unaware R3 had facial hair present and was not toileted as care planned. DON stated she expected staff to complete all cares following resident care plans, which included toileting, incontinence cares, and removing facial hair. DON indicated she expected staff to remove facial hair during morning cares. DON stated it was important for residents to have facial hair removed to promote dignity and to assure they looked their best. DON indicated she expected staff to provide routine toileting and incontinence cares to promote dignity, prevent skin breakdown, prevent urinary infections and to promote good hygiene and cleanliness. DON stated she would expect staff to ask for assistance if they were unable to complete cares timely.

During a telephone interview on 7/5/23 at 5:11 p.m., family member (FM)-A stated sometimes they discovered R3 had not been brought to the bathroom or been changed. FM-A indicated he was not aware if R3's facial hairs bothered her now due to the effects of her dementia, however believed staff should have assisted her by

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2 915	Continued From page 12 removing her facial hair to promote dignity. The facility policy titled Activities of Daily Living-ADL revised May 2020, identified the resident's abilities in ADLs would not diminish unless circumstances of the individual's clinical condition demonstrated that diminution was unavoidable, which included: hygiene: bathing, dressing, grooming and oral care, and elimination: toileting. The facility policy titled Bowel And Bladder Management revised 4/2020, identified there was a system to ensure that each resident with bowel and bladder incontinence would receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible. The policy indicated a resident who was incontinent of bladder would receive appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependent on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing	2 920		7/31/23

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2 920	Continued From page 13 home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement therapy recommendations and routinely provide ambulation services to maintain function for 2 of 3 residents (R1 and R3) reviewed for ambulation. Findings include: R1 R1's quarterly Minimum Data Set (MDS) dated 6/20/23, identified R1 was cognitively intact and had diagnoses which included cancer, coronary artery disease, diabetes mellitus. Indicated R1 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting, personal hygiene and walking with assistance of one facility staff. Identified R1 was not steady moving from a seated to standing position and moving on and off toilet however was able to stabilize without human assistance. R1 had no functional limitations with range of motion (ROM), utilized a wheel chair and had received physical therapy (PT) services from 3/6/23 to 4/17/23. R1's significant change Care Area Assessment (CAA) dated 3/20/23, identified R1 required limited assistance with ADL's and was at risk for further decline in ADL's, falls, contractures, isolation, complications with immobility, pressure	2 920	Immediate Corrective Action: A process for documenting ambulation per therapy recommendations was established and entered into the medical record for R1 and R3. Corrective Action/Others: Other residents with therapy recommendations for ambulation will be reviewed to ensure the recommendations are accurately reflected in the resident's medical record, and that a system for documentation is established allowing staff to document accordingly. Prevent Recurrence: The policies titled “Restorative Program” and “Activities of Daily Living” were reviewed and remain current. Nursing staff will be educated on the policy and documentation expectations for residents with ambulation programs. Date of Alleged Compliance: 7/31/2023 Ongoing Monitoring: Random visual and documentation audits will be conducted to ensure dependent residents receive assistance with ambulation in accordance with individualized care planned interventions and therapy recommendations. Three audits will be conducted as follows: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks	

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2 920	Continued From page 14 ulcers, muscle atrophy, and incontinence. To proceed with plan of care to prevent and minimize risk. R1's care plan undated, revealed R1 had actual deficits with ADL's related to current medical, cognitive and physical status. The care plan indicated R1 was independent with ambulating in her room, hallway, to/from meals with front wheeled walker (FWW). R1 would utilize call light for assistance if not feeling well and would ask to ambulate with FWW. R1 would require one staff assistance for safety while ambulating and staff were to ask and remind R1 about walking. The care plan identified staff were to follow PT recommendations as able or accepted. R1's Physical Therapy Discharge Summary dated 4/14/23, identified R1 had met goals to maximum potential at that time. R1 was appropriate to ambulate with FWW verses the four wheeled walker (4WW) at the time due to reduced safety with the 4WW. Recommendations were for staff to assist R1 at all times with hallway ambulation and identified R1 tolerated up to 150 feet in a single bought on good days. The discharge plan revealed R1 had ambulated up to 150 feet with her FWW at the time of discharge from skilled therapy services. During an interview on 7/5/23 at 10:46 a.m., R1 stated she attempted to do things for herself most of the time and would call staff when she required assistance with cares. R1 indicated she had not been receiving the assistance she needed with walking. She stated would go out into the hallway to ask for assistance with walking and was not certain they had enough staff to help. R1 indicated staff would inform her they would return later to assist her with walking and stated they	2 920	A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: DON/Designee	

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never returned. R1 indicated she used to attend PT and had since graduated to restorative therapy. R1 stated her 4WW went too fast and she was informed by staff to use her FWW instead when walking. In a follow up interview at 3:31 p.m., R1 confirmed she had not been offered to be walked by staff today and stated that was frequently the case. R1 indicated staff were expected to be walking her daily and stated they only offered once in a while.

During an observations on 7/5/23 at 9:36 a.m., R1 was seated in her wheel chair and wheeled herself independently into the sun room at the end of the 400 wing where other residents were present. R1 was actively participating in looking at pictures in the coloring books.

- at 10:23 a.m. R1 continued to be in activity in the sun room while her and other residents listened to audio books.

- at 10:46 a.m. R1 was seated in her wheel chair in her room, while she was looking at her coloring books. R1 indicated staff had just finished assisting her to the bathroom. R1's walker was located up against her bedroom wall by her door.

- at 11:35 a.m. R1 remained in her wheel chair and in her room. R1's walker was located up against her bedroom wall by the door.

- at 11:46 a.m. R1 was seated in her wheel chair out in the commons area and actively participating in playing trivia.

- at 11:52 a.m. R1 wheeled herself via wheel chair independently into the dining room area for lunch, while passing by several staff members in the commons area.

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- at 12:58 p.m. R1 wheeled herself via wheel chair out of the dining room area and back to her room independently.

- at 3:31 p.m. R1 was seated in her wheel chair in her room visiting with her grandson. R1's walker was located up against her bedroom wall by the door.

- at 3:45 R1 remained the same.

During observations through out the day, staff were not observed to ask/offer or assist R1 with ambulation.

During an interview on 7/5/23 at 12:27 p.m., the occupational therapist (OT) indicated R1 had been receiving PT services and was discharged on 4/17/2023. The OT stated when R1 was discharged from PT she was placed on the walking list to be walked two to three times a day with one staff assistance, distance as tolerated and with wheel chair following behind. The OT indicated R1 was to use her FWW versus her 4WW due to reduced safety with walker and assistance of one staff in hallways with ambulation at all times. R1 was able to ambulate 150 feet in a single instance on good days. The OT indicated the nursing staff were responsible for ensuring R1's daily walking program was completed and was not certain how nursing staff were tracking the program. The OT stated she expected staff to follow the recommendations made by PT and to ask/offer R1 to walk and if she refused, staff should have documented the refusals. The OT indicated she was currently working with registered nurse (RN)-A on a system to track the walking program.

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During an interview on 7/5/23 at 3:22 p.m., nursing assistant (NA)-B confirmed R1 was currently on a walking program and she had not offered or asked R1 to ambulate that day. NA-B indicated R1 was able to walk usually half way to the dining room at times when offered. NA-B stated R1 was supposed to be walked three times a day for 30 min and staff were expected to report to the nurse any refusals. NA-B indicated R1 was pretty good about walking when asked and hardly ever refused when offered.

During an interview on 7/5/23 at 3:35 p.m., NA-C indicated R1 propelled herself independently in her wheel chair to maneuver around the facility. NA-C stated she was not aware R1 was currently on a walking program. NA-C indicated R1 did not walk very often and NA-C confirmed she had not asked or offered to ambulate R1 that day.

During an interview on 7/5/23 at 4:48 p.m., RN-A confirmed R1 was currently on a walking program and had been recently discharged from therapy. RN-A indicated PT recommended staff were to walk R1 two to three times a day to keep up her strength. RN-A stated she would expect staff to walk the residents, to offer encouragement when they refused and to follow PT recommendations. RN-A indicated the facility currently did not have a way of tracking the facility walking program.

R3

R3's significant change Minimum Data Set (MDS) dated 5/3/23, identified R3 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, dementia, and arthritis. Indicated R3 required extensive assistance of two staff with transfers and walking in room and corridor. Identified R3's physical

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therapy ended on 4/25/23, and R3 did not have a restorative nursing program.

R3's significant change Care Area Assessment (CAA) dated 5/4/23, identified R3 had Alzheimer's disease and required extensive assistance with activities of daily living (ADLs).

R3's care plan, undated, identified R3 had complications with deficits with ADLs related to dementia, weakness and left foot ulcer. R3's care plan directed staff to ambulate with assistance of one and follow with wheelchair per therapy. R3's care plan directed staff to walk to and from three meals each day, approximately 150 feet.

R3's Physical Therapy Discharge Summary dated 4/6/23 to 4/25/23, included discharge recommendations to ambulate R3 with assistance of one staff to/from meals three x/day with the use of front wheeled walker (FWW), staff to walk along side R3 with wheelchair to follow.

R3's medical record lacked documentation R3 had been walked to meals, as recommended by therapy since 4/25/23.

During an observation on 7/5/23 at 10:16 a.m., R3 was seated in her wheelchair in the doorway to her room. R3 propelled herself in her wheelchair down the hallway to the common area near the nurses desk, where R3 stopped and remained. At 11:06 a.m., R3 was noted in the common area near the dining room at the exercise activity program. At 11:53 a.m. R3 went to the dining room for lunch. At 12:36 p.m. R3 propelled herself in her wheelchair out of the dining room to an empty room in the 600 hallway where she remained. At 12:57 p.m. trained

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medication aide (TMA)-A wheeled R3 down the hallway to a nearby bathroom where TMA-A and registered nurse (RN)-A provided R3 with toileting assistance.

During an interview on 7/5/23 at 3:26 p.m., RN-A confirmed the facility had a list of residents who were supposed to be walked, which included R3. RN-A indicated they had been working with therapy to develop a system to assure walking was completed as therapy recommended.

During interview on 7/5/23 at 3:33 p.m., occupational therapist (OT)-A confirmed the facility had a list of residents who required walking, and the nursing department was responsible to assure the residents were being walked. OT-A reviewed R3's electronic medical record and confirmed staff were expected to walk to meals since 4/25/23. OT-A stated it was important for R3 to be walked to maintain her leg strength, her transferring ability, for her cardiovascular health, and to increase blood flow for healing of her foot ulcer. In addition, OT-A stated it was good for R3 to walk to decrease her anxiety, as R3 had a desire for movement.

During an interview on 7/5/23 at 1:33 p.m., nursing assistant (NA)-A stated R3 was on a walking schedule, and her usual practice was to attempt to walk R3 to at least one meal per day. NA-A confirmed she had not assisted R3 to walk that day.

During an interview on 7/5/23 at 1:42 p.m., NA-B stated R3 walked well, and she had walked with R3 in the past, however had not assisted her to walk today.

During an interview on 7/5/23 at 1:47 p.m., NA-C

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indicated she was responsible for R3's cares that day. NA-C stated R3 was to be walked to meals and confirmed she had not assisted her with walking that day. At 2:57 p.m. during a follow up interview, NA-C indicated she had not asked for assistance with R3 to complete her cares, including walking to meals.

During a telephone interview on 7/5/23 at 5:11 p.m., family member (FM)-A stated it bothered him that R3 was always in her wheelchair. FM-A indicated when R3 was discharged from therapy, he was informed R3 was able to walk with her walker, however felt R3 was not being assisted with walking as needed. FM-A stated he felt the facility should at least walk R3 daily so R3 would not lose her ability to walk.

During an interview on 7/5/23 at 4:16 p.m., director of nursing (DON) stated the facility was working on creating new group sheets, to include information regarding residents who needed to be walked. DON confirmed she was not aware if the facility had a system to track when residents were walked to assure it was completed and stated they had discussed the need to document it in the resident's medical record. DON indicated she was not aware R3 and R1 were not being walked as care planned. DON stated she expected staff to follow resident care plans, to walk residents per therapy recommendations, and encourage and educate them as needed if they refused. DON indicated walking residents was important to help keep their muscle and bone strength, endurance, balance, and ability to continue to walk. DON stated she expected staff to ask for assistance if they could not complete resident's cares.

The facility policy titled Restorative Program

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revised May 2020, identified while in the facility, all residents were supported to maintain or attain their highest level of functioning. The policy further identified all residents were assessed upon admission and at each care plan meeting for possible inclusion in restorative programs, which were individualized to meet the resident needs. Restorative programs included training and skills practice in ambulation.

The facility policy titled Activities of Daily Living-ADL revised May 2020, identified the resident's abilities in ADLs did not diminish unless circumstances of the individual's clinical condition demonstrated that diminution was unavoidable, which included: mobility: transfer and ambulation, including walking.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies and procedures related to resident assistance with activities of daily living. The DON or designee, could provide training for all nursing staff related assisting residents activities of daily living. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.