

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Apple Rehab Rocky Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Elm Street Rocky Hill, CT 06067	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for accidents with injuries, the facility failed to ensure the resident received orthopedic follow-up timely per Emergency Department (ED) directives following a fall with a fracture within the facility. The findings include:</p> <p>Resident #2's diagnoses included anoxic brain damage (oxygen deprivation to the brain which can lead to brain cell death), muscle weakness and anxiety disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Staff Assessment for Mental Status indicative of intact memory with consistent/reasonable decision making and required extensive assistance with bed mobility and was dependent on staff for transfers.</p> <p>The Resident Care Plan (RCP) dated 9/22/24 identified that Resident #2 sustained a right tibial/ankle fracture, and a cast was placed and when the cast was removed on 12/3/24, a stage 2 pressure ulcer was noted to the ankle under the cast with interventions included to follow-up with the orthopedic doctor as recommended.</p> <p>A nurse's note dated 9/21/24 at 11:13 AM identified that Resident #2 was observed on the floor next to his/her bed by staff and was noted to have an abrasion to the back of the right ankle which was cleansed and covered with a dry dressing. The note identified that range of motion was within normal limits, but the resident complained of pain to the right knee, so the provider was notified and directed to obtain an x-ray of the right knee.</p> <p>Review of the right knee x-ray dated 9/21/24 identified that there was a high suspicion of a depressed traumatic fracture of the medial tibial plateau (part of the knee joint), better assessed by dedicated CT imaging (x-rays that create cross-sectional images of the body that can be used to diagnose bone fractures).</p> <p>A nurse's note dated 9/21/24 at 6:05 PM identified that the x-ray showed a fracture of the right knee, the provider was notified, and new orders were obtained to send Resident #2 to the hospital for evaluation.</p> <p>Review of the hospital Inter-Agency Referral Report dated 9/22/24 identified that Resident #2 sustained a [NAME] (fifth metatarsal) fracture of the right extremity, a splint was placed, and the resident was to follow-up with the orthopedic surgeon's office in a week.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician's orders dated 9/22/24 through 12/3/24 failed to identify an order for orthopedic follow-up following the 9/21/24 fall with fracture.</p> <p>Review of progress notes from 9/22/24 through 11/21/24 failed to identify that the orthopedic office had been contacted or that Resident #2 had followed-up with the orthopedic office following the fracture as directed.</p> <p>A nurse's note dated 11/22/24 at 1:34 PM identified that Resident #2 has an orthopedic follow-up appointment scheduled for 12/3/24.</p> <p>Review of Orthopedic Trauma Clinic Note dated 12/3/24 identified that Resident #2 presented for an initial evaluation for an injury to his/her right foot after he/she was found to have a base of fifth metatarsal fracture following a fall on 9/22/24 and for concerns regarding the right knee but the resident denied any right knee pain. It reported that the resident was placed in a short leg splint in the Emergency Department (ED) and sent back to the rehab facility, and the visit was the first outpatient evaluation since the injury occurred two and a half (2.5) months ago. The note identified that the resident had diffuse osteopenia (loss of bone density) and x-rays showed a stable appearance of the fracture with the resident denying any pain. It identified that the splint/immobilization was no longer needed and noted no activity restrictions. The provider took down the resident's splint, there was a dressed superficial abrasion over the lateral (outer) aspect of his/her leg approximately six (6) centimeters (cm) proximal (closer to the center) of the lateral malleolus (bony bump on the outside of the ankle) about the size of a quarter that was not infectious appearing but would require wound care and daily dressings to monitor the wound. Additionally, the note identified that the provider raised his/her concerns for the resident's lack of follow-up as it appeared that the resident's splint was left in place for nearly two and a half (2.5) months.</p> <p>Interview with the Orthopedic Medical Assistant on 1/17/25 at 11:27 AM identified that although the ED notes directed for Resident #2 to follow-up with them within one (1) week, the facility did not reach out to them or send clinical information until 11/22/24 (61 days after ED visit).</p> <p>Interview with RN #4 (prior DNS) on 1/17/25 at 12:46 PM identified that although Resident #2's spouse (Person #1) made most of the resident's community appointments', she was unsure why there was such a delay in the resident following up with orthopedics as directed, and the facility should have ensured the orthopedic appointment was made timely. She identified that nursing was responsible for making the appointment and then notifying the receptionist, who would notate the appointment in the appointment book and then set up transportation. She reported that the State Agency was in the building at the time of the fall with fracture and the ED visit directives were overlooked and she was unsure why no one caught the mistake until 11/22/24.</p> <p>Interview with APRN #1 on 1/17/25 at 1:55 PM identified although she expected that Resident #2 follow-up with orthopedics within one (1) week as directed by the ED, she was unsure why he/she didn't follow-up until 12/3/24.</p> <p>Although requested, facility policies on following physician's orders and outside community appointments were not obtained.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for pressure ulcers, the facility failed to inspect the residents skin following the application of a splint in accordance to facility policy resulting in a pressure ulcer. The findings include:</p> <p>Resident #2's diagnoses included anoxic brain damage (oxygen deprivation to the brain which can lead to brain cell death), muscle weakness and anxiety disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Staff Assessment for Mental Status indicative of intact memory with consistent/reasonable decision making and required extensive assistance with bed mobility and was dependent on staff for transfers.</p> <p>A nurse's note dated 9/21/24 at 11:13 AM identified that Resident #2 was observed on the floor next to his/her bed by staff and was noted to have an abrasion to the back of the right ankle which was cleansed and covered with a dry dressing. The note reported that range of motion was within normal limits, but the resident complained of pain to the right knee, so the provider was notified and directed to obtain an x-ray of the right knee.</p> <p>Review of the right knee x-ray dated 9/21/24 identified that there was a high suspicion of a depressed traumatic fracture of the medial tibial plateau, better assessed by dedicated CT imaging (x-rays that create cross-sectional images of the body that can be used to diagnose bone fractures).</p> <p>A nurse's note dated 9/21/24 at 6:05 PM identified that the x-ray showed a fracture of the right knee, the provider was notified, and new orders were obtained to send Resident #2 to the hospital for evaluation.</p> <p>Review of the hospital Inter-Agency Referral Report dated 9/22/24 identified that Resident #2 sustained a [NAME] (fifth metatarsal) fracture of the right extremity, a splint was placed, and the resident was to follow-up with the orthopedic surgeon's office in a week.</p> <p>A Nursing admission assessment dated [DATE] identified that Resident #2 had a right tibial fracture with a soft cast in place to the right lower leg and an abrasion was noted to the right outer ankle.</p> <p>The Resident Care Plan (RCP) dated 9/22/24 identified that Resident #2 sustained a right tibial/ankle fracture, and a cast was placed and when the cast was removed on 12/3/24, a stage 2 pressure ulcer was noted to the ankle under the cast with interventions that included to follow-up with the orthopedic doctor as recommended, check the circulation, motion and sensory of the extremity as ordered/per policy, provide measures to prevent skin breakdown (Braden scale per facility policy, consult with wound care specialist as needed and inspect skin when providing care for signs and symptoms of breakdown) and watching for signs of infection and reporting to the provider as needed.</p> <p>A physician's order dated 1/11/24 directed that a body Audit be completed on admission and every week by a licensed nurse on shower day and directed to document on the Body Audit Form every evening shift every Thursday.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician's order dated 9/22/24 directed to monitor the soft cast to the right lower extremity every shift for circulation, movement, and sensation.</p> <p>Review of the Skin Care policy (undated) directed, in part, that licensed nursing personnel are to observe for circulation, mobility and skin integrity and document that the circulation, mobility and skin are checked once per shift on the Treatment Administration Record (TAR). Any concerns are to be documented in nurse's notes including physician notification.</p> <p>Review of the physician's orders dated 9/22/24 through 12/2/24 failed to ensure an order was obtained to assess the skin under the splint.</p> <p>Review of nurse's notes dated 9/22/24 through 12/2/24 failed to identify that the skin was assessed under the splint to the right lower extremity.</p> <p>Review of Orthopedic Trauma Clinic Note dated 12/3/24 identified that Resident #2 presented for an initial evaluation for an injury to his/her right foot after he/she was found to have a base of fifth metatarsal fracture following a fall on 9/22/24 and for concerns regarding the right knee but the resident denied any right knee pain. It reported that the resident was placed in a short leg splint in the Emergency Department (ED) and sent back to the rehab facility, and the visit was the first outpatient evaluation since the injury occurred two and a half (2.5) months ago. The note identified that the resident had diffuse osteopenia (loss of bone density) and x-rays showed a stable appearance of the fracture with the resident denying any pain. It identified that the splint/immobilization was no longer needed and noted no activity restrictions. The provider took down the resident's splint, there was a superficial abrasion over the lateral (outer) aspect of his/her leg approximately six (6) centimeters (cm) proximal (closer to the center) of the lateral malleolus (bony bump on the outside of the ankle) about the size of a quarter that was not infectious appearing but would require wound care and daily dressings to monitor the wound. Additionally, the note identified that the provider raised his/her concerns for the resident's lack of follow-up as it appeared that the resident's splint was left in place for nearly two and a half (2.5) months.</p> <p>Review of the Weekly Body Audit Assessments identified that body audits were not completed on Resident #2 on 9/26/24, 10/3/24, 10/10/24, 10/17/24, 10/31/24, 11/7/24, 11/21/24 and 11/28/24. On 10/24/24, the assessment identified that Resident #2 had no noted areas and did not mention the soft cast to the right lower extremity.</p> <p>A nurse's note dated 12/3/24 at 2:56 PM identified that Resident #2 followed-up with orthopedics and the soft cast/boot was removed from the right lower extremity. The note reported that the previous skin tear/abrasion from the initial fall remains open, presenting as a pressure area measuring 3.5 cm by 2.0 cm.</p> <p>A wound care specialist note dated 12/4/24 identified that Resident #2 was seen for evaluation of the right lateral ankle wound that was identified upon the removal of the rigid cast on 12/3/24. The note identified that a Stage 2 (partial thickness loss of skin where the top layer of skin is broken) pressure ulcer measuring 0.5 cm (length) by 0.2 cm (width) by 0 cm (depth) was present to the right lateral ankle with erythema (redness) noted. Treatment recommendations included applying skin prep (fast drying, liquid film-forming skin protectant) to the base of the wound every shift and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RN #4 (prior DNS) on 1/17/25 at 12:46 PM identified that although she expects both the licensed nurses and RN #1 (Infection Control nurse) to notify her of all pressure ulcers, she was not notified and was unaware that Resident #2 was noted with a pressure ulcer when the splint was removed from his/her right foot on 12/3/24. She identified that it's policy for all removable splints/casts that the skin is inspected underneath every shift and as needed unless otherwise noted and it should be entered as an order and signed off every shift that it was completed. She reported that she was unsure why there was no order to check the skin, but that the nurse that completed the readmission on [DATE] should have entered the order when they entered the order to monitor the soft cast to the right lower extremity every shift for circulation, movement, and sensation.</p> <p>Interview with APRN #1 on 1/17/25 at 1:55 PM identified that for all soft casts/boots, she would expect licensed staff to be checking the skin under the soft casts/boots every shift, as that's a standard order and she was unsure why the order was not in place, as it should have been. She identified that they also should have been noting that the cast/boot was in place and documenting on the skin under the cast/boot on the weekly skin check.</p> <p>Interview with the DNS on 1/17/25 at 2:45 PM identified that although she was not employed at the facility between September through December 2024, all residents with a soft splint/boot should have an order in place to either check the skin integrity under the device or not to remove the device to check skin integrity, and that the removal was not prohibited, the staff should have documenting every shift on the skin integrity under the splint/boot.</p> <p>Interview with MD #2 (wound doctor) on 1/22/25 at 8:58 AM identified that she evaluated the wound of Resident #2 on 12/4/24 after being notified that there was an area to the left lateral ankle once orthopedics removed the boot for evaluation. She identified that if there was no physician's order to leave the boot in place, the facility should have been removing the boot for skin checks per policy, stating that if the skin was being checked frequently, it could have prevented the formation of the stage 2 pressure ulcer to the left lateral ankle.</p> <p>Although attempted, interviews with LPN #2, LPN #3 and RN #3 were not obtained.</p> <p>Review of the Skin Care policy (undated) directed, in part, that licensed nursing personnel are to observe for circulation, mobility and skin integrity and document that the circulation, mobility and skin are checked once per shift on the Treatment Administration Record (TAR). Any concerns are to be documented in nurse's notes including physician notification.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy and interviews for one sampled resident (Resident #1) who was at risk for falls, the facility failed to ensure a staff member did not leave Resident #1 unattended while ambulating without an assistive device to prevent a fall that resulted with Resident #1 sustaining a fracture of the right humerus and laceration to the right eyebrow. The findings include:</p> <p>Resident #1's diagnoses included dementia, difficulty walking, weakness, osteoporosis and chronic pain.</p> <p>A physician's order dated 9/30/24 directed assist of one (1) with transfers and ambulate with a rolling walker.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status score of six (6) indicating Resident #1 had poor memory recall, required extensive assistance with transfers, supervision or touching assistance when ambulating, utilized a walker for mobility, and had two (2) falls with no injuries in the past ninety (90) days.</p> <p>The Resident Care Plan dated 10/22/24 identified Resident #1 was a fall risk and preferred to push his/her wheelchair for stability.</p> <p>Interventions directed to encourage the resident to ask and wait for staff for assistance, encourage proper and non-skid footwear, redirect to use wheelchair by sitting on for ambulation and not use it as a walker, re-enforce the need to call for assistance, and remind of transfer/ambulation status of assist of one with rolling walker frequently.</p> <p>The Advanced Practice Registered Nurse (APRN) note dated 12/31/24 at 9:45 AM identified Resident #1 had a witnessed fall, sustained a laceration, and was transferred to the hospital.</p> <p>The nurse's note dated 1/1/25 at 8:02 PM identified Resident #1 returned from the hospital at 5:45 PM after receiving treatment for a fall that resulted in a closed fracture of the right proximal humerus and a right eyebrow laceration. The note indicated Resident #1 complained of mild pain in the shoulder and was medicated to manage the discomfort.</p> <p>Review of the investigation identified Resident #1 was observed pushing the wheelchair in the hallway, then Resident #1 walked away from the wheelchair and was ambulating without a device and as a nurse aide, Nurse Aide (NA) #1, was getting the wheelchair, Resident #1 fell. The report indicated another staff member witnessed Resident #1 walking in the hallway and instructed NA #1 to get Resident #1's wheelchair. The report identified NA #1 turned her back on Resident #1 to get the wheelchair, the other staff member went into her office, therefore Resident #1 was not in eyesight of either staff member.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with NA #1 on 1/14/25 at 11:34 AM identified on 12/31/24 she observed Resident #1 in the hallway, passed by and walked away from Resident #1 at which time the secretary asked her if Resident #1 was supposed to be walking by him/herself. NA #1 identified she went to obtain Resident #1's wheelchair which was behind Resident #1 and while she was getting the wheelchair, Resident #1 sustained a fall. NA #1 identified she was within reach of Resident #1 but did not have eyes on Resident #1 at the time of the fall. NA #1 identified she was aware Resident #1 required assistance when ambulating and Resident should not have been ambulating alone. NA #1 did not give a reason as to why she did not assist Resident #1 over to the wheelchair.</p> <p>Interview with the Infection Control Nurse, Registered Nurse (RN) #1, on 1/14/25 at 12:05 PM identified on 12/31/24 she observed Resident #1 in the hallway in his/her wheelchair, then observed Resident #1 get up from the wheelchair and begin ambulating without assistance. RN #1 identified although she did not assist NA #1 with Resident #1, she did instruct NA #1 to get Resident #1's wheelchair, which was behind Resident #1, and then she went into her office. RN #1 identified when she was in her office, she heard a thud and went out to find Resident #1 on the floor.</p> <p>Interview and clinical record review with the Director of Nursing (DON) on 1/14/25 at 12:39 PM identified Resident #1's ambulation status on 12/31/24 was assistance of one (1) staff member with a rolling walker. The DON indicated at the time of the fall, although NA #1 was near Resident #1, Resident #1 was not within NA #1's eyesight. The DON identified it was reported that Resident #1 had gotten up and was walking rapidly when the receptionist alerted the staff. The DON identified that when NA #1 went to get Resident #1's wheelchair there was some distance between NA #1 and Resident #1. The DON identified Resident #1 should have been directed towards the wheelchair with the staff member instead of leaving Resident #1 in the process of getting the wheelchair.</p> <p>Review of the facility policy titled Ambulation, directed, in part, all residents will be evaluated for ambulatory capabilities and for appropriate therapeutic equipment and services as needed, assistive devices as ordered to assist the residents in achieving and maintaining the highest practicable level of ambulation. Additionally, the policy directed to ambulate the resident according to his/her plan of care and tolerance.</p>		