STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karlstad Healthcare Center Inc	304 Washington Avenue West Karlstad, MN 56732

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide restorative ambulation services and respond to a decline in ambulation status for 1 of 3 residents (R26) reviewed for ADLs. Findings include:R26's quarterly Minimum Data Set (MDS) dated [DATE], identified R26 had mild cognitive impairment and required set up/clean up assistance for eating, substantial/maximal assistance for bathing and upper body dressing and was dependent on staff for all other care areas. Diagnoses included dementia, hypertension, diabetes, weakness, and chronic pain. R26's care plan revised [DATE], identified R26 had an ADL Self Care Performance Deficit related to weakness and malaise (a general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify). Interventions included: Ambulate R26 with front wheeled walker (FWW) and staff assistance of 1 once daily as desired/as tolerated. R26 was able to ambulate short distances. [NAME] used for transfer in room as able. The care plan also identified R26 had limited physical mobility and was at risk for falls due to weakness, chronic pain, and unsteadied gait/balance. Interventions included: NURSING REHAB: Ambulate daily with 1 staff and FWW- distances as able.R26's Functional Abilities Care Area Assessment (CAA) dated [DATE], identified R26 required staff assistance with ADLs. Staff offered morning and evening cares as well as toileting around the clock. R26 was able to alert staff as needed using call lights. R26 was working with therapy to regain independence where she was able. Goal was for R26 to not have any falls. The facility document Daily Rehab Responsibilities updated [DATE], identified R26 was to ambulate with 1 staff and forward wheeled walker (FWW)- distances as able.R26's undated, untitled nurse aide care sheet identified staff were to encourage the activity well fit program and R26 was to ambulate with staff and FWW daily.R26's Nursing Rehab Point of Care documentation dated [DATE] - [DATE], identified the following:[DATE] R26's ambulation was not applicableXXX[DATE] R26's ambulation was not applicableXXX[DATE] R26's ambulation was not applicableXXX[DATE] R26 refused ambulationXXX[DATE] R26's ambulation was not applicableXXX[DATE] R26's ambulation was not applicableXXX[DATE] R26's ambulation was not applicableXXX[DATE] R26 ambulated for 15 minutesXXX[DATE] R26's ambulation was not applicable.During an interview on [DATE] at 2:41 p.m., R26 stated R26 couldn't walk anymore. The staff needed to help R26 to get in my bed and wheelchair.During an interview on [DATE] at 2:41 p.m. R26 stated she did exercises for an hour every week for an activity but doesn't do any exercises with the aides anymore. R26 shook her head and stated no, I don't do that. I can't do that anymore.During an interview on [DATE] at 7:39 a.m., nursing assistant (NA)-A stated the nursing assistants were responsible for resident ambulation. The aides were not completing the task, and the director of nursing (DON) had talked to NA-A about restarting a formal nursing rehab program with an assigned restorative aide. NA-A stated she did not know how that was going to work because the residents who needed those services were in bed when NA-A was working. During an interview on [DATE] at 9:17 a.m., NA-B stated the nursing assistants were supposed to do the resident ambulation but I'm not going to lie, that's not very often. When staff did not complete the task, they documented it as not applicable because it just didn't get done. NA-B stated R26 did not walk at all and used a sit to stand lift with assist of two staff for all transfers. R26 needed this type of assistance for at least several (continued on next page)

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks because it just wasn't safe to ambulate R26 with a walker.During an interview on [DATE] at 9:22 a.m., registered nurse (RN)-A stated the nursing assistants were responsible to complete the resident ambulation, but it just didn't get done. Nursing did have a meeting not that long ago to discuss ideas or to come up with a plan to fix this, but there was no plan created. Staff were expected to complete these tasks because not doing so could lead to contractures or a decline in the residents' ability to perform activities of daily living (ADLs). R26's medical record lacked an assessment for ADL decline including any revision to the ambulation care plan.During an interview on [DATE] at 11:52 a.m., the DON stated therapy made recommendations regarding resident restorative needs and the facility had a Well Fit program where the residents performed exercises as able in the activity room. Assignments were listed on the nurse aide care sheet directing staff who had resident ambulation and what that consisted of. The DON stated R26 was care planned to walk daily as tolerated but the care plan needed to be revised because the DON wouldn't transfer R26 with an assist of 1. The care plan stated that exercises were to be done as desired or tolerated, but staff should notify the DON if R26 was not able to perform the task. R26's condition had changed, and a therapy evaluation should have been requested to evaluated R26. On [DATE] at 1:25 p.m., attempted to observe R26's ambulation but R26 declined. That's just not my thing. Although R26's care plan and restorative program directed daily ambulation with a front wheeled walker and assist of one, staff interviews on [DATE] confirmed R26 had not ambulated for several weeks and required a sit-to-stand lift with assist of two for transfers.An ADL or resident ambulation policy was requested but not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure range of motion (ROM) was completed in accordance with therapy recommendations to prevent the loss of mobility for 1 of 3 residents (R3) reviewed for restorative nursing services. Findings include:R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had mild cognitive impairment and was dependent on staff for all care areas. Diagnoses included diabetes, hemiplegia (paralysis affecting one side of the body) and hemiparesis (partial weakness affecting one side of the body). R3's Functional Abilities Care Area Assessment (CAA) dated 10/9/25, identified staff assisted R3 every 2-3 hours with toileting and repositioning. Staff anticipated R3's needs and R3 was able to ask for assistance as needed by using the call light. Goal was for R3 to continue at current level of functioning and avoid complications of immobility.R3's care plan revised 1/19/22, identified R3 had limited physical mobility and a fall risk related to weakness, hemiplegia, hemiparesis, involuntary movements, contractures, and limited range of motion. Intervention included:Nursing Rehab: 3 times per week. Bilateral lower extremity passive range of motion (PROn to active range of motion (AROM) See instructions in room, passive hamstring stretch: hold 30 seconds, repeat 3 times and passive Heel Cord Stretch: hold 30 seconds, repeat 3 times. R3 frequently refused stretching exercises. NURSING REHAB: PROM to both hands for finger flexion and extension. The following were to be completed 10 times, being held for 3 seconds, 5 times per week: Hip flexion/extension, Abduction/Adduction, Rotation, and Foot Pronation/Supination- Ankle Inversion/Eversion R3 frequently refused stretching exercises. NURSING REHAB: Assistance with splint or brace at least 3 times per day for 1 hour and overnight as tolerated. Nursing to apply: RIGHT HAND: foam anti-spasticity splint with finger separator. LEFT HAND: Cone splintR3's untitled nurse aide care sheet undated, identified R3 had a restorative program and to encourage the Well Fit program in the activity room. R3's Nursing Rehab Point of Care documentation dated 4/20/26-5/19/26, identified R3 wore the hand splints 41 times and was documented as not applicable 20 times out of the 90 opportunities. The documentation failed to identify R3 refused to wear the hand splints. R3's leg stretches were performed 3 times out of the 30 opportunities. The documentation failed to identify why no further leg were or were not performed.During an interview on 5/19/26 at 8:00 a.m., nursing assistant (NA)-B stated staff were to encourage residents to participate in the Well Fit program and R3 only wore his splints when he wanted to. R3 sometimes went to the Well Fit program and other times R3 would just rather watch tv. It just depended on the day. Staff were supposed to do R3's PROM and AROM but it didn't get done very often. Most of the time, staff just documented it as not applicable because it wasn't offered.During an interview on 5/19/26 at 9:22 a.m., registered nurse (RN)-A stated the nursing assistants were responsible to complete the resident restorative programs, but it just didn't get done. Nursing did have a meeting not that long ago to discuss ideas or to come up with a plan to fix this, but there was no plan created. Staff were expected to complete these tasks because not doing so could lead to contractures or a decline in the residents' ability to perform activities of daily living (ADLs). During an interview on 5/19/26 at 11:52 a.m., the director of nursing (DON) stated we have therapy make recommendations and we have a well fit program where they do exercises there as able. Assignments were posted on the NA care sheet. R3 was care planned to apply splints to his hands. He had one that he would wear at night when R3 allowed it. R3 was alert and oriented and decided that. R3 was to have ROM to hand and fingers as he allowed, and he hated it. R3 was to also have leg stretches and R3 hated that too. The DON stated staff should have offered the tasks and documented R3's refusals but the DON supposed when a resident repeatedly refused staff stopped offering. The DON stated R3's restorative program needed to be updated because it should have been based off what R3 wanted to do. The DON stated she was unaware staff were documenting R3s nursing rehab tasks as not applicable, and staff would (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be educated regarding that.Although R3 intermittently refused ROM and splinting interventions, staff interviews confirmed restorative tasks frequently were not offered and were documented as ?not applicable' rather than refused.The facility policy Restorative Program Process updated 10/26/21, the facility would ensure our resident(s) achieve and maintain their highest level of function. Process: a) Upon admission, quarterly, and with significant change the resident's level of function will be assessed by the licensed nurse or in collaboration with therapy. b) Based on the results of the assessment the licensed nurse will develop a care plan showing the resident's individual problems, determine approaches/interventions and set goals. c) The licensed nurse will develop a restorative nursing program with individualized interventions and goals which may include recommendations for strategy and adaptive equipment from therapy. d) The licensed nurse will educate all direct care staff assigned to the resident(s) on their restorative nursing program. e) The licensed nurse will monitor staff and resident(s) to ensure compliance with the restorative nurse program. f) The licensed nurse will monitor the daily restorative nursing program documentation in POC and follow-up with staff as needed. g) The licensed nurse will write a monthly restorative nursing summary to track the resident(s) progress. h) The licensed nurse will update the care plan and the restorative nursing program to reflect the resident(s) specific goals and interventions as needed. i) The licensed nurse will make referrals to therapy as needed. j) The licensed nurse will develop a discharge plan for the resident(s) who no longer need a restorative nursing program.