| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245570 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Maple Lawn Senior Care | 400 Seventh Street NE<br>Fulda, MN 56131 |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interview and record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day, 7 days a week for 1 of 92 days reviewed. This had the potential to affect all 33 residents. Findings include: Review of the facilities November 2025, December 2025, and January 2026 schedules identified on 11/29/25 the facility had no registered nurse on duty. Interview on 2/26/26 at 8:23 a.m., with the director of nursing identified she was responsible for the licensed nurse schedule. She reported she was on duty Monday through Friday 8 consecutive hours and if she needed to leave early, she would ensure there was another RN to cover the 8-hour requirement. On the weekends she ensured there was a RN scheduled 8 consecutive hours and if the facility did not have an RN to work over the weekend, she or another facility RN would come in and cover the RN 8 consecutive hours requirement. She confirmed that there had been no RN coverage on 11/29/25. Review of undated, RN Coverage policy identified the facility would ensure the services of a registered nurse were provided onsite for 8 consecutive hours per day, 7 days a week. Review of the Sufficient and Competent Nurse Staffing Review pathway, located in the Surveyor Resources Folder at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-h identified Note: The rule of 4 or more days is used for the purposes of the PBJ Staffing Data Report. The expectation of CMS is that the survey team would consider issuing a citation when a minimum of one day is identified to not meet the nurse staffing requirement for both a Registered Nurse and Licensed nursing staff. |

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 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on observation, interview, and document review, the facility failed to designate a qualified person to serve as the director of food service to oversee the dietary department. This had the potential to affect all 33 residents.Findings include: Interview on 2/23/26 at 12:00 p.m., with the facility designated dietary manager (DM) revealed she was not certified. She had been enrolled but dropped the class this past December because of personal life issues that made it difficult for her to continue. She had not submitted any of her course work that was required to complete the class and currently was not enrolled in any program. Interview on 2/24/26 at 11:22 a.m., with the registered dietician identified she was the DM's preceptor and was available to her to help her with any questions and review her coursework, however, her understanding was the DM was out on medical leave and was unable to complete the course work, therefore she had dropped the class. Interview on 2/26/26 at 8:31 a.m., with the administrator identified she would have expected the DM to be certified for the position, but at minimum, be enrolled in the class and have a serve safe certification to safely oversee the department and staff. Review of the facility provided 10/20/21, Dietary Director Job Description signed by the dietary director on 3/28/23, identified qualification for the position included taking or willing to take the Dietary Managers Course and THAT STAFF must pass the sanitation test or be willing to take a course approved by the state. |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>Based on interview and document review, the facility failed to ensure the resident had a care conference to be able to participate in the planning process and development of interventions of their care for 1 of 1 sampled resident (R7) who had been at the facility for 3 months with no care conference scheduled. Findings include: R7's 12/01/25, accepted admission Minimum Data Set (MDS) assessment identified that R7 had admitted to the facility in the middle of November 2025. R7 cognition was intact. She used a walker or a wheelchair for mobility and required partial assistance with some activities of daily living (ADL's). She had diagnoses of arthritis, thyroid disorder, diabetes, renal disease, and hypertension. R7's plan was to remain living in the facility. Additionally, a 2/20/26, accepted quarterly MDS assessment was completed identifying again R7's cognition was intact. Interview on 2/23/26 at 2:33 p.m., with R7 identified, she had not been invited to or attended a care conference since coming to the facility. Review of R7's progress 11/12/25 through 2/22/26, had no mention of a care conference occurring since admission to the facility. Interview on 2/24/26 at 1:42 p.m., with the activity director identified that care conferences followed the MDS schedule. There was to be a progress note made and the multidisciplinary care conference form filled out by each department following a care conference. Review of R7's assessments lacked any assessment titled Interdisciplinary care conference and there were no assessments identified as a care conference form. Interview on 2/25/26 at 10:47 a.m., with registered nurse (RN)-A identified that typically a care conference was scheduled by the social service designee (SSD) within 2 weeks of the MDS assessment completion. The facility would document a care conference meeting on the care conference form under the assessment section in point click care (PCC) and make a progress note. RN-A confirmed she could not find documentation that a care conference had occurred for R7 since admission. Interview on 2/25/26 at 10:58 a.m., with SSD identified that when a resident admitted to the facility a care conference would be set up within the first 2-4 weeks of admission. Care conference would then take place every quarter after that. She confirmed that R7's initial care conference had been missed stating it was just an overlook but she did have one scheduled now in March, confirming that was 4 months after admission to the facility. Interview on 2/26/26 at 8:23 a.m., with the director of nursing (DON) identified she was unsure of when resident care conferences should take place and stated, I would have to reference our policy. Review of the undated, Care Plan Meeting policy identified each resident admitted to the facility would receive a person-centered, comprehensive care plan developed through the interdisciplinary team and the resident and/or representative. The care plan would be developed via assessments and consultation with the residents and/or representatives. The care planning meeting would be held, 7-10 days following the completion of the comprehensive MDS assessment and then quarterly thereafter. Care plan meeting shall also be held when there is a significant change in the resident's status, or when requested by the resident/representative or facility. The residents shall participate in the care planning process and if unable the representative will be involved. The care plan meeting would be documented and include the date and time of the meeting, who attended, and a summary of the meeting. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the ombudsman was notified following discharge from the facility for 3 of 3 sampled residents (R1, R3, and R41).<br><br>Findings include:<br><br>R1's 1/2/26, accepted discharge return anticipated Minimum Data Set (MDS) assessment identified he had an unplanned discharged to the hospital on [DATE].<br><br>Review of nursing progress note dated 12/17/25 at 1:47 p.m., identified R1 was sent to the hospital emergency department via ambulance for evaluation due to having poor color, lips cyanotic, and R1 was shaking.<br><br>Review of nursing progress note dated 12/22/25 at 12:13 p.m., identified the facility had received a nurse-to-nurse report from the hospital. R1 was admitted to the hospital on [DATE], with diagnoses of acute hypoxia with respiratory failure. R1 returned to the facility on [DATE].<br><br>Confirmation of ombudsman notice of discharge was requested for R1; however, the facility did not provide one by the end of the survey period.<br><br>R3's 2/16/26, accepted modified Minimum Data Set (MDS) assessment identified she had diagnoses including chronic obstructive pulmonary disease (COPD), dementia with moderate mood disturbance, Alzheimer's, congestive heart failure (CHF), A-fib, hepatic failure, CKD stage 3, anxiety disorder, type II diabetes, hypertension (HTN), and chronic respiratory failure with hypoxia.<br><br>R3's 2/20/26 at 5:59 p.m. progress note identified beginning of a change in condition, and following notification of the MD and review of ordered laboratory results R3 was hospitalized on [DATE].<br><br>R41's 2/6/26, accepted discharge with return not anticipated, MDS identified R41 was admitted on [DATE] and discharged on 1/30/26.<br><br>R41's1/30/26 at 10:00a.m. Discharge Summary identified R41's family arrived at the facility on 1/30/26 and reported they were taking R1 home without waiting for results of the home safety evaluation. R41 was discharged to home Against Medical Advice (AMA).<br><br>Interview on 2/25/26 at 1:09 p.m. with the social services designee (SSD) reported she had not completed Ombudsman notifications since 2024. She stated, she thought she might have done some notifications in 2025 but had no record of doing so. She reported she was not aware of the requirement to provide notification of hospital admissions or facility discharges, and as a result she had not done so.<br><br>Interview on 2/25/26 at 2:07 p.m. with the director of nursing (DON) identified she was aware of the regulation for notification of the ombudsman of hospitalizations and discharges, but not aware it was not being completed.<br><br>Confirmation of ombudsman notice of discharge was requested for R1, R3 and R41; however, the (continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility did not provide documentation the ombudsman had been notified of the discharges by the end of the survey period. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 5 sampled residents (R28) reviewed for unnecessary medication review. Findings include: R28's 12/29/25, accepted quarterly Minimum Data Set (MDS) assessment identified R28's cognition was intact. R28 used a walker or wheelchair for mobility and required partial to moderate assistance from staff for activities of daily living (ADL's). R28 took a daily anticoagulant medication. R28's 2/25/26, printed diagnosis list identified persistent atrial fibrillation (abnormal heart rhythm), high blood pressure, history of broken wrist, long term use of anticoagulants (blood thinner) and a history of stroke. R28's 2/24/26, Order Summary Report identified R28 took Apixaban (anticoagulant medication to prevent blood clots or stroke for people with atrial fibrillation) 2.5 milligrams twice a day for atrial fibrillation. There was no order or mention of monitoring for side effects of the anticoagulant medication that can cause bleeding, nausea, and increased bruising. R28's September 2025, care plan identified R28 had potential for nutritional problems related to low body mass, high blood pressure, atrial fibrillation, irritable bowel syndrome, and gout. There was no mention that R28 took an anticoagulant medication or the need for staff to monitor any side effects of that medication. Interview and document review on 2/2/26 at 9:44 a.m., with registered nurse (RN)-A identified she completed a review and updated the care plan following completion of an MDS assessment. All nurses were able to and should be updating the resident care plans as things change as she was not the only one who updated care plans. She confirmed there was no mention on R8s care plan of anticoagulant medication or for staff to monitor for side effects on R28's care plan. She agreed that information should be on the care plan. Interview on 2/26/26 at 8:23 a.m., with the director of nursing (DON) identified any resident taking anticoagulant should have interventions and monitoring identified on the care plan and include the side effects of the medication. Review of January 2025, Care plans, Comprehensive Person-Centered policy identified that each resident would have a person-centered care plan that included measurable goals to meet the resident's physical, psychosocial and functional needs. The care plan interventions would be developed through assessments, gathering information from the interdisciplinary team, the resident/representative, and the attending physician. The care plan would include goals, treatments, specialized services, to aid in preventing or reducing decline in the resident's status and enhance optimal functioning while reflecting current standards of practice. The care plan should be developed or revised within 7 days of the completion of the MDS assessment. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interview and document review, the facility failed to appropriately assess, document, and revise the care plan for 1 of 1 sampled resident (R8) who had restorative therapies identified on his care plan, but was not receiving or completing those therapies as indicated. Findings include: R8's 2/16/26, accepted quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 was noted to have impairments bilaterally on his upper and lower extremities. R8 used a wheelchair for mobility. R8 was independent with eating, required substantial assistance from staff for dressing, personal hygiene, and required total assistance from staff for toileting and bathing. R28 used a Sit to Stand mechanical device with substantial assistance from staff for transfers. R8 was not noted to ambulate. R8 had not participated in any formal type of therapy or restorative program. R8's 2/26/26, printed Medical Diagnosis list identified pulmonary disease, symptoms involving the musculoskeletal system, asthma, tremors, radiculopathy of lumbar region (compressed or irritated nerve roots in lower spine often referred to as sciatica), functional implants, emotional liability ( exaggerated, and uncontrollable swings in emotion), polyneuropathies (widespread damage of peripheral nerves, causing numbness, tingling, burning pain, and muscle weakness), Arthritis, high blood pressure, and restless leg syndrome. R8's 7/10/25, care plan identified R8 was at risk for weakness and loss of self-care and mobility independence. R8 would participate in an informal restorative program with staff assistance to maintain lower and upper body strength and ambulation through the review date. R8's exercises included 3-4 times a week dowel (a 3/4 inch rod or broomstick) exercises with 3 pounds while seated for 15 repetitions. R8 was also to perform seated legs exercises with a number 2 therapy band times 15-20 repetitions and had a walking plan for 5 times a week to ambulate with four-wheeled walker assisted by a restorative aid bringing the wheelchair along. Review of R8's Functional Abilities and Goals assessments identified:On 1/10/25, R8 used a walker and wheelchair. For mobility R8 required partial/moderate assistance with transfers and supervision or touching assistance for ambulation of up to 50 feet.On 7/10/25, R8 used a walker and wheelchair. R8 only walked occasionally with the restorative aides who walked with him bringing a wheelchair behind. For mobility, R8 required substantial/maximal assistance with transfers and was dependent on staff to ambulate 10 feet. R8 did not attempt to ambulate 50 feet due to medical conditions or safety concerns.On 10/18/25, R8 used a wheelchair. For mobility R8 was dependent on staff for transfers. R8 did not attempt to walk 10 or 50 feet due to medical condition or safety concerns.On 11/14/25, R8 used a wheelchair. For mobility R8 was dependent on staff for transfers. R8 did not attempt to walk 10 due to medical condition or safety concerns.On 2/11/26, R8 used a wheelchair. For mobility R8 required substantial/maximal assistance with transfers. Walking 10 feet was identified as Not applicable.There were no other assessments related to R8's restorative exercise abilities found in his medical record. Review of progress notes identified on:On 12/10/25 R8's restorative therapy plan was reviewed. R8's restorative program was changed to ambulate to breakfast in the morning as tolerated. There was no mention of why the restorative program was reviewed or details of the assessed program even though the 11/14/25 functional assessment identified R8 did not attempt to walk.On 12/17/25, Staff reported R8 was having more difficulty, and at times unable to stand as his legs buckled and then he would hang from the lift. R8 seemed weaker and less able to assist with his cares. There was no mention of any nurse assessing the reported difficulty with standing or safety concern of using the standing lift.On 1/8/26, R8 was uncooperative throughout the day, during a transfer he would repeatedly refuse to place his hands on the equipment handles as instructed. Only after 5 verbal prompts did R8 comply with assisting. R8 also refused to wear his shoes during the transfer process. Interview on 2/23/26 at 1:25 p.m., with R8 identified he did not participate in a restorative exercise program. He reported he squeezed a ball he had and that it worked just the same. R8 reported he used to go and exercise where he rode the bike; however, the<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility had cut that to save money. Interview on 2/26/26 at 9:14 a.m., with nursing assistant (NA)-A identified that R8 never walked, he did have a walking restorative program, but he was very particular with his cares and how he wanted things, he refused to walk. R8 used a standing lift for all transfers with one staff assistance. If staff note a decline in a residents function the staff are to tell the nurse. The nurse would assess the resident and if needed the resident was seen by the physician if they did not get better. Interview on 2/26/26 at 9:21 a.m., with licensed practical nurse (LPN)-A identified R8 used to walk but he would not walk anymore. When he was participating in his restorative program, he did not want to walk and would tell staff he was just waiting to die. Staff would try to get him to walk, but he refused. R8 not wanting to walk, might have something to do with his leg issues. He has an implant in his back that needs to be charged in a special chair every week. When the battery in his implant is getting low sometimes his legs don't want to work, and they really start to bother him. All nurses could update a resident's care plan, however, registered nurse (RN)-A typically reviewed and made updates to care plans following the completion of a resident's MDS assessment. Interview on 2/26/26 at 9:44 a.m., with RN-A identified she reviewed care plans following completion of the MDS; however, all nurses were able to and should be updating the resident care plans as things change. R8 did have a restorative program and there was a task for staff to document on his completion of the restorative program however, she had removed the task that would identify staff were to ensure R8 completed his walking, as he was refusing to walk. R8 had been working with restorative therapy until the staff that worked in that department had resigned; however, she was unsure if he was walking with the restorative staff either. IF a nurse identified a need for a change in the residents care they were responsible for updating the care plan. She confirmed R8's care plan should have been updated to reflect his status. Review of R8's medical record lacked identification of refusals of his restorative exercises and lacked an updated assessment for identified restorative exercises or risk to benefit showing R8 was made aware of potential decline by not completing his restorative treatments. Interview on 2/26/26 at 9:58 a.m., with the director of nursing (DON) identified she had re-assessed R8's restorative program back in December 2025 and changed his program to walking once a day to breakfast with staff assistance. She reported R8 was walking at the time, but he kept refusing to walk. She confirmed she should have updated the care plan when she first changed his restorative program back in December 2025 and when she was made aware he was refusing to walk at all. The facility had a good formal restorative program back around November or December of 2025 with a couple of staff. When she and the administrator had spoken to the restorative staff about some charting concerns, both staff placed their resignation, and the program was no longer fully staffed at that time. The facility had the direct care staff complete as many of the restorative programs as possible and had a light duty staff recently returned to work that was working on restorative programs, but the facility was unable to staff a formal program. She confirmed the residents were getting their restorative therapy, but not as much restorative therapy as they should as the facility still needed to fill the restorative positions. She revealed there was room for improvement in the restorative program and with the new therapy department starting on 3/2/26, all residents would be re-assessed at that time. Review of January 2025, Care plans, Comprehensive Person-Centered policy identified that each resident would have a person-centered care plan that included measurable goals to meet the resident's physical, psychosocial and functional needs. The care plan interventions would be developed through assessments, gathering information from the interdisciplinary team, the resident/representative, and the attending physician. The care plan would include goals, treatments, specialized services, to aid in preventing or reducing decline in the resident's status and enhance optimal functioning while reflecting current standards of practice. The care plan should be developed or revised within 7 days of the completion of the MDS assessment. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, interview, and document review, the facility failed to re-assess nursing interventions and communicate findings for skin wound for 1 of 1 sampled resident (42) once an open area had been identified by nursing. Findings include: R42's 2/24/26, admission Record identified that R42 was admitted to the facility mid-February 2026, from an assisted living facility. R42 had diagnoses of heart failure, diabetes, dementia, high blood pressure, and a history of stroke. Interview on 2/23/26 at 1:08 p.m., with R42 identified she had a sore on the back of her right leg that the nurse kept covered because otherwise she scratched it.?R42's 2/19/26, baseline care plan identified R42 required partial assistance of one staff for cares, transfers, and ambulation. There was no mention of wounds or risk of wounds on R42's care plan. R42's 2/20/26, Weekly Skin Audit/Bath Form identified 3 small bruises on her left arm, and some bruising was noted on her lower abdomen caused by insulin injections for her diabetes. The skin audit identified there were no open lesions, cuts, lacerations, open skin folds, or skin tears. There were also no identified blisters, open ulcers, no dry or flaky skin, and no edema. R42's progress notes from 2/19/26 through morning of 2/24/26 identified on: 2/19/26, an initial skin assessment was completed. No open areas were noted. 2/22/26, R42 received a small bandage to her right shin for a small broken scab, measuring less than 1 centimeter all around. The progress notes made no mention of a wound on the back of R42's right leg lacking evidence that the wound had been communicated for continued monitoring for healing. Interview on 2/24/26 at 9:59 a.m., with nursing assistant (NA)-B identified R42 did have dressing on the back of her leg but she was not sure what was under the dressing. R42's February 2025, treatment record and orders had no mention of a dressing to the back of R42's right leg. Interview, document review and observation on 2/24/26 at 12:58 p.m., with licensed practical nurse (LPN)-A and R42 identified LPN-A was unable to find in R42's medical record, any documentation R42 had a wound on the back of her right leg. There were no nursing or physician orders for wound treatment or monitoring. LPN-A also reviewed R42's last skin audit that was completed on 2/20/26 that only identified small bruises on arms and abdomen. She was unable to find any progress note about a wound since R42's admission the prior week however, she did find a note that a band aide had been applied to the front of R42 right shin. LPN-A then went to observe the back of R42's right leg and identified a self-adhesive padded dressing on R42 right calf that was dated 2/20/26 with no initials of who applied. The dressing was removed by LPN-A with a small amount of drainage on the bandage and a small open wound. LPN-A described as a possible scab that was scratched open. R42 at this time denied she scratched the back of her leg but maybe she had rubbed it on her recliner. LPN-A stated she had no clue R42 had an open sore on the back of her leg. LPN-A confirmed the nurse that identified the sore and applied the dressing should have made a progress note, set up a treatment, and updated the provider. Interview on 2/24/26 at 3:36 p.m., with director of nursing (DON) identified R42 had admitted from an assisted living facility and the day she arrived she refused to get undressed for the male staff. She was uncomfortable with the male staff completing the skin audit and that should have been delegated to another nurse. R42's wound was a recurrent one and it had just opened prior to her coming here and was one of the indications for her coming here as well. When the nurse identified the wound on the back of R42's leg the nurse should have contacted R42's primary provider for orders and set up the treatment. The DON revealed she would also expect a progress note of the wound assessment. Review of the undated, Pressure Ulcer/Skin Breakdown-Clinical Protocol policy identified newly admitted residents will have a skin examination done by the nurse to identify any existing pressure ulcers or other skin concerns. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245570 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Maple Lawn Senior Care | 400 Seventh Street NE<br>Fulda, MN 56131 |

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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and document review, the facility failed to provide services to maintain and/or prevent decrease in range- of-motion (ROM) for 1 of 1 sampled resident (R35) reviewed for limited range of motion. Findings include: R35's 8/19/2025, comprehensive Minimum Data Set (MDS) assessment identified his cognition was moderately impaired. He had diagnoses of cerebral palsy (condition primarily affecting leg movement and muscle stiffness) and dementia. R35's 2/10/26, Functional Abilities and Goals assessment identified R35 was dependent on staff for Activities of Daily Living (ADL)'s. He had no impairment to his upper extremities but was impaired on both sides of his lower extremities and used a manual wheelchair for mobility. R35's current, undated care plan identified he was at risk for decline in his physical condition related to cerebral palsy (condition primarily affecting leg movement and muscle stiffness) and was dependent on a wheelchair for mobility. The goal was for R35 to participate in a restorative exercise program to maintain his upper body strength. On 6/30/25, staff were to begin assisting R35 with the use of an arm bike (used to maintain upper body strength while limiting lower body movement) with moderate resistance for 15 minutes daily. Interview on 2/23/26 at 2:11 p.m., R35 identified staff do not do any ROM exercises with him. Interview on 2/26/26 at 8:04 a.m., with nursing assistant (NA)-A identified staff sometimes do some restorative exercises but generally NA-B was responsible to do that. NA-A was unable to recall the last time she had completed restorative with R35. Interview on 2/26/26, at 8:20 a.m., with director of nursing (DON) identified the facility had recently started having NA-B complete some restorative exercises with residents. R35 was to have the arm bike offered to him daily, however, she was aware they had a gap, and it was unlikely R35's restorative exercise were getting done every day. Staff are just not getting it done. Re-education of staff and audits are needed as We know our restorative program needs work. Interview on 2/26/26, at 13:32 a.m., with NA-B identified she was on light duty following an injury. She previously had been the bath aid but was temporarily assisting residents with light restorative exercise. Mainly helping residents on and off the NuStep exercise bike. The DON gave NA-B a list of residents she was to assist with using the NuStep bike but R35 was not on the list, and she has not completed any restorative exercises with R35. Interview on 2/26/26, at 8:24 a.m., with the administrator identified she would expect staff to complete restorative exercises with residents as care planned. They recently discussed this and plan to hire restorative aid for the facility. Review of the facility provided, undated, Restorative Nursing Policy, identified restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services and promotes the resident's ability to adapt and learn to live as independently and safely as possible. Restorative goals and objectives are individualized, resident-centered, and are outlined in the resident's care plan. Restorative goals may include but are not limited to adjusting or adapting to changing abilities, developing, maintaining, or strengthening his/her physiological and psychological resources. Maintaining dignity, independence, and self-esteem; and participating in the development and implementation of his/her care plan. |