Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2023

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: June 29, 2023

Dear Administrator:

On June 29, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 September 29, 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 December 29, 2023 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO RESTORATIVE CARE CENTER	660 MAPLE STREET WABASSO, MN 56293

(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
E 000	Initial Comments On 6/26/23 through 6/29/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/26/23 through 6/29/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 with NO deficiencies cited: H54003048C (MN93090), H54003050C (MN94183), H54003051C (MN94417), and H54003060C (MN89537). The following complaints were reviewed: H54003049C (MN94476) with a deficiency cited at F610. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2023

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 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to thoroughly investigate an allegation of resident to resident physical abuse for 2 of 2 residents (R25 and R8). Findings include: R25's quarterly Minimal Data Set (MDS) dated 3/31/23, indicated R25 was cognitively intact, without hallucinations or delusions noted and no other behaviors were identified.	F 610	F610 1: R25 and R8 have the potential to have a serious adverse outcome. No other residents were identified. 2: All residents have the potential to be affected in this area. 3: All staff have read and been educated on resident abuse policies, including steps to be taken to ensure the safety of all residents and investigation of resident-to-resident abuse.	8/14/23

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F 610	Continued From page 2 R8's quarterly MDS dated 5/31/23, indicated R8 as cognitively intact, had not hallucinations, delusions, or other behaviors noted. Review of facility report to the State Agency (SA) dated 6/13/23, identified R25 had reported R8 had entered R25's room alleging R25 of theft and began yelling at R25. R8 scratched R25's arms and punched R25 in left cheek. R8 was sent to local hospital for evaluation. Review of facility 5-day investigation submitted to the SA dated 6/13/12, identified the facility investigation lacked evidence of other residents being interviewed or assessed to ensure for their safety. On 6/28/23, at 12:55 p.m. interview with Social Services Designee (SSD) identified after an allegation of potential resident to resident abuse, a review of other residents to ensure their safety was to be done. The SSD continued that she could not find documentation of that having occurred after the initial report and before the facility 5-day investigation had been completed. The SSD confirmed that if it was not found within facility documentation, then it was not done and should have been. On 6/28/23, at 1:44 p.m. interview with Director of Nursing (DON) identified during the time of the incident most of the resident were "likely sleeping" and she expressed that was why that part of the investigation had not been completed. The DON stated she saw the importance of having done interviews with other residents to make sure they felt safe and to ensure their safety.	F 610	4: All reports to the State Agency will be audited x 3 months to ensure that the investigation includes interviews of the resident, resident's roommate, and other residents residing in the facility by the SSD or designee. Results of audits will be brought to the QAPI committee for further recommendations.	

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F 610	Continued From page 3 Review of facility policy titled "Abuse Investigating and Reporting" revised date 4/2021, identified the role of the facility investigator. The individual conducting the investigation was to interview the resident, resident's roommate, family member, and/or visitors.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		8/14/23

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F 623	Continued From page 4 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 623		

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F 623	Continued From page 5 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the Office of the Long-Term Care (LTC) Ombudsman of transfer for 2 of 3 resident (R6 and R20), reviewed for hospitalization. Findings include: R20's 5/7/23, Discharge Return Anticipated, Minimum Data Set (MDS) identified R20 was being discharged unplanned from the facility. R20's 5/12/23 Entry MDS identified R20 was	F 623	F623 1: R6 and R20 did not have adverse outcomes from Discharge with Anticipated Return not being reported to the LTC Ombudsman. 2: All residents who discharge with anticipated return have the potential to be affected in this area. 3: The Transfer or Discharge Policy has been reviewed and updated to include notification of LTC Ombudsman will be notified of Discharge with Anticipated	

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F 623	Continued From page 6 readmitted to the facility on that date. R6's MDS identified on: 1) 1/17/23, R6 was admitted to the facility. 2) 2/12/23, R6 had a Discharge Return Anticipated MDS assessment. 3) 2/15/23, R6 was re-admitted to the facility. 4) 3/24/23, had a Discharge Return Anticipated MDS assessment. 5) 6/12/23, R6 was readmitted to the facility. R20's and R6's medical records lacked any evidence the LTC Ombudsman had been notified of any transfers or discharges. Interview on 6/28/23 at 3:59 p.m., with the Social worker Designee (SSD) identified the Admission/Discharge To/From forms are done quarterly and faxed to the Ombudsman. SSD was able to show examples of how she sends the faxes for admission and discharge to the Ombudsman which also included discharges of residents against medical advice (AMA). SSD said, She did not notify the Ombudsman for R6 and R20's transfers or discharges. She only notifies the ombudsman for resident-initiated discharges, against medical advice (AMA) discharges, or facility initiated discharges. SS confirmed that she does not notify the ombudsman when a resident is transferred or discharge with return anticipated due to hospitalization. Facility provided policy titled "The Transfer or Discharge Policy" dated 10/22, did not identify the process regarding notification to the Ombudsman for transfers or discharge return anticipated for hospitalization.	F 623	Return to be notified per current regulation. 4: Audits of all Discharges with Anticipated Return will be audited by SSD or designee at time of discharge for notification of the LTC Ombudsman per current regulation x 3 months. Results of audits will be brought to the QAPI committee for further recommendations.	

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F 755	Continued From page 7	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medication was obtained and administered as ordered for 1 of 4	F 755	F755 1: R14 has the potential to have an adverse outcome. No other residents	8/14/23

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F 755	Continued From page 8 residents (R14). Findings include: Observation on 6/27/23 at 9:35 a.m., with trained medication aide (TMA)-A as she administered Vitamin D3 (cholecalciferol) to R14. TMA-A accessed R14's medication administration record on Point Click Care (PCC) and began pulling medication punch cards from the cart and after comparing the card to the order on the computer screen, dispensed the medication into a medication cup. TMA-A retrieved a stock multiple dose bottle of Vitamin D3 (cholecalciferol) 400 international units (IU) per tablet and placed two tablets into the medication cup. She took the medication cup of to administer to R14 and explained she had her morning medications. Interview on 6/27/23 at 9:45 a.m. with TMA-A reported she was aware the physician's order was for 1000 IU per day, but she used the stock bottle due to R14 not having a pharmacy dispensed card of the medication and the 400 IU tablets was the stock medication available in the medication cart. TMA-A denied asking the charge nurse or updating the doctor or pharmacy to obtain the correct dosage or obtain a change in the ordered dosage. Interview on 6/28/23 at 8:45 a.m., with the director of nursing (DON) confirmed the MD order for Cholecalciferol 1000 IU by mouth (PO) every day (QD) for R14. She reported the medication should have been reordered for the dose identified if the medication was not available in the stock supply. The DON reported administration of two 400 IU tablets was not the ordered dose and was a medication error. The	F 755	were identified. 2: All residents have the potential to be affected in this area. 3: Medication pass audits will be completed to ensure proper administration of all medications. 4: All TMA staff have been educated to alert nurses immediately if the correct dose of a medication is not available to pharmacy can be contacted to obtain the correct dose. 5: Medications will be audited by DON or Designee weekly x 3 weeks then, two times a month for 2 months, then monthly x 2 months. Results will be brought to the QAPI committee for further recommendations	

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F 755	Continued From page 9 DON identified her expectation for staff to follow the prescriber's orders and if there was a problem to communicate with the MD or pharmacy to correct the problem. The facility policy for medication administration was requested but not provided.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 761	F761	8/14/23

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F 761	Continued From page 10 review the facility failed to ensure insulin pens were appropriately labeled according to manufacturer's guidelines with an open date for 5 of 5 resident (R9, R12, R16, R23, and R28). Additionally, the facility failed to ensure staff followed the facility policy and protocols to verify narcotic count to prevent potential diversion. Findings include: Observation and interview on 6/26/23 at 5:00 p.m., with registered nurse (RN)-A of the south medication cart identified R12's Lantus insulin pen with no open date, R23's insulin Aspart injection flex-pen that was ½ gone with no open date, and R28's Lantus insulin pen that was ½ gone with no open date. Observation of the North medication cart identified R16's Basaglar Kwikpen that was almost empty with no opened date and R9's insulin Aspart injection flex- pen with no opened date. RN-A confirmed that the insulin pens had no opened dates identified and staff were to date when starting a new pen. R12's medication administration record (MAR) identified order for Lantus subcutaneous solution 100 unit/milliliter (ml) inject 30 units subcutaneously two times a day for diabetes mellitus. R23's MAR identified order for insulin Aspart flex-pen subcutaneous solution pen-injector 100 units/ml inject 10 units subcutaneously with meals. R28's MAR identified order for Lantus subcutaneous solution 100 units/ml inject 28 units subcutaneously at bedtime.	F 761	1: R9, R12, R16, R23 and R28 have the potential to have a serious adverse outcome. No other residents were identified. 2: All residents requiring insulin have the potential to be affected in this area. 3: All nurses and TMA staff have been educated on the dating of insulin at the time of the insulin pen is opened with date opened. 4: Audits of medication being labeled with dates will be completed weekly x 4 weeks then monthly x 2 months by DON or Designee. Results will be brought to the QAPI committee for further recommendations. 5: All nurses and TMA staff have been educated on policy for verification of narcotic count to prevent potential diversions. Medication Storage list to include expiration dates of medications has been placed on medication carts. 6: Audits of narcotic and E-kit counts will be audited weekly x 4 weeks then monthly x 2 months by the DON or Designee. Results will be brought to the QAPI committee for further recommendations.	

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F 761	Continued From page 11 R16's MAR identified order for Basaglar Kwikpen subcutaneous solution pen injector 100 units/ml inject 40 units subcutaneously at bedtime. R9's MAR identified order for insulin Aspart flex-pen 100 units/ml inject as per sliding scale 0-150=0, 151-200=2, 201-250=4, 251-300=6, 301-350=8, 351-400=10 subcutaneously before meals and at bedtime. Review of current, Basaglar KwikPen manufacture instruction identified to throw away the pen you are using after 28 days, even if it still has insulin left in it. Review of current, Insulin Aspart injection FlexPen manufactures instruction identified to throw away the pen you are using after 28 days, even if it still has insulin left in it. Review of the current, Lantus Solostar pen manufactures instruction identified after 28 days to throw your opened Lantus pen away, even if it still has insulin in it. Interview on 6/26/23 at 5:53 p.m., with director of nursing (DON) identified her expectation would be that staff date insulin pens when first opening them for use along with expiration date identified. Observation and interview on 6/26/23 at 7:17 p.m., with RN-B of the medication room identified a lock refrigerator that RN-B revealed had an emergency kit locked box inside that contained liquid Ativan and insulin. RN-B opened the locked refrigerator and checked the red tag number 9811487 which did not match what had been documented in the narcotic count book of 9811490 and RN-B stated "oh no" as she had just	F 761		

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F 761	Continued From page 12 completed count with the nurse leaving the day shift. RN-B opened the door to the medication room and asked the DON who was just outside the door to obtain the narcotic count book to verify the number again. The number was not a match, and the DON was made aware and the DON stated, "oh that is my fault, I worked this weekend and took insulin out of there 3 different times and documented on the form inside the tagged E-kit box in the locked refrigerator and forgot to document the new number in the narc book". The liquid Ativan was accounted for and the 3 times the DON had been in the locked box and had been documented on the form kept inside of the box with the correct red tag number documented. Review of the narcotic count book identified that the tag number of 9811490 had been documented starting on 6/18/23 through 6/26/23 at 1800 (5:00 p.m.) and signed off by 2 staff that it had been verified that the emergency kit box was sealed and number matched. Interview on 6/26/23 at 7:35 p.m., with DON agreed that staff could not have checked the red tag number on the locked box in the medication room as she had changed the red tag number on Sunday when she had worked the day shift and took an item out of the emergency kit in the medication room refrigerator. She agreed it should have been checked Sunday afternoon, Monday morning, and Monday afternoon shift and frankly she was embarrassed that the red tag had not been checked. She confirmed staff are to be checking the number on the emergency kit in the medication room refrigerator. Review of February 2023, Medication Labeling	F 761		

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F 761	Continued From page 13 and Storage policy identified multi-dose medications like a vial that have been opened or accessed example; needle puncture is dated and discarded within 28 days unless the manufacturer specifies a longer or shorter date. There was no mention specifically to insulin pens, eye drops or inhalers to be dated when opened and discarded according to manufactures instructions. Review of November 2022, Controlled Substances policy identified that controlled substance inventory will be monitored and reconciled to identify potential diversion or loss. The nursing staff are to count controlled medication inventory at the end of each shift, using the records to reconcile the inventory count. Some controlled medication may be stored in the emergency medication supply. Reconciliation of controlled substances in the emergency kit is conducted at intervals established by the director of nursing.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		8/14/23

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F 812	Continued From page 14 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure refrigerators and freezers were maintained in a clean and sanitary manor and resident personal food items were labeled and dated in the facility's resident refrigerator and freezer located in the dining room. Additionally, the facility failed to ensure food products with an expiration date were disposed of after the expiration date. Findings include: Observation and interview on 6/26/23 at 10:45 a.m., with cook-A of the resident side by side refrigerator freezer located in the dining room. On the door was a taped note identifying all personal items must be in sealed container with open date and resident's name. All items will be discarded in 3 days by dietary staff. Inside the refrigerator there had been something spilled that appeared sticky and yellow on the outside of the refrigerator drawers and on the bottom of the refrigerator. Cook-A agreed the refrigerator was dirty and stated she was not sure who was responsible for cleaning the resident refrigerator. The refrigerator contained a ½ gallon of skim milk with an expiration date of 5/27/23, 2 yogurts with an expiration date of 6/2/23, an open package of chopped ham sandwich meat that was half gone with expiration date of 6/1/23, a piece of jello poke cake in a container with expiration date of 6/23/23. Additionally, there was 3 ½ cheese	F 812	1. It is the policy of Wabasso Rehabilitation and Wellness Center that food brought by family/visitors that is left with the resident to consume later is labeled and stored. Daily audits are being performed to check for names and dates on all resident foods. 2. All residents have the potential to be affected in this area. Daily audits will identify outdated, non-labeled items and items will be discarded. 3. Policy education was given to the food service staff and audits explained in detail. 4. Audits will be used to monitor appropriate interventions are completed. The audit will be completed by the food service staff daily x 9 weeks, and weekly x 3 months with the results of the audits brought to the QAPI committee for further recommendations.	

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F 812	Continued From page 15 sandwiches in zip lock baggies with no date, 1 cheddar brat in an open package with no date or name, 1 bottle of red-hot sauce, 1 bottle of Sangria (wine) no alcohol, 1 plastic grocery bag with some grapes including mushy grapes, a bottle of spicy hot vegetable juice all which had been opened with no name or date identified on them. Inside the attached freezer was several items with no name or date identified which included several containers of ice cream, and 2 frozen meals. Cook-A confirmed that all items kept in the resident refrigerator or freezer needed to be labeled with the resident's name and a date. Cook-A stated she was unsure who was responsible to monitor the resident side by side refrigerator freezer for expired food and that all items were labeled and dated. Interview on 6/26/23 at 2:18 p.m., with consultant dietician identified the facility had a daily and weekly cleaning list and that should include refrigerators and freezers. She confirmed she would expect food items to be labeled and dated. She revealed she was unsure of the facility policy for maintaining the resident refrigerator but would expect that to be done by the kitchen staff with their cleaning schedule. She confirmed that items kept in the refrigerator and freezer should be monitored for expiration. She was unsure who was responsible for that task but would expect the kitchen staff to monitor that. Interview on 6/26/23 at 4:56 p.m., with cook-B identified we do daily cleaning and monthly cleaning. She revealed there was no list to clean the refrigerator or freezers however, staff would clean if they saw something dirty. She stated staff did not document if they cleaned the refrigerator or freezer. She was unaware of who was	F 812		

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F 812	Continued From page 16 responsible to monitor the refrigerator and freezer in the dining room for expired food items and that items were labeled and dated. Review of June kitchen cleaning schedule identified a daily cleaning tasks of dish room/drying area, sweep and mop floors, kitchen/pantry/dish room. There was no detail of what the cleaning entailed for each area. Review of undated, Food and Dining procedure identified resident food may be stored in the dining room refrigerator but must be labeled and dated. Open food may be stored for 72 hours before being discarded if outdated or unlabeled. The facility will not be responsible for food in the dining room refrigerator. The procedure did not identify who would be responsible for monitoring the dining room refrigerator. Review of undated, Food, Nutrition and Dietary Services policy and procedures identified, the facility will have a procedure for storage of foods brought in to ensure safe and sanitary storage, handling, and consumption. The dietary manager would be responsible for these protocols.	F 812		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and maintain a safe, sanitary, and comfortable environment for 6 of 6 residents (R3, R8, R11, R14, R19, and R23)	F 925	1. It is the policy of Wabasso Rehabilitation and Wellness Center to provide and maintain a safe, sanitary, and comfortable environment.	8/14/23

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F 925	Continued From page 17 who expressed concern about pest control for flies in the facility while eating, during cares, and sleeping. This deficient practice had the potential to affect all 36 residents who resided in the facility. Findings include: R3's 6/1/23, Significant change Minimum Data Set (MDS) assessment identified R3's cognition was intact, and she had improved in her abilities for activities of daily living (ADLs). She required extensive assist of one for bed mobility, transfers, dressing, toileting, & personal hygiene, supervision with eating, and locomotion on/off unit. R3 had diagnosis (DX) including heart failure, high blood pressure, arthritis, osteoporosis, non-Alzheimer's dementia, malnutrition, anxiety disorder, and depression. R3 used an electric wheelchair for mobility and was able to move about independently. Observation/interview on 6/26/23 at 12:00 p.m., of R3 as she sat in the dining room eating her noon meal and reported her food was good, but it was very annoying that there was such a problem with flies. Flies were observed buzzing by R3 and landing on the table as she waved her hands to prevent them from landing on her food. She reported the flies were not just in the dining room but in all areas of the facility. R3 reported it was hard to sleep sometimes because of the flies and it really bothered her when they landed on her food. R3 reported she and other residents had complained to administration about the fly problem, but nothing had been done to resolve the problem. Observation on 6/26/23 at 2:00 p.m., as R3 sat at	F 925	2. All residents have the potential to be affected in this area. 3. Pest control vendor was called to service the facility and facility ensured they are on a pest-control rotation with the vendor. 4. The inspection and pest control treatment was conducted on 06/27/2023 and 07/06/2023. Monthly audit will be completed to ensure compliance and completion of facility pest control.	

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F 925	Continued From page 18 the large table in the lounge area playing a dice game and was observed to use a fly swatter to swat at flies buzzing around her and other residents at the table. Observation and interview on 6/27/23 at 10:00 a.m., with R3 as she sat in her wheelchair in her room holding a fly swatter. She repeatedly complained of all the flies in facility, how they got into resident's food, and there was nothing done about it. R3 reported she had filed a grievance about her concerns but had not received any response. A copy of the Grievance was requested from the social services designee but not provided. R8's 5/13/23, Quarterly MDS assessment identified R3 had severe cognitive impairment and required supervision for her ADLS. Her diagnoses included Ulcerative Colitis, Crohn's disease, Inflammatory Bowel Disease, Anxiety, and depression. Observation and interview on 6/26/23 at 12:10 p.m., with R8 identified she was seated at a table in the dining room. R8 was vocalizing her concerns which included the flies that were "everywhere". When her food was placed in front of her, she began eating and was observed swatting at flies that had landed on the table and were flying around her. R11's 6/7/23, admission MDS assessment identified her cognition was intact and she required extensive assistance with dressing, toileting, and personal hygiene. Observation and interview on 6/26/23 at 5:15 p.m. with R11 identified she came into the dining	F 925		

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F 925	Continued From page 19 room and sat at the table for supper. R11 waved her hands to chase a couple of flies that had landed on the table and a dietary aide came over to wipe the table with a sanitizing solution. R11 reported she was pleased with her stay at the facility other than the problem with the flies. She reported they were everywhere and reported there should be something that could be done about them. Observation and interview on 6/27/23 at 1:00 p.m., during the resident council meeting identified R11 reported she thought the facility had done some sort of spraying right after the survey team had entered and the fly situation was little better but reported her agreement with other residents in attendance that something needed to be done because the flies were all over the facility including getting into food at mealtimes. R14's, 6/2/23 5-day MDS identified her cognition was intact, and she needed supervision with her ADLS. She had diagnosis that included anemia, high blood pressure, diabetes, epilepsy, malnutrition, depression, asthma, and pain. Observation on 6/26/23 at 11:45 a.m. of R14 seated in the dining room eating her noon meal waving her hand at flies that were buzzing around table. At 3:35 p.m. as she laid in bed sleeping with a fly swatter in her hand. At 6:00 p.m. R14 reported she should have brought her fly swatter with her, because the flies were a bother during meals, and she did not like to have them land on her or her food. Observation on 6/27/23 at 5:02 p.m. with R14 identified she was was seated at a table in the dining room eating and waving her hand to shoo	F 925		

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F 925	Continued From page 20 away a fly that was bothering her. Flies were also observed buzzing around in the room and landing on tables. R19's 5/12/23 Quarterly MDS identified his cognition was intact and he required supervision with his ADLs. He had diagnoses of heart failure, pneumonia, depression, chronic obstructive pulmonary disease, and asthma. Observation and interview of R4 on 6/27/23 at 1:00 p.m., during the resident council meeting as he reclined on the sofa waving his hands as a fly buzzed around him. R19 voiced his displeasure with the number of flies in the facility and reported he through there should be something done to help the problem. He added he was aware there would be a few flies due to persons going in and out the doors, but reported they were everywhere, and everyone had to have a fly swatter. R23's 4/30/23, Admission MDS identified her cognition was intact, and she was independent with transfers and locomotion. R23 required supervision of one with eating, and personal hygiene. R23 had diagnoses of anemia, heart failure, high blood pressure, diabetes, malnutrition, bipolar disorder, and PTSD. Observation and interview on 6/27/23 at 1:15 p.m. with R23 who attended the Resident council meeting reported the flies were bad throughout the facility and she did not feel the facility had tried to do anything about it. Interview on 6/27/23 at 2:30 p.m. with the administrator reported she was not aware the fly issue was that bad and directed the assistant administrator to contact pest control to come and	F 925		

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F 925	Continued From page 21 take care of the problem. The administrator reported the issue in the facility was due to the resident population and number of residents going in and out of the smoking area which he felt allowed flies to come into the building. Observation/interview on 6/29/23 at 10:45 a.m., with the maintenance supervisor (MS) for 2 of 3 ultraviolet, sticky trap units. The first unit observed was in the resident hall which exited to the smoking area. The MS lifted the unit down to allow observation of the interior of the unit and reported there was supposed to be a sticky pad located in the unit to catch insects and it was not present. There were multiple live and dead insects in the bottom of the unit. The MS reported he did not know when the pest control company that was supposed to service the units had last been in the building. He reported he checked the units occasionally, and could change the sticky pads, but it had been a couple of weeks since he last checked them. The second unit was in the hall that contained the dining room and kitchen. When that unit was lowered it was noted a sticky pad was in place with multiple dead insects covering the pad. There was a paper taped to the unit with a December 2022 date and during Interview the MS reported he thought that could have been when the units were last serviced. he reported he had called Plunket pest control 2 weeks ago and was told they were waiting until they received a couple more calls from customers in the area before coming out. The MS reported it could be up to a month before they were able to come to the facility and possibly spray. He voiced agreement the facility did have a problem with the number of flies in the building both in the dining room and resident rooms.	F 925		

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	245400	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 925	Continued From page 22 Interview on 6/29/23 at 11:42 a.m., with a Plunket Pest Control technician identified he arrived at the facility and when asked if he had come to monitor or deal with the fly problem, he replied "no" that the company had only received payment for previous services 6/28/23. He reported he was not aware of when Plunket had last been in the building but could check to find out. The technician reported he had checked with his supervisor and the last time service had been performed was 12/21/22 for rodents and crawling insects. Due to lack of payment Plunket had stopped providing service to the building. He reported Plunket had received a call at 9:12 a.m. that morning of the need to come and investigate the fly problem. He reported the glue boards had likely not been replaced since 10/28/23 when he was last in the building. A policy on pest control was requested and not provided prior to survey exit.	F 925		

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	245400	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/27/2023. At the time of this survey, Wabasso Restorative Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/07/2023

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The original building was constructed in 1964, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1994 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a capacity of 44 beds and had a census of 37 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to test the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25 (2011 edition), Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 14.2.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include:	K 353	1. It is the policy of Wabassso Rehabilitation and Wellness Center to ensure Life Safety measures are followed timely. 2. All residents have the potential to be affected in this area. 3. Life Safety education was given to the maintenance director to ensure that inspection of sprinkler piping and branch	8/14/23

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K 353	Continued From page 3 On 06/27/2023 at 1030AM, it was revealed by a review of available documentation that an inspection of sprinkler piping and branch lines shall be conducted every 5 years. The last inspection was on 04/29/2017. An interview with the Maintenance Director verified this or these deficient finding at the time of discovery.	K 353	lines is conducted every 5 years. 4. The vendor was contacted immediately to complete the inspection. Documentation showing the date last checked, who provided the test, and source will be completed.	