DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZO2F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00949

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245400**

2.STATE VENDOR OR MEDICAID NO.
(L2) **854542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **WABASSO REHABILITATION & HEALTHCARE CENTER**
(L4) **660 MAPLE STREET**
(L5) **WABASSO, MN** (L6) **56293**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2017**

6. DATE OF SURVEY **01/09/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A,4** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
The facility's request for a waiver of the following health deficiency(ies) has been forwarded to the CMS Region V Office for its determination.
F-727 CFR §483.35(b)(1) Registered Nurse 8 consecutive hours a day, 7 days a week.
Approval of the waiver request has been recommended.

17. SURVEYOR SIGNATURE Date :
Nicole Osterloh, Unit Supervisor 02/14/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 02/14/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/14/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 14, 2020

CMS Certification Number (CCN): 245400

Administrator
Wabasso Rehabilitation & Healthcare Center
660 Maple Street
Wabasso, MN 56293

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 31, 2020 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

Your request for waiver of has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

An equal opportunity employer.

Electronically delivered
February 14, 2020

Administrator
Wabasso Rehabilitation & Healthcare Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: November 20, 2019

Dear Administrator:

On January 3, 2020, CMS notified you a remedy was imposed. On January 9, 2020 the Minnesota Department(s) of Health completed a revisit, as well as on February 7, 2020 Public Safety completed a revisit, both to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 31, 2020.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 20, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 12, 2019, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 20, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 31, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Your request for a continuing waiver involving the deficiency(ies) cited under F-727 at the time of the November 20, 2019 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZO2F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00949

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(L2) **854542100**

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(L3) **WABASSO REHABILITATION & HEALTHCARE CENTER**
(L4) **660 MAPLE STREET**
(L5) **WABASSO, MN** (L6) **56293**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2017**

6. DATE OF SURVEY **11/20/2019** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
3. 24 Hour RN
X 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B, 4** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Angela Hatch, HFE NE II 01/02/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/12/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 12, 2019

Administrator
Wabasso Rehabilitation & Healthcare Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: November 20, 2019

Dear Administrator:

On November 20, 2019, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Fax: 507-537-7194

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 February 20, 2020 (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 May 20, 2020 (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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO REHABILITATION & HEALTHCARE 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
F 000	INITIAL COMMENTS On 11/17/19 through 11/20/19, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. In addition, a complaint investigation(s) were also completed at the time of the licensing survey. The following complaint(s) were found to be SUBSTANTIATED: H5400012C, with a deficiency cited at F610 H5400014C, with a deficiency cited at F610 H5400016C, however no deficiencies were cited. The following complaint(s) were found UNSUBSTANTIATED: H5400013C. H5400015C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 583 SS=F	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		1/2/20

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

Electronically Signed | 12/22/2019

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.

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 _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO REHABILITATION & HEALTHCARE CENTER	660 MAPLE STREET WABASSO, MN 56293

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F 583	Continued From page 1 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to	F 583	Resident R8 was educated on 12/17/2019 on the policy titled "HIPPA" and it was inappropriate to be on the nurses laptop playing around with the	

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 _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 583	Continued From page 2 unauthorized personnel for 1 of 1 resident (R28). This had the potential to affect all 37 residents whose records were stored electronically and unsecured by staff. Findings include: R8's 11/14/19, progress note identified trained medication aide (TMA)-A reported to the licensed social worker (LSW) she walked away from the medication cart computer and found R8 viewing other residents medical charts. TMA-A immediately advised R8 that was private information. R8 was not allowed to view other resident's medical records without their consent. Observation on 11/18/19 at 10:42 a.m., with licensed practical nurse (LPN)-A during a medication pass, identified LPN-A left the computer screen open and did not lock the screen when he entered R26's room to administer medications. He returned to the computer after one minute. No staff or other residents walked by the medication cart at this time. Private information would have been able to be viewed by passers-by. Interview on 11/19/19 at 2:28 p.m., with licensed social worker (LSW) identified TMA-A reported R8 looked at R28's medical records when TMA-A left the computer open and unlocked. She identified there were no investigations or incident reports were completed for this concern. Interview on 11/19/19 at 2:35 p.m., with the director of nurses (DON) identified she was not aware of the incident that occurred on 11/14/19. She indicated staff education should have occurred immediately with the offending staff, and	F 583	mouse and clicking buttons. When interviewing resident R8, resident R8 told Administrator and Social Worker "I was not trying to access medical records, I was just playing around. Resident R28 was notified by Administrator & Social Worker on 11/19/19 that PHI was allegedly seen by another resident in facility. On 11/22/19, after completion of the investigation Administrator and Social Worker notified resident R28 that in conclusion of the investiation the facility did not feel that his PHI was seen by another resident, based off of interview conducted and investigation completed. Resident R28 stated he still felt safe in facility. All residents have the potential to be affected by privacy breech. All nursing staff educated on the the policy titled "HIPPA" on 11/19/2019 with the focus on the need for the nurse to completely sign out of the e-MAR/TAR when not in use. An audit has been made to monitor resdient access to e-MAR/TAR. DNS or designee is responsible to complete audit weekly for 3 months. Results of audit will be reported to QAPI meeting for further recommendations. QAPI committe will determine when the audit can be stopped. Compliance date: January 2nd, 2020	

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 _____	11/20/2019

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WABASSO REHABILITATION & HEALTHCARE 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
F 583	Continued From page 3	F 583		

other staff to prevent reoccurrence.

Interview on 11/19/19 at 3:04 p.m., with the administrator identified he was not aware of the incident on 11/14/19. Staff education should have been completed right away. The resident whose information was breeched needed to be notified and an investigation needed to be stated to prevent the violation from reoccurring.

Interview on 11/20/19 at 11:32 a.m., with the administrator identified the facility population was much younger and more "tech savvy". We are going to start logging off before the staff leave the computer. When staff are accessing the electronic medical record, anyone residents could learn how to access the medical record.

Interview on 11/20/19 at 11:49 a.m., with R28 identified that he was just notified by facility staff and he felt violated. "The resident that looked at my records should have to leave this place because my privacy is now out in the open." "We all know gossip, what they did see is going to be spread around here."

Interview and observation on 11/20/19 at 1:00 p.m., R28 came into the facility office. He stated he called the ombudsman and was going to contact a lawyer. He was visibly upset.

Interview on 11/20/19 at 1:32 p.m., TMA-A identified she was at the medication cart it was around 3:00 p.m. R8 asked me to get the charge nurse to unhook her from her intravenous (IV) antibiotic. When TMA-A walked away from the computer she hit the screen lock button. The charge nurse was in the beauty shop. When TMA-A came out of the beauty shop, R8 was

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F 583	Continued From page 4 viewing the computer. TMA-A told R8 to step away from the computer. The computer was on R28'S treatment record screen. TMA-A reported it to the SW and then the charge nurse. She was away from the computer for approximately five minutes. She was not aware if R8 was able to see other residents personal information. Interview on 11/20/19 at 3:13 p.m., with the DON identified her expectation would be she should have been notified of the breech of privacy immediately and interventions should have been put in place at the time the incident occurred. Review of the undated Health Insurance Portability and Accountability Act (HIPAA) policy identified the facility was to safeguard all resident records to protect the confidentiality of the information. Access to resident medical records was to be limited to authorized staff and business associates.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to	F 585		1/2/20

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resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those

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F 585	Continued From page 6 grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 585		

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F 585	Continued From page 7 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R27) grievance was acted upon and a resolution provided. Findings include: R27's 10/17/19, admission, Minimum Data Set (MDS), identified R27 had intact cognition, had no behaviors and was independent with all activities of daily living (ADL)'s. Interview on 11/17/19, at 12:57 p.m., identified R27 she had asked for a room transfer approximately three weeks ago because her room had a strong urine odor that would not go away. "It is not healthy for me because the smell was so strong." R27 had informed staff of the foul urine odor in her room. R27 felt she should not have had to beg for a room change, for her room to be cleaned or sprayed and stated "I feel totally disrespected." Interview on 11/18/19, at 11:26 a.m.,with the MDS coordinator identified R27's roommate does not like to get out of bed. There had been a strong urine smell in R27's room for a few weeks, but it has gotten better in the last couple of days. Interview on 11/18/19, at 11:29 a.m., with nursing assistant (NA)-A identified there had been a urine smell in R27's room for the last few weeks. Management was aware of the concern. Interview on 11/18/19, at 11:44 a.m., with LPN-A identified R27 had complained about the strong urine smell in her room. LPN-A suggested R27 notify the licensed social worker (LSW) for a room change a few weeks ago. Further, indicated	F 585	Resident R27: Grievance on urine odor was resolved on 11/25/19. Resident was informed of the follow up of items put into place to prevent the smell of urine in room. Resident states satisfaftion with action taken. All residents have the potential to be affected by grievances/concerns. All staff educated on the policy "Grievances" on 11/21/19 with the focus being on the need to follow up when residents express concern or until resoluiton is found. An Audit has been created to monitor resident's grievances / concerns expressed in writing or verablly with timely follow up by facility and providing resoulution information to the resdient expressing grievance. Audit will be completed by Social Worker or designee weekly x3 months. Results of audit will be reported to QAPI meeting for further recommendations. QAPI Committee will determine when the audit can be stopped.	

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F 585	Continued From page 8 there was definitely a strong urine smell in R27's room. Interview on 11/18/19, at 12:39 p.m., with housekeeping (H)- B identified she had cleaned R27's room many times and there was definitely a very strong urine odor. Interview on 11/18/19, at 2:48 p.m.,with the H supervisor identified R27's roommate wets the bed. To clean the mattress we spray it and wipe it down. Sometimes urine will get on the rug and we have to wipe that off. There was a strong odor of urine. You could smell it in the hallway. Interview on 11/19/19, at 9:27 a.m., with LSW identified a grievance form should have been filled out weeks ago when R27 complained about the urine odor and an investigation should have been completed and we should have followed up with R27. Interview on 11/19/19, at 9:44 a.m., with the administrator (A) identified a grievance form should have been filled out when R27 complained about the room smell. If staff were not able to come up with a resolution, he should have been notified of this. He was not aware of this concern until recently. Review of the 2017, Grievance Policy identified the compliance office or designated associate will document and keep a log of all grievance expressed either orally and/or in writing on the day that it is received or as soon as possible after the event of events that precipitated the grievance.	F 585		
F 610	Investigate/Prevent/Correct Alleged Violation	F 610		1/2/20

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F 610 SS=D	Continued From page 9 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 observation, interview and document review, the facility failed to appropriately assess and implement interventions to ensure residents were free from resident to resident abuse for 3 of 3 resident (R5, R6, and R30). Findings include: Review of the 9/21/19, initial report to State Agency (SA) identified LPN-E witnessed R5 put her hands on R6 arm. R6 punched R5 in the chest. The 9/23/19, 5 day investigation report identified LPN-E stated she only saw R5 grab onto R6's arm. LPN-E did not see R6 hit R5 back. Writer of report spoke to R5, who denied striking R6. R6 stated she was sitting by the television in the lobby and R5 came up to her, called her a	F 610	Resident R6, R5 and R30: R5: Residents was not physically injured and has returned to baseline. Care plan was reviewed and updated with interventions to keep residents safe. Resident and family refuse psych intervetntion. 15 minute checks have stopped and will be re-implemnted as behaviors indidcate. R6: Resident was not physically injured and has returned to baseline. Care Plan was reviewed and updated with interventions to keep resident safe. R30: Resident was not physically injured	

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F 610	Continued From page 10 [expletive], grabbed her arm and scratched her. The facility identified both residents were separated and had been placed on 15 minute checks. R6 had noticeable red scratches on her arm. 15 minute checks by staff were to be implemented on 9/22/19 ending 9/23/19. There was no mention in the report how staff determined to end the 15 minute checks or what other interventions were placed after the checks stopped on 9/23/19, to prevent further potential abuse. Review of the 10/4/19, report filed to the SA identified R5 was in the walkway of the facility lobby when R30 tried to get through while in her wheelchair. R30 asked R5 to move. R5 refused to be moved and got closer to R30. R30 hit R5 in the face, knocking off her glasses. Staff intervened and separated the residents. R30 continued through the walk way. R5 was removed from the area and brought to the director of nurse's office to be redirected. R30 was placed on 15 minute checks to ensure the residents remained separated. Review of the 10/7/19, completed investigation report regarding the 10/4/19 between R30 and R5 identified both were interviewed following the incident. Neither R5 or R30 recalled the incident. The licensed social worker (LSW) was documented as witnesing R30 hitting R5 in the face due to R5 being in her way and refusing to move. Both residents were to be on 15 minute checks. Residents were educated on inappropriate behaviors. R5's 9/8/19, quarterly Minimum Data Set (MDS) identified R5 had severe cognitive impairment, physical behaviors directed towards others,	F 610	and has returned to baseline. Care Plan was reviewed and updated with interventions to keep residents safe. All Residents have the potential to be affected in this area. All Staff were educated on the policy titled "Abuse PRevention" on 11/21/19 with a focus on the need for timely reporting of all alleged abuse/neglect accusations. An audit has been created to monitor timeliness of abuse/neglect reporting to MDH. Social Worker or designee is responsible for completion of audit weekly x3 months. Results of audit will be reported to QAPI meeting for further recommnedation. QAPI committee will determine when the audit can be stopped. Compliance date: 01/02/2020	

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required extensive assist of one for bed mobility, transfers, dressing and toilet use. R5 did not ambulate and was able to propel her wheel chair independently. R5's diagnoses included dementia and anxiety.

R5's current undated, care plan identified R5 was rude towards others, made negative statements and talk negatively about others. R5 may become physical by kicking or slapping others. R5 was intrusive by going into other's rooms, slamming doors and drawers. Staff were to assist R5 to develop more appropriate methods of coping and interacting, and encourage R5 to express her feelings appropriately. Staff were to provide opportunities for positive interaction, such as a program of activities and redirect R5 from other's rooms or others she disturbed. The dining room was identified as providing too much stimulation. No new interventions have been implemented since 3/28/18.

R5's behavior monitoring identified R5 was coumented as physically aggressive in:
1) August 2019, 17 times.
2) September 2019, identified 35 episodes.
3) October 2019, 74 times R5 was physically aggressive.

R6's 9/10/19, quarterly, MDS identified R6 was cognitively intact, had no behaviors, and was independent with cares and locomotion. R6 diagnoses included mild cognitive impairment, osteoarthritis, depression, dementia with behavioral disturbance and alcohol dependence.

R6's current, undated, care plan identified R6 had behaviors of asking repetitive questions, swearing at other residents, making false accusations

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about others, being rude, eavesdropping on conversations, and having difficulty getting along with others. R6 would calm down with 1:1 staff intervention and with staff redirection. R6 will be kept safe and free from abuse through next review. The care plan lacked new interventions to prevent resident to resident abuse following the 9/21/19 resident to resident altercation.

R30's 4/29/19, quarterly MDS identified R30 had severe cognitive impairment, physical symptoms directed at towards others, and rejected care 1-3 days during assessment period. R30 required extensive assistance with dressing, toileting and personal hygiene. R30 required limited assist with transfers and supervisor for bed mobility and eating. R30 was frequently incontinent of bowel and bladder and had diagnoses of muscle weakness, and dementia without behavioral disturbance, macular degeneration (disease with gradual vision loss).

R30's 4/23/19, care plan identified staff were to explain what services they were to provide before providing cares. Staff were to ensure not to place R30 near others who disturb her, explain her environment if she does not understand, and remove her from potentially dangerous situations. R30 sometimes had behaviors such as refusing cares, being verbally and physically aggressive, and crying. Staff needed to allow R30 to make decisions about her treatment to provide a sense of control. The care plan lacked new interventions to prevent resident to resident abuse following the incident on 10/4/19.

Review R30's of the Resident Location forms dated 10/4/19 through 10/8/19, identified the 15 minute checks ended on 10/8/19 at 11:45 a.m.

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There was no documentation why the checks ended or if new interventions were put into place.

Interview on 11/18/19 at 2:38 p.m., nursing assistant (NA)-A identified she had worked when R5 had either been hit or hit another resident but was unaware of the date. R5 was quick and it "was hard to keep an eye on her".

Interview on 11/19/19 at 7:09 a.m., with the director of nursing (DON) and LSW regarding the investigation of R5 and R6 identified R6 was not known to have been aggressive and had no history of striking out. After the investigation, it was determined LPN did not actually see R6 hit R5, although the report failed to identify how that was determined. Following the event 15 minute checks were completed but no new interventions put into place on care plan. The LSW verified the 15 minute checks had been done for two days only. There were no documentations implemented to identify how staff were to ensure resident safety after the 15 min checks were discontinued.

Interview on 11/19/19 at 1:11 p.m., with the LSW identified both R5 and R30 were put on 15 min checks for 48-72 hours post incidents. If there were no additional incidents during the period of 15 minute checks they are discontinued. LSW agreed care plans should have been updated with interventions to attempt to keep R5 and other residents safe. R5 is vulnerable and was at risk for abuse because of her behaviors. There are times when R5 is unsupervised, but we try to keep an eye on her.

Interview on 11/20/19 at 7:39 a.m., with nursing assistant (NA)-A identified R30 had behaviors of

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hitting out at staff, swearing, and wandering. If R30 was in a "mood" staff needed to "step back and give her room". R30 and R5 have had physical altercations where staff have had to intervene.

Observation 11/20/19 at 8:04 a.m., identified R30 was wheeling self in wheelchair independently throughout facility without incidenty at that time.

Interview on 11/20/19 at 8:37 a.m., with licensed practical nurse (LPN)-E identified R5 and R6 were in front of the television. R5 and R6 were heard talking back and forth. Staff overheard one of the residents state "Get away from me... if you don't, I'm going to hit you", but was unsure which resident made the comment. LPN-E said she was in the nurses' office by the common area. She got up from her seat when she heard the residents and observed she saw R6 hit R5 in the chest area. LPN-E informed the director of nursing (DON) and was directed to report the incident to the SA. After the incident, leadership had not called or discussed the event during the investigation. LPN-E felt R5 should be in a different facility as R5 has more behaviors than any of the others in the facility.

Observation and interview on 11/20/19 at 8:50 a.m., of R5 with identified R5 was propelling her wheelchair towards R6 in the day room. R5 was seated in a chair watching television and stated "get her away from me or I will knock you on your [expletive]." LPN-C moved R5 to another table to color in the day room as an intervention. Interview immediately after with R6 indicated when she was in the day room, R5 came near her and called her a "fat ton of bricks," so she told her she would "knock [R5] on her [expletive]".

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F 610	Continued From page 15 Interview on 11/20/19 at 8:57 a.m., LPN-C identified R5 and R6 do not get along. Interview on 11/20/19 at 11:14 a.m., with LSW identified there should have been new interventions to try and keep R5 and other residents safe. R5 knows how to push R6's buttons, which has been going on for a while. R5 and R6 are like sisters and have a love/hate relationship. LSW verified there had been no new interventions on R6 care plan since 1/22/19. When she does an investigation, she types the information in the computer as she investigates. If she performed interviews, she would document that information in the investigation. LSW verified she did not document the reported interview she completed with LPN-A. There had been no interventions added to or updated on the care plan for R5, R6, or R30 following the incidents. Interview on 11/20/19 at 3:17 p.m., with the DON identified her expectation would be that new interventions be put in place to protect R5 and the other residents from abuse. The DON identified the facility protocol for resident to resident altercations was to immediately implement 15 minute checks to ensure residents were safe while completing the investigation. The DON acknowledged the need to keep everyone safe. It was a challenge in a facility this size. DON agreed there had been no new interventions added to the care plan for R6 or R5 care plan following the 9/21/19 altercation. The DON agreed better documentation was needed with follow up following for allegations of abuse. Review of the 6/9/19, Abuse Policy and Procedure identified residents have the right to be	F 610		

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F 610	Continued From page 16 free from abuse. An ongoing review and analysis of abuse incidents was to be completed timely to identify trends and implementation of changes to prevent future occurrences. an ongoing review and analysis of abuse incidents would be completed to identify trends and implementation of changes to prevent future occurrences of abuse. The policy indicated the investigation at a minimum would include interviews with the person reporting the incident, witnesses, the resident (if appropriate), staff members and other residents. Witness reports will be obtained in writing, signed and dated. The investigation will be recorded on approved documentation forms. Review of the undated, Resident to Resident Altercations Policy directed staff to separate residents, institute measures to calm the situation, and make necessary changes in the care plan approaches to any or all of the involved individuals.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow physician's orders by arranging a cardiology (heart) appointment and	F 684	Resident R12: R12 was seen by cardiologist on	1/2/20

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F 684	Continued From page 17 testing within one week following admission for 1 of 1 resident (R12) with chronic congestive heart failure, or notify the primary care provider services had not been obtained. Findings include: R12's Diagnoses Report 11/19/19, included diagnoses of acute heart failure (CHF), type 2 diabetes, high blood pressure, cardiomyopathy (disease of the heart muscle), and chronic kidney disease. R12's 9/26/19, admission Minimum Data Set (MDS) identified R12's cognition was intact. R12 had diuretic (excess fluid "water pill" medication) use. R12 participated in both occupational and physical therapy. R12's care plan identified staff were to give cardiac medications as ordered, and monitor and document signs and symptoms of CHF. There was no mention of R12 needed a follow up appointment with cardiology with additional testing. R12's September 2019, admission orders identified R12 needed to follow up with a cardiologist clinic within one week from admission. R12's admission orders further included a cardiac PET (an imaging test that helps reveal how your tissues and organs are functioning) scan for next week. Interview on 11/17/19 at 1:26 p.m., with R12 identified he needed heart surgery and he has been waiting four years to get his heart "fixed". R12 said licensed practical nurse (LPN)-B was to set up his appointment for PET scan of his heart	F 684	12/3/2019. Resident relays to nursing that this resident will not need heart surgery. No further appointments were indicated upon return. Resident did not suffer adverse consequences due to delayed apppointment. All residents have the potential to be affected by delayed followed up appointments. All nursing staff educated on policy "Role of admitting nurse" with a focus on the need for admitting nurse to communicate the need for follow up appointments and to update appointment book daily. An audit was created to monitor the timeliness of follow up appointments after admission. DNS or designee is responsible for completion of audit weekly x3 months. Result of audit will be reported to QAPI meeting for further recommendations. QAPI Committee will determine when the audit can by stopped.	

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F 684	Continued From page 18	F 684		

and it was not done yet.

Interview on 11/18/19 at 1:49 p.m., with R12 identified no appointment had been made yet.

Interview on 11/18/19 at 1:51 p.m., with LPN-B identified R12 had orders for a follow-up appointment. Staff needed to send R12 to a larger hospital [name withheld] for the specific PET test as local hospitals were unable to provide this test. LPN-B contacted the facility, and was awaiting a call back for scheduling. R12 had not been seen by a cardiologist yet.

Interview on 11/18/19 at 1:54 p.m., with LPN-C identified he just called [name withheld] hospital, and received a fax number to send R12's information too, in order to get R12 appointment set up. LPN-C was unaware if staff had provided the information when the hospital was first called.

Interview on 11/19/19 at 8:37 a.m., with director of nursing (DON) identified the admitting nurse would be the one to set up the follow up appointments for the resident. R12 was concerned as he just talked to her about it. She would have expected R12 to have been seen by cardiologist as ordered. R12 still had no cardiologist appointment set up at this time.

Interview on 11/19/19 at 9:01 a.m., with R12's primary nurse practitioner (NP)-C identified she would expect an appointment to be made as ordered. NP-C was unaware R12 had no appointment established with a cardiologist.

Review of R12's progress note on 9/20/19, identified R12 had combined systolic and diastolic heart failure, cardiomyopathy, and left ventricular

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F 684	Continued From page 19	F 684		

hypertrophy. There was no mention of a cardiology appointment being made.

Progress note on 9/25/19, identified R12 complained of shortness of breath and bilateral lower extremity swelling. R12 had been refusing to take his Lasix (water pill) for a couple of days. There was no mention the PCP was notified of the missing medication doses or R12's current health status change.

Review of the progress noted dated 10/30/19, indicated information was sent to [name withheld] hospital for his PET scan and cardiology appointment. There was no documentation the appointment was made.

Review of the progress note on 11/8/19 at 3:19 p.m., identified social services spoke to R12 about a conversation she had with his case worker. R12 became upset. At 11:07 p.m., R12 complained of chest pain left anterior and left upper arm and rated it as an 8 out 10. R12 was given Nitroglycerin sublingual 0.4 milligrams (mg) every 5 minutes for max dose of 3 doses in 15 minutes for chest pain. R12 had no relief and 911 was called to transport to hospital for evaluation. All of R12's test came back negative and R12 returned to the facility on 11/9/19 at 9:20 a.m. There was no mention a cardiologist appointment had been made at that time.

On 11/18/19 at 3:42 p.m., progress notes identified R12 had chest pain and was given Nitroglycerin sublingual 0.4 mg. At 4:30 p.m., R12 told nurse this happens all the time and there is nothing you can do about it. R12 expressed he was frustrated with the wait to get into see a cardiologist and get his heart fixed.

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F 684	Continued From page 20 On 11/19/19 at 12:08 p.m., a progress note indicated a cardiology appointment with a PET scan was now scheduled for December 3rd. A policy for following doctors' orders and setting up appointments was requested but not provided.	F 684		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight hours a day, including weekends, since June 2019. This had the potential to affect all 37 residents who resided in the facility. Findings include: Review of the facility's licensed staff schedule identified there was not an RN scheduled eight hours a day seven days a weeks two weekends	F 727	The Daily posting of nursing hours is posted and includes facility census, daily hours in 8 hour shifts and is updated at the end of 8 hours and as needed as staff hours change. All resident have the potential to be affected in this area. All staff educated on 11/19/19 on the need for the facility to post nursing hours daily including resident census, hours in 8 shift	1/2/20

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F 727	Continued From page 21 out of each month beginning 6/8/19. Interview on 11/19/19 at 9:39 a.m.,with the administrator identified the facility is in the process of applying for the RN waiver. He verified the facility had failed to have eight consecutive hours of RN coverage on an every other weekend basis as per the requirement. He indicated his expectation was there was to have been RN coverage. Those weekends should have been covered 8 hours a day/7 days a week. Interview on 11/20/19 at 8:45 a.m., with licensed practical nurse (LPN)-C identified that she worked on the weekends when there was was no RN coverage. If she had a concern or question, she would call the DON. Interview on 11/20/19 at 4:28 p.m., with the DON., verified that 6/8/19 was the first weekend there was no RN coverage at the facility and this has occurred 2 weekends per month from June until November. A policy was requested, but was not provided by the end of the survey.	F 727	(not 12 hours shifts), and updated at the end of every 8 hours and as needed. An RN waiver letter was sent into the regional office on 01/02/2020. The reason for this request is the facility has one full-time registered nurse regularly on duty 40 hours a week. An audit has been created to monitor the daily posting of nursing hours including the resident census information, nursing hours in 8 hour shifts (not 12 hour shifts) and update at the end of every 8 hours and as needed. Audit will be completed by DNS or designee weekly x 3 months. Results of audit will be reported to QAPI meeting for further recommendations. QAPI committee will determine when the audit can be stopped. Compliance Date: 01/02/2020	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		1/2/20

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F 732	Continued From page 22 resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post accurate facility census information along with detailed staff hours scheduled per shift. This had the potential to effect all 37 current residents, their families and visitors. Findings include: Observation on 11/17/19 at 2:00 p.m., the facility	F 732	The Daily posting of nursing hours is posted and includes facility census, daily hours in 8 hour shifts and is updated at the end of 8 hours and as needed as staff hours change. All resident have the potential to be affected in this area. All staff educated on 11/19/19 on the need	

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F 732	Continued From page 23 nurse staff posted hours dated 11/17/19, was posted near the front entrance by the day room and lacked the facility census and evening hours all showed zeros, which would indicate no staff were working during the evening hours. Observation on 11/18/19 at 3:00 p.m., the nurse staff posted hours did not include a facility census and the evening hours were all marked as zero. Observation on 11/19/19 at 7:17 a.m., the nurse staff posted hours did not include resident census or staff working evening hours . Interview on 11/19/19 at 9:20 a.m. with the director of nurses (DON) confirmed there was no census on the posted daily assignment sheet. She was not aware the current census needed to be included on the nursing posted hours. The DON agreed staff scheduled also needed to be identified. Interview with the administrator on 11/19/19 at 9:21 a.m., confirmed the daily resident census should have been included. A policy was requested, but not provided by the end of the survey.	F 732	for the facility to post nursing hours daily including resident census, hours in 8 shift (not 12 hours shifts), and updated at the end of every 8 hours and as needed. An audit has been created to monitor the daily posting of nursing hours including the resident census information, nursing hours in 8 hour shifts (not 12 hour shifts) and update at the end of every 8 hours and as needed. Audit will be completed by DNS or designee weekly x 3 months. Results of audit will be reported to QAPI meeting for further recommendations. QAPI committee will determine when the audit can be stopped. Compliance Date: 01/02/2020	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		1/2/20

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F 880	Continued From page 24 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 25 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow appropriate facility infection control policies by posting signage and supply of required personal protective equipment (PPE), for 1 of 1 resident (R16) with known highly contagious infections. Findings include: R16 was admitted with with diagnosis of Clostridium Difficile (C-Diff), (a highly contagious bacterium that causes diarrhea and an inflammation of the colon), Methicillin Resistant Staphylococcus aureus, (MRSA) (a highly contagious bacterium resistant to commonly used antibiotics), and extended spectrum beta-lactamase, (ESBL) (highly contagious bacterium with low levels of effectiveness of antibiotics.	F 880	R16 has completed antibiotics for C-Diff and and contact isolation was discontinued on 11/20/2019. All residents with C-Diff and any other infection requiring isolation have the potential to be affected in this area. Currently no residents have C-Diff that would require contact precautions. All staff education on the policy titled, "C-Diff and Standard Precautions and PPE" with a focus on the need for the facility to post and place a resident with active C-Diff or any other infection requiring isolation in contact isolation precautions until the resident goes 48 hours without symptoms.	

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F 880	Continued From page 26 R16's 9/29/19, quarterly Minimum Data Set (MDS), identified her cognition was intact and required supervision with activities of daily living (ADLs), and extensive assistance for getting dressed. Observation and interview on 11/17/19, at 2:00 p.m. with R16 identified she was aware of an infection, and was having loose stools because of it. R16 indicated she had received education prior to her recent hospital discharge on the need to follow precautions related to the nature of her infection. There was no signage placed at the entrance to R16's room notifying staff and/or visitors of the need for precautions. There was no PPE available at R16's room entrance for staff and/or visitors who wished to enter the room. R16 indicated staff had not worn PPE when they entered her room and assisted with her ADLs. Unidentified staff persons were observed entering R16's room. On 11/17/19, at 2:45 p.m., the director of nursing (DON) was observed posting a notice on the outside of R16's door, which indicated contact precautions were in place for staff or visitors entering the room. No PPE was made available for staff/visitor use, located outside of R16's room. R16 was interviewed on 11/18/19, at 10:22 a.m. regarding the new signage on her door. R16 indicated she continued to have "watery" stools, but had been able to remain continent and was careful to wash her hands after toileting. R16 stated she had cleaned the bathroom herself after having an accident, (bowel) as she didn't want staff to have to clean up after her. She	F 880	System Change: The facility has set up a premade isolation kit for immediate use if a resdient is diagnosed with C-Diff or any other infection requiring isolation. An audit was created to monitor posting of contact precautions for residents with C-Diff and any other infection requiring isolation. The audit will be completed by DNS or designee weekly x3 months. Results of audit will be reported to QAPI meeting for further recommendations . QAPI committee will determine when the audit can be stopped. Compliance date: 01/02/2020	

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F 880	Continued From page 27 indicated she was able to take herself to the toilet and staff did not see her stools, only asked if she had bowel movements and if they were loose or formed. Licensed practical nurse (LPN)-A was interviewed on 11/18/19, at 2:11 p.m. and indicated she had completed R16's readmission on 11/15/19. She confirmed she was aware of the documented diagnosis of C-Diff but had not initiated any signage or precautions as a result. LPN-A indicated the expected protocol was to place a sign for "contact precautions" outside the resident's room and notify staff of the need for precautions. LPN-A failed to place any visible notification of precautions or the need for PPE outside R16's room following her readmission. During interview with the DON, Infection Control Preventionist (ICP) and corporate office nurse consultant (CONC) on 11/18/19, at 2:27 p.m. it was verified the facility policy had not been followed for the use of contact precautions with PPE for R16 who returned from hospitalization with diagnoses of C-diff, MRSA, and ESBL. Review of the undated facility policy Clostridium Difficile: Policy Statement Preventative measures will be taken to prevent the occurrence of C-diff infections among residents and precautions will be taken while caring for residents with C-diff (to prevent the transmission of C-diff to others). Residents with diarrhea associated with C-diff will be placed on Contact Precautions. Those precautions include: a. Healthcare workers will wear gloves and gowns upon entering the room of a resident with C-diff and will remove gowns and gloved prior to exiting the room.	F 880		

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 _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO REHABILITATION & HEALTHCARE CENTER	**660 MAPLE STREET WABASSO, MN 56293**

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F 880	Continued From page 28 b. Visitors will be encouraged to wear gowns and gloves, and instructed on proper hand hygiene. c. Residents who are colonized with C-diff but are asymptomatic do not require Contact Precautions. d. Residents with diarrhea and suspected C-diff will be placed on contact precautions while awaiting laboratory results. e. Residents who are asymptomatic (diarrhea free) for 48 hours can be removed from precautions. f. Residents with C-diff will be placed in a private room if available. If a private room is not available, residents will be cohorted with a dedicated commode for each resident. The policy for MRSA infection precautions was requested but not provided.	F 880		

RECEIVED
JAN 06 2020
Minnesota Department of Health
Marshall

Wabasso
Rehabilitation & Healthcare Center

January 2, 2020

To the Regional Office, acting on behalf of the Secretary:

The purpose of this letter is to request an RN waiver for the plan of correction in citation F 727 RN coverage citation that requires all long term care facilities to provide 24 hour licensed nursing services requiring an RN work in house for 8 consecutive hours a day, 7 days a week (more than 40 hours a week), and that there be an RN designated as a Director of Nursing on a full time basis. In our rural town of Wabasso, Minnesota*, the population is 696 (2019), of those 696 people living in Wabasso, 161 of them are between the ages of 25-64 years old* making very difficult to find nurses and even more difficult to find Registered Nurses. Wabasso Rehab and Healthcare Center currently employs two RN's. The first RN is the Director of Nursing who works Monday thru Friday 8a-430p. The second RN is an overnight charge nurse who works 4p-4a or 6a Wednesday thru Tuesday (seven days on) and then seven days off and seven days on and seven days off. Generally, between the two RN's, they are able to suffice the 8 consecutive RN hours that are needed to comply with rules and regulations. However, we do run into issues the two weekends a month when our RN charge nurse is off. We have relied heavily on staffing agency for these 4 shifts a month (sometimes 6 shifts depending on the month), but it is to the point where a lot of the staffing agencies are struggling to find RN's to supply LTC facilities. Over 2019 Wabasso RHCC had approximately 14 days that there was not an RN in facility and was cited for F727 by Minnesota Dept. of Health during our recent Annual Survey.

Wabasso Rehabilitation and Healthcare Center has worked diligently over the last year on recruiting nursing staff including RN's. We have a corporate office (Superior Healthcare Management) who has a specific staffing dept. who has helped along the way and continue to help and guide us to find these RN's so that we may be in compliance. The following are a list of things that the facility has done to recruit RN's to work in Wabasso including:

-Posting RN position on a variety of job sites

-Posting RN position on facility Facebook page

-Attended ALL Job Fairs within a 45-60-mile radius

-Offered up $5,000 sign-on bonuses for an RN

-Increased hourly wages for RN's

-Called every RN that had worked in facility over the last few years and attempted to recruit to come back and work at Wabasso RHCC.

-Offer tuition assistance of up to $500/ month to anybody wanting to go to nursing school.

-Purchased the list of nurses by zip codes from the State of Minnesota.

-Sent out a direct mailing after purchasing the list of nurses in the state of Minnesota highlighting all of the perks that the facility was willing to give to nurses.

-Attempted to share staff with sister facilities in the area and pay for mileage, travel time and overtime wages for RN's willing to work both facilities.

The Director of Nursing has filled in many weekends and days/nights on the floor as a charge nurse making sure that we are in compliance, but she can only keep that up for so long before she burns out.

I feel the facility has demonstrated that it has made diligent efforts to recruit RN's but, unfortunately have not been able find and hire them. I also feel that with our resident population in facility it would not endanger the health or safety of the residents. Our Director of Nursing is available by phone call 24 hours a day, 7 days a week, 365 days a year and if she is going to not be available we have corporate regional nurse support that are available in the Director of Nursing's absence, as well as telehealth medicine through Tapestry that would be available to our staff as needed and would respond immediately to phone calls from facility for periods when an RN is not available in facility.

At this time, Wabasso Rehabilitation and Healthcare Center would like to request a waiver from the 8 consecutive hours a day, 7 days a week RN requirement. If the facility is granted this waiver it would notify all residents of the facility and/or their responsible guardian and members of their immediate families of the waiver. We appreciate your time and consideration of our requests.

Sincerely,

Austin Svejda

Administrator

Wabasso Rehabilitation & Healthcare Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2019**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 21, 2019. At the time of this survey, Wabasso Rehab and HCC was found not to be 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2019

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 1 445 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Wabasso Rehab and HCC was constructed as follows: 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 fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 37 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 20 out of 44 residents. FINDINGS INCLUDE: On facility tour on 11/21/2019 at 1:00 PM, it was observed that the facility had an emergency battery light by the therapy bathroom no documentation could not be located to indicate that the emergency light had received a 30 second test monthly and the annual 90 minute test. This deficient practice was confirmed by the Administrator at the time of discovery.	K 291	The emergency light at the end of South Hallway has been checked and is in proper working condition. To prevent reoccurrence of this deficient practice a monthly inspection task has been added to the preventative maintenance program "TELS" for a monthly inpsection to ensure proper working condition. The maintenance director or designee is responsible for the completeion of this audit. Compliance Date: 11/21/2019	11/21/19

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2019

Administrator
Wabasso Rehabilitation & Healthcare Center
660 Maple Street
Wabasso, MN 56293

Re: State Nursing Home Licensing Orders
Event ID: ZO2F11

Dear Administrator:

The above facility was surveyed on November 17, 2019 through November 20, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Fax: 507-537-7194

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00949	A. BUILDING: _____ B. WING _____	11/20/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/17/19 through 11/20/19, the Minnesota Department of Health, Licensure and Certification surveyors visited Wabasso Rehab & HCC and the following correction orders were issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 In addition, a complaint investigation(s) were also completed at the time of the licensing survey. The following complaint(s) were found to be SUBSTANTIATED: H5400012C, H5400014C, and H5400016C The following complaint(s) were found UNSUBSTANTIATED: H5400013C and H5400015C. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag". The state statute/rule found out of compliance is listed in the "Summary Statement of Deficiencies" column, and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidence by ...". Following the surveyors findings are the " Suggested Method of Correction " and the "Time Period for Correction " . PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight hours a day, including weekends, since June 2019. This had the potential to affect all 37 residents who resided in the facility. Findings include: Review of the facility's licensed staff schedule identified there was not an RN scheduled eight hours a day seven days a weeks two weekends out of each month beginning 6/8/19. Interview on 11/19/19 at 9:39 a.m.,with the administrator identified the facility is in the process of applying for the RN waiver. He verified the facility had failed to have eight consecutive hours of RN coverage on an every other weekend basis as per the requirement. He indicated his expectation was there was to have been RN coverage. Those weekends should have been covered 8 hours a day/7 days a week. Interview on 11/20/19 at 8:45 a.m., with licensed practical nurse (LPN)-C identified that she worked on the weekends when there was was no RN coverage. If she had a concern or question, she would call the DON.	2 810	Facilty schedules an RN 8 hours in 24 hours. All residents have the potential to be affected in this area Facility continues to advertise and seek additional RN's for employment. DNS and Administrator educated on the MN State Staffing requirements mandating the need for 8 hour continual RN coverage in a 24 hour period on 12/17/2019 An Audit was created to monitor for the posting of nursing hours for at least 8 hours of continous RN coverage in a 24 hours period. Audit will be completed by DNS or designee weekly x3 months. Results of audit will be reported to QAPI meeting for further recommendations. QAPI committee will determine when the audit caqn be stopped. Compliance Date: January 2nd, 2020	1/2/20

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2 810	Continued From page 3 Interview on 11/20/19 at 4:28 p.m., with the DON., verified that 6/8/19 was the first weekend there was no RN coverage at the facility and this has occurred 2 weekends per month from June until November. A policy was requested, but was not provided by the end of the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided eight hours per day, seven days per week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an	21390		1/2/20

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21390	Continued From page 4 immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow appropriate facility infection control policies by posting signage and supply of required personal protective equipment (PPE), for 1 of 1 resident (R16) with known highly contagious infections. Findings include: R16 was admitted with with diagnosis of Clostridium Difficile (C-Diff), (a highly contagious bacterium that causes diarrhea and an inflammation of the colon), Methicillin Resistant Staphylococcus aureus, (MRSA) (a highly contagious bacterium resistant to commonly used antibiotics), and extended spectrum beta-lactamase, (ESBL) (highly contagious bacterium with low levels of effectiveness of antibiotics. R16's 9/29/19, quarterly Minimum Data Set	21390	R16 has completed antibiotics for C-Diff and and contact isolation was discontinued on 11/20/2019. All residents with C-Diff have the potential to be affected in this area. Currently no residents have C-Diff that would require contact precautions. All staff education on the policy titled, "C-Diff and Standard Precautions and PPE" with a focus on the need for the facility to post and place a resident with active C-Diff in contact isolation precautions until the resident goes 48 hours without symptoms. System Change: The facility has set up a premade isolation kit for immediate use if a resdient is diagnosed with C-Diff.	

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(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) COMPLETE DATE
21390	Continued From page 5 (MDS), identified her cognition was intact and required supervision with activities of daily living (ADLs), and extensive assistance for getting dressed. Observation and interview on 11/17/19, at 2:00 p.m. with R16 identified she was aware of an infection, and was having loose stools because of it. R16 indicated she had received education prior to her recent hospital discharge on the need to follow precautions related to the nature of her infection. There was no signage placed at the entrance to R16's room notifying staff and/or visitors of the need for precautions. There was no PPE available at R16's room entrance for staff and/or visitors who wished to enter the room. R16 indicated staff had not worn PPE when they entered her room and assisted with her ADLs. Unidentified staff persons were observed entering R16's room. On 11/17/19, at 2:45 p.m., the director of nursing (DON) was observed posting a notice on the outside of R16's door, which indicated contact precautions were in place for staff or visitors entering the room. No PPE was made available for staff/visitor use, located outside of R16's room. R16 was interviewed on 11/18/19, at 10:22 a.m. regarding the new signage on her door. R16 indicated she continued to have "watery" stools, but had been able to remain continent and was careful to wash her hands after toileting. R16 stated she had cleaned the bathroom herself after having an accident, (bowel) as she didn't want staff to have to clean up after her. She indicated she was able to take herself to the toilet and staff did not see her stools, only asked if she had bowel movements and if they were loose or	21390	An audit was created to monitor posting of contact precautions for residents with C-Diff. The audit will be completed by DNS or designee weekly x3 months. Results of audit will be reported to QAPI meeting for further recommendations . QAPI committee will determine when the audit can be stopped. Compliance date: 01/02/2020	

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	00949	A. BUILDING: _____ B. WING _____	11/20/2019

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21390	Continued From page 6 formed. Licensed practical nurse (LPN)-A was interviewed on 11/18/19, at 2:11 p.m. and indicated she had completed R16's readmission on 11/15/19. She confirmed she was aware of the documented diagnosis of C-Diff but had not initiated any signage or precautions as a result. LPN-A indicated the expected protocol was to place a sign for "contact precautions" outside the resident's room and notify staff of the need for precautions. LPN-A failed to place any visible notification of precautions or the need for PPE outside R16's room following her readmission. During interview with the DON, Infection Control Preventionist (ICP) and corporate office nurse consultant (CONC) on 11/18/19, at 2:27 p.m. it was verified the facility policy had not been followed for the use of contact precautions with PPE for R16 who returned from hospitalization with diagnoses of C-diff, MRSA, and ESBL. Review of the undated facility policy Clostridium Difficile: Policy Statement Preventative measures will be taken to prevent the occurrence of C-diff infections among residents and precautions will be taken while caring for residents with C-diff (to prevent the transmission of C-diff to others). Residents with diarrhea associated with C-diff will be placed on Contact Precautions. Those precautions include: a. Healthcare workers will wear gloves and gowns upon entering the room of a resident with C-diff and will remove gowns and gloved prior to exiting the room. b. Visitors will be encouraged to wear gowns and gloves, and instructed on proper hand hygiene. c. Residents who are colonized with C-diff but are asymptomatic do not require Contact	21390		

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21390	Continued From page 7 Precautions. d. Residents with diarrhea and suspected C-diff will be placed on contact precautions while awaiting laboratory results. e. Residents who are asymptomatic (diarrhea free) for 48 hours can be removed from precautions. f. Residents with C-diff will be placed in a private room if available. If a private room is not available, residents will be cohorted with a dedicated commode for each resident. The policy for MRSA and ESBL infection prevention precautions was requested but not provided. SUGGESTED METHO OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding isolation precautions for resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-educatioon anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. In additon, the DON or designee should review and ensure compliance with g-tube feeding/medication administration with audits to ensure policies are being followed to ensure on-going competence. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390		

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to administer initial Tuberculin Skin Testing (TB), following for 4 of 6 new employees, nursing assistants (NA-D, NA-E, NA-F and NA-G) and 4 of 6 residents (R36, R38, R34, and R39). The facility also failed to ensure 1 of 6 employees (NA-C) and 2 of 6 residents (R12, and R10) received a second step TB test after the TB test became available September 2, 2019. Findings include:	21426	Residents R36, R38, R39, R34, R10 and R12 have received 2 step TB with results documented in PCC. All new residents have the potential to be affected in this area. All current residents have received a current 2 step Mantoux. All nursing staff were educated on the policy titled "TB screening for residents" on 11/20/2019 with a focus on the need for all new residents and new hire staff to	1/2/20

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21426	Continued From page 9 Review of employee files identified the following NA's had either not received a TB test initially or as a second test after it had become available. 1. NA-C was hired on 8/7/19. NA-C had their first TB test on 8/1/19, however no second TB test was documented. 2. NA-D was hired 11/5/19, NA-E was hired 10/31/19, NA-F was hired 9/26/19, and NA-G was hired 11/5/19. Non of those staff received a TB test after the TB test became available. Review of the immunization records for the following residents identified: 1. R36 was admitted on 10/23/19, R38 was admitted 10/30/19, R34 was admitted 10/22/19, and R39 was admitted on 11/5/19. None of these residents had received a TB test after the test became available. 2. R12 was admitted on 9/20/19 and received a first step TB on 9/20/2019. R10 was admitted 9/17/19, and received a first step TB on 9/20/2019. Neither resident received a second step once the test became available. Review of the undated, Tuberculosis Screening-Administration and Interpretation of Tuberculin Skin Test policy identified The facility was to administer and interpret TST in accordance with recognized guidelines and pertinent regulations. Review of the undated, Tuberculosis Screening for Residents policy identified facility staff shall screen all residents for tuberculosis infection and disease (TB).	21426	complete a 2 step Mantoux process ensuring they are free from active TB. An audit was created to monitor staff and residents 2 step Mantoux administration. The audit will be completed by DNS or designee weekly x 3 months. Results of audit will be reported to QAPI meeting for further recommendations. QAPI committee will determine when the audit can be stopped. Compliance Date: January 2nd, 2020	

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21426	Continued From page 10 Interview on 11/20/19 at 11:55 a.m., with the director of nursing (DON) and nurse consultant identified the facility had not obtained TB testing after it had been made available. The facility had not developed a plan for administration of TB testing. The DON agreed, staff should have administered the testing once the vaccine became available. SUGGESTED METHOD OF CORRECTION: The DON could review and educate staff on TB policies and procedures to ensure compliance. The DON could audit resident and employee files to ensure compliance with assessments and screenings including appropriately administered and documented TSTs. The findings should be taken to the Quality Assurance performance Improvement (QAPI) committee to determine any need for continued monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to	21860		1/2/20

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21860	Continued From page 11 complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel for 1 of 1 resident (R28). This had the potential to affect all 37 residents. Findings include: R8's 11/14/19, progress note identified trained medication aide (TMA)-A reported to the licensed social worker (LSW) she walked away from the medication cart computer and found R8 viewing other residents medical charts. TMA-A immediately advised R8 that was private information. R8 was not allowed to view other resident's medical records without their consent. Observation on 11/18/19 at 10:42 a.m., with licensed practical nurse (LPN)-A during a medication pass, identified LPN-A left the computer screen open and did not lock the screen when he entered R26's room to administer medications. He returned to the computer after one minute. No staff or other residents walked by the medication cart at this time. Private information would have been able to be viewed by passers-by. Interview on 11/19/19 at 2:28 p.m., with licensed	21860	Resident R28 was informed of alleged PHI privacy breech on 11/19/2019. Resident was spoken to by Administrator and Social Worker explaining that R28 information was thought to have been seen by another resident in this facility. All residents have teh potential to be affected by a privacy breech. All nursing staff educated on the policy titled "HIPPA" on 11/19/19 with the focus on the need for the nurse to completely sign out of MAR/TAR when not in use. An audit has been made to monitor resident accesss to e-MAR /TAR. DNS or designee is responsible to complete audit weekly for 3 months. Results will be reported to QAPI meeting for further recommendations. QAPI committee will determine when the audit can be stopped. Compliance Date: January 2, 2020	

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21860	Continued From page 12 social worker (LSW) identified TMA-A reported R8 looked at R28's medical records when TMA-A left the computer open and unlocked. She identified there were no investigations or incident reports were completed for this concern. Interview on 11/19/19 at 2:35 p.m., with the director of nurses (DON) identified she was not aware of the incident that occurred on 11/14/19. She indicated staff education should have occurred immediately with the offending staff, and other staff to prevent reoccurrence. Interview on 11/19/19 at 3:04 p.m., with the administrator identified he was not aware of the incident on 11/14/19. Staff education should have been completed right away. The resident whose information was breeched needed to be notified and an investigation needed to be stated to prevent the violation from reoccurring. Interview on 11/20/19 at 11:32 a.m., with the administrator identified the facility population was much younger and more "tech savvy". We are going to start logging off before the staff leave the computer. When staff are accessing the electronic medical record, anyone residents could learn how to access the medical record. Interview on 11/20/19 at 11:49 a.m., with R28 identified that he was just notified by facility staff and he felt violated. "The resident that looked at my records should have to leave this place because my privacy is now out in the open." "We all know gossip, what they did see is going to be spread around here." Interview and observation on 11/20/19 at 1:00 p.m., R28 came into the facility office. He stated he called the ombudsman and was going to	21860		

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21860	Continued From page 13 contact a lawyer. He was visibly upset. Interview on 11/20/19 at 1:32 p.m., TMA-A identified she was at the medication cart it was around 3:00 p.m. R8 asked me to get the charge nurse to unhook her from her intravenous (IV) antibiotic. When TMA-A walked away from the computer she hit the screen lock button. The charge nurse was in the beauty shop. When TMA-A came out of the beauty shop, R8 was viewing the computer. TMA-A told R8 to step away from the computer. The computer was on R28'S treatment record screen. TMA-A reported it to the SW and then the charge nurse. She was away from the computer for approximately five minutes. She was not aware if R8 was able to see other residents personal information. Interview on 11/20/19 at 3:13 p.m., with the DON identified her expectation would be she should have been notified of the breech of privacy immediately and interventions should have been put in place at the time the incident occurred. Review of the undated Health Insurance Portability and Accountability Act (HIPAA) policy identified the facility was to safeguard all resident records to protect the confidentiality of the information. Access to resident medical records was to be limited to authorized staff and business associates. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the importance of complaince with handling and securing medical records. The DON or designee, could perform observational audits to ensure staff	21860		

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21860	Continued From page 14 are locking access to medical records when not physically present. The DON or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21860		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by	21880		1/2/20

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21880	Continued From page 15 an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R27) grievance was acted upon and a resolution provided. Findings include: R27's 10/17/19, admission, Minimum Data Set (MDS), identified R27 had intact cognition, had no behaviors and was independent with all activities of daily living (ADL)'s. Interview on 11/17/19, at 12:57 p.m., identified R27 she had asked for a room transfer approximately three weeks ago because her room had a strong urine odor that would not go away. "It is not healthy for me because the smell was so strong." R27 had informed staff of the foul urine odor in her room. R27 felt she should not have had to beg for a room change, for her room to be cleaned or sprayed and stated "I feel totally disrespected." Interview on 11/18/19, at 11:26 a.m.,with the MDS	21880	Resident R27: Grievance on urine odor was resolved on 11/25/19. Resident was informed of the follow up of items put into place to prevent the smell of urine in room. Resident states satisfaftion with action taken. All residents have the potential to be affected by grievances/concerns. All staff educated on the policy "Grievances" on 11/21/19 with the focus being on the need to follow up when residents express concern or until resoluiton is found. An Audit has been created to monitor resident's grievances / concerns expressed in writing or verablly with timely follow up by facility and providing resoulution information to the resdient expressing grievance. Audit will be completed by Social Worker or designee weekly x3 months. Results of audit will be	

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21880	Continued From page 16 coordinator identified R27's roommate does not like to get out of bed. There had been a strong urine smell in R27's room for a few weeks, but it has gotten better in the last couple of days. Interview on 11/18/19, at 11:29 a.m., with nursing assistant (NA)-A identified there had been a urine smell in R27's room for the last few weeks. Management was aware of the concern. Interview on 11/18/19, at 11:44 a.m., with LPN-A identified R27 had complained about the strong urine smell in her room. LPN-A suggested R27 notify the licensed social worker (LSW) for a room change a few weeks ago. Further, indicated there was definitely a strong urine smell in R27's room. Interview on 11/18/19, at 12:39 p.m., with housekeeping (H)- B identified she had cleaned R27's room many times and there was definitely a very strong urine odor. Interview on 11/18/19, at 2:48 p.m.,with the H supervisor identified R27's roommate wets the bed. To clean the mattress we spray it and wipe it down. Sometimes urine will get on the rug and we have to wipe that off. There was a strong odor of urine. You could smell it in the hallway. Interview on 11/19/19, at 9:27 a.m., with LSW identified a grievance form should have been filled out weeks ago when R27 complained about the urine odor and an investigation should have been completed and we should have followed up with R27. Interview on 11/19/19, at 9:44 a.m., with the administrator (A) identified a grievance form should have been filled out when R27 complained	21880	reported to QAPI meeting for further recommendations. QAPI Committee will determine when the audit can be stopped. Compliance Date: January 2, 2020	

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21880	Continued From page 17 about the room smell. If staff were not able to come up with a resolution, he should have been notified of this. He was not aware of this concern until recently. Review of the 2017, Grievance Policy identified the compliance office or designated associate will document and keep a log of all grievance expressed either orally and/or in writing on the day that it is received or as soon as possible after the event of events that precipitated the grievance. SUGGESTED METHOD OF CORRECTION: The Adminstrator and/or designee could review the facility polices in regards to grievances, and educate staff on how to submit and act upon gievances in a timely manner. They could monitor these a routine basis to ensure grievances were acted upon. The administrator or designee should take that information to QAPI for oversight to identify complaince or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21880		