Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

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

RE: CCN: 245400
Cycle Start Date: February 28, 2024

Dear Administrator:

On February 28, 2024, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 May 28, 2024 (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 August 28, 2024 (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.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: YIX411

Dear Administrator:

The above facility was surveyed on February 27, 2024 through February 28, 2024 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

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

RE: CCN: 245400
Cycle Start Date: February 28, 2024

Dear Administrator:

On February 28, 2024, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 May 28, 2024 (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 August 28, 2024 (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.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: YIX411

Dear Administrator:

The above facility was surveyed on February 27, 2024 through February 28, 2024 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00949	A. BUILDING: _____ B. WING _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 2/27/24 and 2/28/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed: H54001195C (MN00100462); H54001194C (MN00099434); H54001190C (MN00099255); H54001192C (MN00098202); H54001189C (MN00098199); H54001191C (MN00096437); H54001193C (MN00096312); H54001197C (MN00095237); H54001196C (MN00093563); and H54001326C (MN00100600) with a licensing orders issued at 0690, 0830, and 1925. 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 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive discharge summary that included all four components (recapitulation of stay, final summary of resident's status, medication reconciliation, and	2 690	Corrected - 3/22/2024	3/17/24

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 690	Continued From page 3 post-discharge plan) as required for 2 of 2 residents (R2, R9) who were discharged to the community. Findings include: R1's admission Minimal Data Set (MDS) dated 10/31/23, indicated R1 had diagnoses which included alcohol induced acute pancreatitis, alcoholic hepatitis, and was cognitively intact. Further, MDS revealed R1 did not exhibit any behaviors and wished to discharge to the community. R1's progress note dated 11/20/23, indicated R1 was going to discharge to her grandmother's home on this day, and was going to be transported by her aunt until R1 was accepted into an inpatient chemical dependency facility. R1's Social Services- Discharge Summary dated 11/20/23, revealed R1 discharge to community with family, and was working on possible admission to an inpatient chemical dependency facility on 11/27/23. Recapitulation of stay was included, medication/treatment instructions sent with resident, and medications were sent with resident. R1's discharge summary lacked evidence of a final summary of R1's status. R9's significant change MDS dated 7/12/23, indicated R9 had diagnoses which included acute respiratory failure, major depressive disorder, psychoactive substance abuse and was cognitively intact. Further, MDS revealed R9 did not exhibit any behaviors and wished to discharge to the community. R9's progress note dated 7/20/23, indicated R9 discharge to home on this day. R9 took all	2 690		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 690	Continued From page 4 personal belongings. R9 would not allow nurse to review discharge instructions or medications. R9 left the facility without taking his discharge packet and without taking medications that the nurse had packaged for him to take home. R9's record lacked evidence of a discharge summary being completed which included: recapitulation of stay, final summary of resident's status, and post-discharge plan. On 2/28/24 at 2:45 p.m., social services (SS)-A stated the facility did not have a policy or procedure for completing a discharge summary, but SS-A or director of nursing (DON) were expected to complete the assessment in the resident's medical record upon resident discharge. SS-A stated the discharge summary would include a recapitulation of resident's stay, services, active diagnoses, if the provider was provided a copy, medications, and post-discharge plan and location. Further, SS-A stated she has 30 days following the resident's discharge to complete the assessment. SS-A confirmed R9's discharge summary completed as the assessment was not in his medical record. On 2/28/24 at 4:01 p.m., DON stated SS-A would be expected to complete the discharge summary form in the resident's record upon discharging the facility and DON would be responsible for completing the recapitulation portion. DON stated she was not aware of the final summary of resident's status as part of the four required components of the discharge summary. Requested facility policy related to discharge summary, facility did not have a policy at time of exit.	2 690		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 690	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures related to discharge summaries to meet the requirements of each resident's dischare. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure each resident had a comprehensive discharge summary completed at the time of discharge. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 690		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete comprehensive analysis/assessment for potential causal factors/root cause to identify and implement individualized interventions and failed	2 830	Corrected - 3/22/2024	3/17/24

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 to revise the care plan with identified interventions to prevent and/or mitigate the risk of falls or falls with serious injury for 1 of 3 residents (R7) reviewed for falls. Finding include: R7's admission record identified she was admitted to the facility on 7/20/23 and had the following diagnoses: diabetes, urinary incontinence, osteoporosis, difficulty in walking, reduced mobility, history of falls, sleepwalking, muscle weakness. R7's quarterly Minimum Data Set (MDS) dated 7/26/23, indicated staff completed R7's cognition assessment that identified short and long term memory were "ok" and had some difficulty in making decisions regarding activities of daily life. MDS further identified R7 was independent with activities of daily living including those involving mobility, however did have functional impairment of one upper extremity. Since the last assessment period R7 had two falls without injury and two falls with injury that was not major. R7's care plan, initiated 7/20/23, identified R7 has a history of falls related to intervertebral disc degeneration of lumbar region, osteoporosis with history of pathological fracture, reduced mobility, repeated falls resulting in fracture, and mild cataracts. Interventions included the following: -Physical therapy (PT) to evaluate and treat as ordered or as needed (dated 7/20/23). R7's activity of daily living care plan dated 8/29/23, identified R7 was independent with ambulation with the use of a front wheeled walker. R7's fall incident report dated 7/23/23 at 5:00	2 830		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 a.m., indicated R7 had an unwitnessed fall and was found on the bathroom floor which had a small amount of urine on it. R4 said she slipped. Immediate intervention was to educate R7 to use the call light. R7's record did not include a comprehensive analysis of potential modifiable causal factors. R7's care plan was not updated until 8/10/23, with the intervention that directed Non-slip footwear when ambulating. R7's fall incident report dated 8/23/23 at 3:30 a.m., indicated R7 had an unwitnessed fall, she was found on the floor next to her bed with bedside table flipped over. R7 hit left her hand on table when it fell which resulted in 2nd and 3rd finger deformity and pain rating of 10/10 on a 0-10 numeric pain scale. R7 was sent to the emergency room for evaluation and diagnosed with fracture of phalanx (bones in hand) left hand. Immediate intervention R7 was educated to call for assistance prior to ambulating; the incident report did not identify R7 had been ambulating when the bedside table was flipped over. R7's record did not include a comprehensive analysis of potential causal factors and probable root cause to ascertain appropriate individualized interventions to prevent and/or mitigate the risk of re-current falls. However, R7's care plan was updated on 8/25/23, with interventions that directed "The resident needs a safe environment with a clear path to the restroom free of clutter, glare-free night light, and a working, reachable call light" The record did not identify why these interventions were implemented in the absence of a causal analysis. R7's fall incident report dated 8/26/23 at 5:16 a.m. indicated R7 had an unwitnessed fall, she was found on the floor in the bathroom. R7 said she slid and fell with no injuries noted. R7's	2 830		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 record did not include a comprehensive analysis of potential causal factors and probable root cause to ascertain appropriate individualized interventions to prevent and/or mitigate the risk of re-current falls. Additionally, not evident care plan interventions for falls reevaluated for effectiveness nor evident new interventions were developed and implemented. R7's fall incident report dated 9/14/23 at 4:55 a.m., indicated R7 had an unwitnessed fall; R7 reported sliding off her bed to the floor. She obtained a skin tear to her left elbow and an abrasion to her left knee. Fall report identified immediate intervention to re-educated R7 to use the call light if she needs help. R7's record did not include a comprehensive analysis of potential causal factors and probable root cause. R7's record identified her fall care plan was not revised until 9/19/23 with fall interventions, however R7's record did not specify the rational for the interventions in the absence of a comprehensive analysis that identified causal factors/root cause. Interventions included; -Keep environment as consistent as possible due to potential visual issues (dated 9/19/23). -Large non-skid strips on front of resident's bed (dated 9/19/23). -Monitor resident for any reports of sleep walking. If found sleep walking assist resident back to bed in a safe manor (dated 9/19/23). R7's care plan was not revised/updated after 9/19/23, despite subsequent falls on 9/21/23, 9/27/23, 10/29/23, and 12/2/23. R7's fall incident report dated 9/21/23 at 2:00 a.m., indicated R7 had an unwitnessed fall; R7 had slipped off her bed. She had gotten up off the floor independently and was walking out to get	2 830		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 staff. R7 indicated she landed on the right knee and obtained a small abrasion to the right knee. Immediate intervention was to educate R7 to use the call light. Fall follow up notes indicate larger gripper strips were added in front of the bed to allow for better coverage for her feet. The report indicated the care plan was reviewed and updated, however, the care plan had previously been revised on 9/19/23. Additionally not evident a comprehensive causal analysis was completed. R7's fall incident report dated 9/27/23 at 2:30 a.m., indicated R7 had an unwitnessed fall out of bed. R7 obtained a bruise on top of her scalp from the fall. Immediate intervention was to educate R7 to use call light for assistance before getting out of bed. R7 asked for a body pillow so she wouldn't fall out of bed and would be reported to the next shift. R7's record did not include a comprehensive analysis of potential causal factors and probable root cause to ascertain appropriate individualized interventions to prevent and/or mitigate the risk of re-current falls. Further not evident the care plan was updated to identify R7's request for a body pillow to prevent falling out of bed or address why R7's request for a body pillow was not implemented. R7's fall incident report dated 10/29/23 at 1:30 a.m., indicated R7 had an unwitnessed fall from bed. R7 had put on her call light to alert staff of the fall. R7 obtained a skin tear to the right knee from the fall. Immediate action taken was to encourage R7 to ask for assistance right away. Fall follow up notes indicate care plan was reviewed, R7 not injured. Will "monitor for an increase in falls and numerous interventions have been put into place". R7's record lacked clarification of a comprehensive fall analysis, identification of a root cause, and no revisions	2 830		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 were evident to R7's care plan. R7's fall incident report dated 12/2/23 at 3:25 p.m., indicated R7's roommate reported R7 rolled out of bed. R7 indicated she was seated at the edge of the bed, slipped, and landed on her buttocks. No injuries noted. Immediate action taken indicated nursing order to monitor R7. Fall follow up notes indicated resident likes to sit on the edge of the bed multiple times a day, discussion was had about possible changes to a lipped [curved] mattress but R7 is independent with bed mobility and the change would limit her abilities. No change to care plan. R7's record did not include further analysis for interventions to prevent R7 from sliding out of bed despite documented falls from bed on 9/14/23, 9/21/23, 9/27/23, 10/29/23, and 12/2/23. During observation and interview on 2/27/24 at 3:45 p.m., R7 was noted to be sitting on the edge of her bed. Black gripper strips were in place in front of her bed and in the bathroom. A body pillow as not observed in R7's room. R7 stated she could walk with a walker independently and did not need help from staff. R7 explained she had fallen numerous times and most of her falls were from rolling out of bed. R7 had requested a body pillow to help her from rolling out, but she had not ever been given one. She was not sure why a body pillow was not provided. During an interview on 2/28/24, at 9:15 a.m., nursing assistant (NA)-A stated R7 walked independently with a walker and sometimes used the call light. NA-A indicated R7 had numerous falls and was able to get herself off the floor. Most of R7's falls happened at night. most of her falls happened at night. R7 could get herself off the	2 830		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 floor in which most of the occurred at night. NA-A explained to prevent R7 from falling grip strips were placed by her bed and staff encourage her to use her call light for assistance. During an interview on 2/28/24, at 3:30 p.m., director of nursing (DON) stated, with a fall the nurse should review everything that happened and put interventions in place. Falls were then discussed at interdisciplinary team meeting (IDT) but could use some improvements in fall prevention program. DON verified R7's medical record lacked some immediate interventions, completion of comprehensive fall assessment, root causes were not identified for each fall, some lacked care plan revisions with appropriate interventions, and interventions were not monitored for effectiveness. Review of Facility policy titled, "Falls, Clinical Protocol", last revised March 2018, identified the staff and practitioner will review each resident's risk factors for falling and document in the medical record. After a first fall, the staff (and physician, if possible) should watch the individual rise from the chair without using his or her arms, walk several places, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur. The staff will evaluate, and document falls that occur while the individual is in the facility. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause. If the individual continues to	2 830		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 fall, the staff and physician will re-evaluate the situation and reconsider possible reason for the resident falling (instead of, or in addition to those that have already been identified) and consider the current interventions. As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes. Review of the facility policy titled, "Assessing Falls and Their Causes", last revised March 2018 identified: Residents must be assessed upon admission and regularly afterward for potential risk factors must be addressed promptly. Identifying causes of a fall or fall risks: -Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. -Evaluate chains of events or circumstances preceding a recent fall. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. -as indicated, the attending physician will examine the resident or may initiate testing to try to identify causes. -Consult with the attending physician or medical director to confirm specific cases and among multiple possibilities. When possible, document the basis for identifying specific factors as the cause. -If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g., workup already done, finding a cause would not change the approach, etc.) When a resident falls, the following information should be recorded in the resident's medical record: the condition in which the resident was	2 830		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 found; assessment data; interventions, first aid, or treatment administered; notification of the physician and family as indicated; completion of a fall risk assessment; appropriate interventions taken to prevent future falls; signature and title of the person recording the data. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed	21925		3/17/24

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 14 of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a room change notice including the reason for the room change for 3 of 3 residents (R10, R11, R12) reviewed for room change. Findings include: R10's admission Minimum Data Set (MDS) dated 2/16/24, identified R10 was admitted to the facility on 2/9/24, and had intact cognition. During an interview on 2/27/24 at 12:40 p.m., R10 indicated the previous day (2/26/24) she was coming out of her bathroom and an unknown facility staff person was packing up her stuff. R10 stated the unknown staff person did not know why she was being moved to another room but was told to move her stuff. R10 stated she had just been moved to that room the day before (2/25/24) from her original room she was admitted to and did not know why she was being moved again. R10 verified she had changed rooms twice since her admission without notice or	21925	Corrected - 3/22/2024	

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 15 a reason why. R10 stated she asked the social worker (SW) and was told a new admission needed the room more than she did. R10 stated, "I was very upset because all my stuff was being touched and moved without any notice. I know my rights, and I feel like they didn't respect my rights." R10 denied ever receiving a documented notice of the move or a reason for the move. In review of 10's record it was not evident R10 was provided with a written notice for a room change. R11's admission MDS dated 2/1/23, identified R11 was admitted to the facility on 1/26/24, and had intact cognition. During an interview on 2/28/24 at 10:35 a.m., R11 indicated he had three room changes since his admission (1/26/24). Further indicated he did not receive any notice or anything in writing for any of the room changes. On one morning of the room change he was returning to his room from the dining room when he saw his personal belongings being wheeled down the hallway. R11 had to ask the staff were taking his things. R11 stated, "I asked why [the room change] and they told me they talked about it at IDT [interdisciplinary team meeting] and you are moving but was never given a straight answer why". R11 denied ever receiving a documented notice of the move or a reason for the move. In review of 11's record it was not evident R10 was provided with a written notice for a room change. R12's admission MDS dated 2/13/24, identified R12 was admitted to the facility on 2//7/24, and had intact cognition.	21925		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 16 During an interview on 2/28/24 at 10:58 a.m., R12 indicated he had changed rooms twice since his admission on 2/8/24. One room change was his request, but the facility moved him to a different room again with only a 30-minute notice and he still did not know why he had to move. R12 denied ever receiving a documented notice of the move or a reason for the move. In review of 11's record it was not evident R10 was provided with a written notice for a room change. During an interview on 2/28/24 at 11:10 a.m., the facility social worker (SW) indicated their process was to have a conversation with the resident but would not give a formal written notice and did not document anything in the resident's medical record. SW stated "I know we should be [giving a written notice] but we don't". During an interview on 2/28/24 at 4:01 p.m., the director of nursing (DON) indicated she did not know if the residents were notified of room changes. Further indicated it would be up to the SW to notify the residents. Facility policy titled, Resident Room Change Policy and Procedure dated 2021, indicates the facility will maintain a room changes process that complies with the regulatory requirements and maintains the resident's personal autonomy, dignity, quality of life, and quality of care. The facility shall promptly notify the resident and the resident representative, if any, when there is a change in room or roommate assignment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or	21925		

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 _____	02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 17 designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a room change. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/27/24 and 2/28/24 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H54001195C (MN00100462); H54001194C (MN00099434); H54001190C (MN00099255); H54001192C (MN00098202); H54001189C (MN00098199); H54001191C (MN00096437); H54001193C (MN00096312); H54001197C (MN00095237); H54001196C (MN00093563); and H54001326C (MN00100600) with a deficiency cited at F559, F625, F661, and F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. .	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	F 559		3/17/24

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

Electronically Signed | 03/17/2024

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 _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 559	Continued From page 1 §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a room change notice including the reason for the room change for 3 of 3 residents (R10, R11, R12) reviewed for room change. Findings include: R10's admission Minimum Data Set (MDS) dated 2/16/24, identified R10 was admitted to the facility on 2/9/24, and had intact cognition. During an interview on 2/27/24 at 12:40 p.m., R10 indicated the previous day (2/26/24) she was coming out of her bathroom and an unknown facility staff person was packing up her stuff. R10 stated the unknown staff person did not know why she was being moved to another room but was told to move her stuff. R10 stated she had just been moved to that room the day before (2/25/24) from her original room she was admitted to and did not know why she was being moved again. R10 verified she had changed rooms twice since her admission without notice or a reason why. R10 stated she asked the social worker (SW) and was told a new admission needed the room more than she did. R10 stated,	F 559	F 559D - Corrected 3/22/2024 Choose/Be notified of Room/Roommate Change: It is the facility □s intent to comply with the regulation to ensure that all residents be notified of room changes before they occur. has determined that all residents have the potential to be affected. All resident records were reviewed to ensure that any discharged residents were informed of their right to hold their bed related to a transfer to the hospital or a leave of absence. Resident 10 was discharged from the facility on 3/12/24 and had resided in the same room until discharged from the facility. Resident #11 Has not had any further room changes, Discharged on 03/14/2024 Room change policy and procedure was reviewed and up-dated to reflect the requirements of advance notice of room changes and the residents right to refuse, A notification form was initiated with all required information on it to ensure the resident has the right to appeal the decision. The form is signed by 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 _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 559	Continued From page 2 "I was very upset because all my stuff was being touched and moved without any notice. I know my rights, and I feel like they didn't respect my rights." R10 denied ever receiving a documented notice of the move or a reason for the move. In review of 10's record it was not evident R10 was provided with a written notice for a room change. R11's admission MDS dated 2/1/23, identified R11 was admitted to the facility on 1/26/24, and had intact cognition. During an interview on 2/28/24 at 10:35 a.m., R11 indicated he had three room changes since his admission (1/26/24). Further indicated he did not receive any notice or anything in writing for any of the room changes. On one morning of the room change he was returning to his room from the dining room when he saw his personal belongings being wheeled down the hallway. R11 had to ask the staff were taking his things. R11 stated, "I asked why [the room change] and they told me they talked about it at IDT [interdisciplinary team meeting] and you are moving but was never given a straight answer why". R11 denied ever receiving a documented notice of the move or a reason for the move. In review of 11's record it was not evident R10 was provided with a written notice for a room change. R12's admission MDS dated 2/13/24, identified R12 was admitted to the facility on 2//7/24, and had intact cognition. During an interview on 2/28/24 at 10:58 a.m., R12	F 559	resident and placed in their records for compliance. Managers, Nursing team members were educated on the proper procedure on when residents can be moved to a different room whether it be their chose according to the policy. Forms will be kept for daily, weekly, and monthly review for 12 consecutive weeks (3 months) with results to the Quality Assurance meeting until such time consistent substantial compliance has been met. Attachment: Room Change form Policy and Procedure Staff Training form	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 559	Continued From page 3 indicated he had changed rooms twice since his admission on 2/8/24. One room change was his request, but the facility moved him to a different room again with only a 30-minute notice and he still did not know why he had to move. R12 denied ever receiving a documented notice of the move or a reason for the move. In review of 11's record it was not evident R10 was provided with a written notice for a room change. During an interview on 2/28/24 at 11:10 a.m., the facility social worker (SW) indicated their process was to have a conversation with the resident but would not give a formal written notice and did not document anything in the resident's medical record. SW stated "I know we should be [giving a written notice] but we don't". During an interview on 2/28/24 at 4:01 p.m., the director of nursing (DON) indicated she did not know if the residents were notified of room changes. Further indicated it would be up to the SW to notify the residents. Facility policy titled, Resident Room Change Policy and Procedure dated 2021, indicates the facility will maintain a room changes process that complies with the regulatory requirements and maintains the resident's personal autonomy, dignity, quality of life, and quality of care. The facility shall promptly notify the resident and the resident representative, if any, when there is a change in room or roommate assignment.	F 559		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		3/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 4 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide notification to the resident and/or resident representative of the facility's bed hold policy at the time of emergency transfer and hospitalization for 1 of 1 (R2) residents reviewed for hospitalization. Findings include:	F 625	F625D - Corrected 3/22/2024 Notice of Bed hold before/after transfer Resident #3 Passed away on 3/3/24 It is the facilities intent to comply with the regulation to ensure that Notice of Bedhold be provided at the time of discharge. The facility has determined that all residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 5 R2's admission Minimal Data Set (MDS) dated 12/10/23, indicated R2 had a diagnoses of end stage renal disease, fluid overload, and dependence on renal dialysis. R2's care plan dated 8/19/22, indicated R2 was independent with activities of daily living (ADLs) such as ambulation, dressing, toileting, and grooming. Further, care plan identified R2 as exhibiting behaviors such as noncompliance with medically needed treatment. R2's Census List dated 2/28/24, revealed R2 had been transferred to the hospital on 1/29/24, 1/15/24, 1/1/24, 12/19/23, 11/24/23, 10/6/23, 9/7/23, 8/19/23, and 7/18/23. R2's progress notes identified R2 was transferred to the hospital nine times between 7/19/23 through 1/29/24. In review of R2's record it was not evident the facility provided the bed hold policy at the time of each of the nine transfers or followed up with R2 and/or his resident representative while R2 was hospitalized. -On 1/29/24, R2 left by ambulance to the emergency room (ER). -On 1/15/24, R2 was sent to the ER for evaluation. -On 1/1/24, R2 was admitted to the hospital. -On 12/19/23, R2 was sent to the ER for evaluation. -On 11/24/23, R2 was transferred to the hospital. -On 10/6/23, R2 was sent to the hospital. -On 9/7/23, R2 was sent to the ER. -On 8/19/23, R2 transferred to the ER for evaluation. -On 7/19/23, R2 transferred to the ER. During an interview, on 2/28/24 at 11:38 a.m.,	F 625	All resident records were reviewed for notification of bed hold policy. An In-service education was provided by the Director of Nursing with all Managers and licensed nursing staff, addressing the facilities notification of bed hold policy and that resident and/or representative needs to informed of transfers and form signed/verbal hold. Residents are informed upon admission of their right to hold their bed in the event that they need to be transferred to another location for treatment. A Bed Hold form was put into place on 2.29.24 which contains the information on their right to hold their bed. All signed bed hold forms will be uploaded into the residents electronic records. Forms will be kept for daily, weekly, and monthly review for 12 consecutive weeks (3 months) with results to the Quality Assurance meeting until such time consistent substantial compliance has been met. Since the survey 2 residents have had a medical related transfer to the hospital and forms were completed as required. Results will be reviewed by the QAA members monthly and quarterly for 4 months until compliance has been maintained. Attachment: Bedhold form Bedhold P&P In-service training form	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 6 licensed practical nurse (LPN)-A stated staff were expected to complete a bed hold form prior to transferring a resident to the hospital if able, if the transfer were an emergency transfer staff would be expected to call the hospital for an update and obtain a verbal bed hold from the resident or representative. Further, LPN-A stated documentation of completed bed hold would be scanned into the resident's medical record or in a progress note. On 2/28/24 at 2:45 p.m., social services (SS)-A stated facility policy related to bed holds were every resident was provided a copy of the policy upon admission and prior to every transfer the resident would be given another copy and would sign the document, unless it was an emergency transfer then staff would obtain a verbal bed hold. Further, SS-A confirmed R2 was not given a bed hold for hospitalizations due to the condition and capacity he was in at the time of transfers. SS-A stated staff would be expected to document in the resident's medical record with a progress note related to the bed hold being obtained or any follow up with the resident or representative. On 2/28/24 at 4:01 p.m., director of nursing (DON) stated during emergency transfers a bed hold form would not be obtained and the facility would automatically hold their bed until they would return. Review of facility policy titled Facility Bed-Hold and Return to Facility Policy and Procedure dated 2020, revealed before a resident was transferred to a hospital, the facility must provide written information to the resident or the resident representative regarding the facility's bed-hold and return policy. Further, at the time of transfer	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 7 of a resident for hospitalization, the facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy and the reserve bed payment policy.	F 625		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 661		3/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 8 Based on interview and document review the facility failed to ensure a comprehensive discharge summary that included all four components (recapitulation of stay, final summary of resident's status, medication reconciliation, and post-discharge plan) as required for 2 of 2 residents (R2, R9) who were discharged to the community. Findings include: R1's admission Minimal Data Set (MDS) dated 10/31/23, indicated R1 had diagnoses which included alcohol induced acute pancreatitis, alcoholic hepatitis, and was cognitively intact. Further, MDS revealed R1 did not exhibit any behaviors and wished to discharge to the community. R1's progress note dated 11/20/23, indicated R1 was going to discharge to her grandmother's home on this day, and was going to be transported by her aunt until R1 was accepted into an inpatient chemical dependency facility. R1's Social Services- Discharge Summary dated 11/20/23, revealed R1 discharge to community with family, and was working on possible admission to an inpatient chemical dependency facility on 11/27/23. Recapitulation of stay was included, medication/treatment instructions sent with resident, and medications were sent with resident. R1's discharge summary lacked evidence of a final summary of R1's status. R9's significant change MDS dated 7/12/23, indicated R9 had diagnoses which included acute respiratory failure, major depressive disorder, psychoactive substance abuse and was	F 661	F661 D - Corrected 3/22/2024 Discharge Summary It is the facility□s intent to comply with regulation to ensure that all resident discharges are completed and reviewed with residents prior to discharge. The facility has determined that all residents have the potential to be affected. Facility updated the Discharge Summary form in PCC on 3.4.24 to ensure that all components of the regulation are being followed. The Summary is started when discharge is known, all resident information is added and the completed form is reviewed and signed by the resident to ensure that they informed of any appointments, medications, and their needs during their stay. If the resident is discharged from the facility a copy of the discharge summary is sent with them to the receiving facility to ensure the continuation of care for them. All Discharge summary□s will be reviewed by prior to resident□s discharge to ensure all aspects are met, The signed summary will be uploaded into residents record. Discharge summary completion will be monitored weekly for 4 weeks than monthly for 3 months with results reviewed by the QAA committee until compliance is maintained. 2 Residents have discharged from the facility and each resident reviewed and signed their discharge summary with all requirements met. Attachment:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 9 cognitively intact. Further, MDS revealed R9 did not exhibit any behaviors and wished to discharge to the community. R9's progress note dated 7/20/23, indicated R9 discharge to home on this day. R9 took all personal belongings. R9 would not allow nurse to review discharge instructions or medications. R9 left the facility without taking his discharge packet and without taking medications that the nurse had packaged for him to take home. R9's record lacked evidence of a discharge summary being completed which included: recapitulation of stay, final summary of resident's status, and post-discharge plan. On 2/28/24 at 2:45 p.m., social services (SS)-A stated the facility did not have a policy or procedure for completing a discharge summary, but SS-A or director of nursing (DON) were expected to complete the assessment in the resident's medical record upon resident discharge. SS-A stated the discharge summary would include a recapitulation of resident's stay, services, active diagnoses, if the provider was provided a copy, medications, and post-discharge plan and location. Further, SS-A stated she has 30 days following the resident's discharge to complete the assessment. SS-A confirmed R9's discharge summary completed as the assessment was not in his medical record. On 2/28/24 at 4:01 p.m., DON stated SS-A would be expected to complete the discharge summary form in the resident's record upon discharging the facility and DON would be responsible for completing the recapitulation portion. DON stated she was not aware of the final summary of	F 661	Blank Discharge Summary form from PCC Need Discharge Summary P&P Training Record	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 10 resident's status as part of the four required components of the discharge summary. Requested facility policy related to discharge summary, facility did not have a policy at time of exit.	F 661		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete comprehensive analysis/assessment for potential causal factors/root cause to identify and implement individualized interventions and failed to revise the care plan with identified interventions to prevent and/or mitigate the risk of falls or falls with serious injury for 1 of 3 residents (R7) reviewed for falls. Finding include: R7's admission record identified she was admitted to the facility on 7/20/23 and had the following diagnoses: diabetes, urinary incontinence, osteoporosis, difficulty in walking, reduced mobility, history of falls, sleepwalking, muscle weakness.	F 689	F689 D - Corrected 3/22/2024 Free of Accident Hazards/ Supervision/Devices The facility has determined that all residents have the potential to be affected. Resident #1has not had a fall since 12/2/2023 and care plan interventions were reviewed at the last fall and has shown to be effective. Resident was given a body pillow per her request on 03/12/24. Despite multiple conversations resident never expressed that she wanted a body pillow for her bed when follow-up investigation was completed. Policy and Procedure was reviewed with staff with added education on what types of interventions need to be completed	3/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 R7's quarterly Minimum Data Set (MDS) dated 7/26/23, indicated staff completed R7's cognition assessment that identified short and long term memory were "ok" and had some difficulty in making decisions regarding activities of daily life. MDS further identified R7 was independent with activities of daily living including those involving mobility, however did have functional impairment of one upper extremity. Since the last assessment period R7 had two falls without injury and two falls with injury that was not major. R7's care plan, initiated 7/20/23, identified R7 has a history of falls related to intervertebral disc degeneration of lumbar region, osteoporosis with history of pathological fracture, reduced mobility, repeated falls resulting in fracture, and mild cataracts. Interventions included the following: -Physical therapy (PT) to evaluate and treat as ordered or as needed (dated 7/20/23). R7's activity of daily living care plan dated 8/29/23, identified R7 was independent with ambulation with the use of a front wheeled walker. R7's fall incident report dated 7/23/23 at 5:00 a.m., indicated R7 had an unwitnessed fall and was found on the bathroom floor which had a small amount of urine on it. R4 said she slipped. Immediate intervention was to educate R7 to use the call light. R7's record did not include a comprehensive analysis of potential modifiable causal factors. R7's care plan was not updated until 8/10/23, with the intervention that directed Non-slip footwear when ambulating. R7's fall incident report dated 8/23/23 at 3:30 a.m., indicated R7 had an unwitnessed fall, she was found on the floor next to her bed with	F 689	immediately upon a resident fall with emphasis on resident supervision. QAA information system reviewed and audit tools and forms put into place to allow an ongoing monitoring of resident falls and interventions put into place for effectiveness. Resident falls are discussed at Inter-disciplinary Team members m also attended by the Therapy department. Details and interventions are discussed to which are determine if any new interventions are needed. Investigation Follow-up form will be completed with any falls which details the description of the situation, summary and recommendations to be done. This information will be present to QAA committee to determine if on-going follow-up will be needed. Investigation Follow-ups will be reviewed daily, weekly and monthly for 3 months with results reviewed by the QAA committee until compliance is maintained. Attachments: Staff Training sheet Policy and Procedure for Assessing Falls and their Causes Investigation Follow-up form Falls Prevention-Potential Interventions Incident Report QA/CQI Log	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 bedside table flipped over. R7 hit left her hand on table when it fell which resulted in 2nd and 3rd finger deformity and pain rating of 10/10 on a 0-10 numeric pain scale. R7 was sent to the emergency room for evaluation and diagnosed with fracture of phalanx (bones in hand) left hand. Immediate intervention R7 was educated to call for assistance prior to ambulating; the incident report did not identify R7 had been ambulating when the bedside table was flipped over. R7's record did not include a comprehensive analysis of potential causal factors and probable root cause to ascertain appropriate individualized interventions to prevent and/or mitigate the risk of re-current falls. However, R7's care plan was updated on 8/25/23, with interventions that directed "The resident needs a safe environment with a clear path to the restroom free of clutter, glare-free night light, and a working, reachable call light" The record did not identify why these interventions were implemented in the absence of a causal analysis. R7's fall incident report dated 8/26/23 at 5:16 a.m. indicated R7 had an unwitnessed fall, she was found on the floor in the bathroom. R7 said she slid and fell with no injuries noted. R7's record did not include a comprehensive analysis of potential causal factors and probable root cause to ascertain appropriate individualized interventions to prevent and/or mitigate the risk of re-current falls. Additionally, not evident care plan interventions for falls reevaluated for effectiveness nor evident new interventions were developed and implemented. R7's fall incident report dated 9/14/23 at 4:55 a.m., indicated R7 had an unwitnessed fall; R7 reported sliding off her bed to the floor. She	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 obtained a skin tear to her left elbow and an abrasion to her left knee. Fall report identified immediate intervention to re-educated R7 to use the call light if she needs help. R7's record did not include a comprehensive analysis of potential causal factors and probable root cause. R7's record identified her fall care plan was not revised until 9/19/23 with fall interventions, however R7's record did not specify the rational for the interventions in the absence of a comprehensive analysis that identified causal factors/root cause. Interventions included; -Keep environment as consistent as possible due to potential visual issues (dated 9/19/23). -Large non-skid strips on front of resident's bed (dated 9/19/23). -Monitor resident for any reports of sleep walking. If found sleep walking assist resident back to bed in a safe manor (dated 9/19/23). R7's care plan was not revised/updated after 9/19/23, despite subsequent falls on 9/21/23, 9/27/23, 10/29/23, and 12/2/23. R7's fall incident report dated 9/21/23 at 2:00 a.m., indicated R7 had an unwitnessed fall; R7 had slipped off her bed. She had gotten up off the floor independently and was walking out to get staff. R7 indicated she landed on the right knee and obtained a small abrasion to the right knee. Immediate intervention was to educate R7 to use the call light. Fall follow up notes indicate larger gripper strips were added in front of the bed to allow for better coverage for her feet. The report indicated the care plan was reviewed and updated, however, the care plan had previously been revised on 9/19/23. Additionally not evident a comprehensive causal analysis was completed.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 R7's fall incident report dated 9/27/23 at 2:30 a.m., indicated R7 had an unwitnessed fall out of bed. R7 obtained a bruise on top of her scalp from the fall. Immediate intervention was to educate R7 to use call light for assistance before getting out of bed. R7 asked for a body pillow so she wouldn't fall out of bed and would be reported to the next shift. R7's record did not include a comprehensive analysis of potential causal factors and probable root cause to ascertain appropriate individualized interventions to prevent and/or mitigate the risk of re-current falls. Further not evident the care plan was updated to identify R7's request for a body pillow to prevent falling out of bed or address why R7's request for a body pillow was not implemented. R7's fall incident report dated 10/29/23 at 1:30 a.m., indicated R7 had an unwitnessed fall from bed. R7 had put on her call light to alert staff of the fall. R7 obtained a skin tear to the right knee from the fall. Immediate action taken was to encourage R7 to ask for assistance right away. Fall follow up notes indicate care plan was reviewed, R7 not injured. Will "monitor for an increase in falls and numerous interventions have been put into place". R7's record lacked clarification of a comprehensive fall analysis, identification of a root cause, and no revisions were evident to R7's care plan. R7's fall incident report dated 12/2/23 at 3:25 p.m., indicated R7's roommate reported R7 rolled out of bed. R7 indicated she was seated at the edge of the bed, slipped, and landed on her buttocks. No injuries noted. Immediate action taken indicated nursing order to monitor R7. Fall follow up notes indicated resident likes to sit on the edge of the bed multiple times a day,	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 discussion was had about possible changes to a lipped [curved] mattress but R7 is independent with bed mobility and the change would limit her abilities. No change to care plan. R7's record did not include further analysis for interventions to prevent R7 from sliding out of bed despite documented falls from bed on 9/14/23, 9/21/23, 9/27/23, 10/29/23, and 12/2/23. During observation and interview on 2/27/24 at 3:45 p.m., R7 was noted to be sitting on the edge of her bed. Black gripper strips were in place in front of her bed and in the bathroom. A body pillow as not observed in R7's room. R7 stated she could walk with a walker independently and did not need help from staff. R7 explained she had fallen numerous times and most of her falls were from rolling out of bed. R7 had requested a body pillow to help her from rolling out, but she had not ever been given one. She was not sure why a body pillow was not provided. During an interview on 2/28/24, at 9:15 a.m., nursing assistant (NA)-A stated R7 walked independently with a walker and sometimes used the call light. NA-A indicated R7 had numerous falls and was able to get herself off the floor. Most of R7's falls happened at night. most of her falls happened at night. R7 could get herself off the floor in which most of the occurred at night. NA-A explained to prevent R7 from falling grip strips were placed by her bed and staff encourage her to use her call light for assistance. During an interview on 2/28/24, at 3:30 p.m., director of nursing (DON) stated, with a fall the nurse should review everything that happened and put interventions in place. Falls were then	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 discussed at interdisciplinary team meeting (IDT) but could use some improvements in fall prevention program. DON verified R7's medical record lacked some immediate interventions, completion of comprehensive fall assessment, root causes were not identified for each fall, some lacked care plan revisions with appropriate interventions, and interventions were not monitored for effectiveness. Review of Facility policy titled, "Falls, Clinical Protocol", last revised March 2018, identified the staff and practitioner will review each resident's risk factors for falling and document in the medical record. After a first fall, the staff (and physician, if possible) should watch the individual rise from the chair without using his or her arms, walk several places, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur. The staff will evaluate, and document falls that occur while the individual is in the facility. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reason for the resident falling (instead of, or in addition to those that have already been identified) and consider the current interventions. As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17 Review of the facility policy titled, "Assessing Falls and Their Causes", last revised March 2018 identified: Residents must be assessed upon admission and regularly afterward for potential risk factors must be addressed promptly. Identifying causes of a fall or fall risks: -Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. -Evaluate chains of events or circumstances preceding a recent fall. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. -as indicated, the attending physician will examine the resident or may initiate testing to try to identify causes. -Consult with the attending physician or medical director to confirm specific cases and among multiple possibilities. When possible, document the basis for identifying specific factors as the cause. -If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g., workup already done, finding a cause would not change the approach, etc.) When a resident falls, the following information should be recorded in the resident's medical record: the condition in which the resident was found; assessment data; interventions, first aid, or treatment administered; notification of the physician and family as indicated; completion of a fall risk assessment; appropriate interventions taken to prevent future falls; signature and title of the person recording the data.	F 689		