DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2026

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

RE: CCN: 245400
Cycle Start Date: April 30, 2026

Dear Administrator:

On June 5, 2026, we notified you a remedy was imposed. On June 16, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 1, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 20, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 5, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 20, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 1, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

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June 17, 2026

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

Re: Reinspection Results
Event ID: 230171-H2

Dear Administrator:

On June 9, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 30, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

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May 13, 2026

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

RE: CCN:245400
Cycle Start Date: April 30, 2026

Dear Administrator:

On April 30, 2026, a survey was completed at your facility by the Minnesota Department of Health 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, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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 July 30, 2026 (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 October 30, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

DEPARTMENT OF HEALTH

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May 13, 2026

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

Re: Event ID: 230171-H1

Dear Administrator:

The above facility survey was completed on April 30, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO RESTORATIVE CARE CENTER	660 MAPLE STREET , WABASSO, Minnesota, 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
F0000	INITIAL COMMENTS On 4/28/26, 4/29/26, and 4/30/26, 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: H54001527C (2986920), H54001453C (2984647), H54001526C (2982999), and H54009440C (2962737) with deficiencies issued at F609, F689, F880, and F697. 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.	F0000		05/15/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult	F0609	1. Corrective action for affected resident: Resident R2's injury was reviewed, and all documentation and follow-up were completed. 2. Identification of other residents at risk: The DON audited incidents and injuries from the previous 30 days to identify any additional reporting concerns, none were identified. 3. Systemic changes implemented: Staff were re-educated on abuse reporting requirements, injuries of unknown origin, and 2-hour reporting timelines by DON/designee with staff being educated by May 28, 2026. Any staff not receiving education by May 28, 2026 will not be allowed to work until they have been educated. Incident reports will be reviewed daily Mon-Friday	06/01/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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

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F0609 SS = D	Continued from page 1 protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to report an injury of unknown origin within the two-hour time period for reporting for 1 of 2 residents (R2) who had an injury of unknown origin of the right tibia (shin bone) and fibula (calf bone). Findings include: Findings include: R2's face sheet dated 4/28/26, identified diagnoses of paraplegia (paralysis to lower half of body), unspecified fracture of shaft of right tibia subsequent encounter for closed fracture with routine healing, unspecified fracture of shaft of right fibula subsequent encounter for closed fracture with routine healing, reduced mobility, weakness, adult failure to thrive neuralgia (severe nerve pain) and neuritis (inflammation of nerve). R2's comprehensive Minimum Data Set (MDS) dated 4/16/26, identified R2 had no cognitive impairment. R2 had impairment to both sides of lower extremities, required staff assistance with dressing, turning, and transferring surfaces. R2 used a wheelchair for mobility. R2's activities of daily living (ADL) care plan dated 5/5/25, identified R2 was able to use a wheelchair independently in the facility, and transferred with total dependence of two with a mechanical lift. Bedrest with air mattress, up to chair for one hour per shift. R2's progress note dated 4/14/26 at 8:05 a.m., identified the night nurse reported that R2 had developed edema (swelling) on the right lower leg. R2 was assessed and denied hitting his leg on anything. Physician was informed of the situation and ordered ACE wraps to begin with. R2 should be	F0609	Continued from page 1 with incidents occurring over the weekend being reviewed on Monday as part of the daily clinical stand up for any incidents that rise to the level of being reported. If any incidents found meeting the standard of reporting will be reported upon discovery and immediate education given to the staff member not notifying the abuse prevention coordinator. 4.Quality Assurance and Performance Improvement Program: QAPI was held on 5/18/2026 to review survey results and approve the education plan. Results of audits will be reviewed through the QAPI process for ongoing compliance monthly x 3 months. 5. Facility alleges substantial compliance on 6/1/26	06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0609 SS = D	Continued from page 2 observed and if the foot does not get better, get an x-ray. R2's legs were wrapped and are being observed. R2's progress note dated 4/14/26 at 10:34 p.m., identified the on-call physician was notified due to increased swelling of R2's right lower extremity. Assessment completed with +3 pitting edema, poor capillary refill noted. R2 was sent to the emergency department for further evaluation of suspected fracture. R2's Emergency Department care summary dated 4/15/26, identified R2 presented to emergency department with complaints of right lower extremity swelling and crepitus (crackling, popping or grinding sensation or sound that occurs in joints, bones, or soft tissue). Facility reported swelling started one to two days ago. No recent falls or notable injury to cause this. X-rays identified R2 had an acute oblique longitudinal fracture of the distal tibial shaft with a lateral cortical step-off measuring up to 6 millimeters (mm) (indicating a higher energy injury), he also had a mildly displaced distal fibular shaft fracture all about 10 centimeters (cm) from the ankle. It was reported that R2 accidentally hit his right lower leg in a wheelchair. R2 was splinted and discharged back to facility. R2's progress notes dated 4/15/26 at 2:17 a.m., identified R2 returned from the emergency department with a diagnosis of closed fracture of right tibia and fibula initial encounter. Physician and director of nursing (DON) notified. Will notify power of attorney (POA) in the morning. The State Agency had no incident report submitted pertaining to R2's fractures. During an interview on 4/29/26 at 12:32 p.m., director of nursing (DON) and admissions director (AD)-A present. DON stated the incident was not reported to the State Agency and that she found out that he had fractures around 8:00 a.m., on 4/15/26. AD-A stated the origin of the injury came from the wheelchair when R2 came back to the facility "he told us and it was in the notes from the hospital so it didn't meet criteria to report". If the source of injury was unknown, facility would report two hours from the time it happened. DON stated before R2 went to the hospital he did not know how the injury occurred. When R2 returned from the hospital the paperwork stated that it was from the wheelchair. R2 had a new power wheelchair and had assessments done and passed them so he was able to use the power chair. AD-A stated R2 changed to a different	F0609		06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0609 SS = D	Continued from page 3 story a couple days after he returned from the hospital, reporting the fracture was caused from a transfer. DON stated as soon as R2's story changed she began education with nursing staff. DON had begun watching staff complete mechanical and sit-to-stand lift transfers, "it is a work in progress". DON stated she watched R2 go in and out of the smoking area door as she thought maybe the door shut to hard and got his foot but R2 went in and out without difficulty. R2 was also reassessed by therapy for the power wheelchair. AD-A stated the facility was unable to determine a root cause for the fracture because all the staff that transferred R2 on the days leading up to the incident could not recall R2 bumping his leg, the names of staff he gave worked on 4/11/26 together, only NA-D worked 4/13/26, and they could not nail down a time so it was inconclusive.	F0609		06/01/2026
F0689 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 ensure accurate comprehensive assessments for full body mechanical lift slings according to manufacturer's guidelines to ensure safe transfers for 2 of 2 residents (R2, R4) reviewed for accidents. The manufacturer instructions for Sling Selection Guide dated 5/1/26, indicated sling selection to use with the full body lift was determined by both the resident's height and weight. The guide identified it was very important to use the correct sized sling and make sure it was fitted properly prior to lifting. Size small ranged from 75 pounds (lb.) to 150 lbs. with height from 4 feet (ft) 11 inches (in) to 5 ft 4 in, medium sized ranged from 125 lbs. to 200 lbs. with height range of 5 ft 3 in to 5 ft 8 in, large slings from 175 lbs. to 300 lbs. with height of 5 ft 7 in to 6 ft, extra-large slings were from 275 lbs. to 500 lbs.	F0689	1 Corrective action for affected residents: Resident R4 Discharged AMA. Resident R2 was assessed to ensure proper mechanical lift sling size and type was being used according to manufacturer guidelines. Care plans and transfer documentation were updated. 2.Identification of other residents at risk: The DON audited all residents using mechanical lifts to verify correct sling assessments, sizing, and documentation. Any identified concerns were corrected immediately with care plan and Kardex updated. 3. Systemic changes implemented: Staff received education on mechanical lift safety, proper sling selection, manufacturer guidelines, and documentation requirements. Procedures were implemented to verify sling appropriateness on admission, quarterly, and with any change in condition. The DON or designee will conduct weekly audits for 4 weeks, then monthly for 2 months, to monitor compliance with sling assessments and safe transfer practices. 4. Quality Assurance and Performance Improvement Program: QAPI was held on 5/18/2026 to review survey results and approve the education plan. Results of audits will be reviewed through the QAPI process for ongoing compliance monthly x 3 months.	06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0689 SS = D	Continued from page 4 with height from 5 ft 11 in to 6 ft 4in, extra extra large slings from 350 lbs. to 600 lbs. with height determined as needed. R2's face sheet dated 4/28/26, identified diagnoses of paraplegia (paralysis to lower half of body), unspecified fracture of shaft of right tibia subsequent encounter for closed fracture with routine healing, unspecified fracture of shaft of right fibula subsequent encounter for closed fracture with routine healing, reduced mobility, weakness, and adult failure to thrive. R2's comprehensive Minimum Data Set (MDS) dated 4/16/26, identified R2 had no cognition issues. R2 had impairment to both sides of lower extremities, required staff assistance with dressing, turning, and transferring surfaces. R2 used a wheelchair for mobility. R2 weighed 235 pounds and was 69 inches (5 feet 7.5 inches). R2's activities of daily living (ADL) care plan dated 5/5/25, identified R2 was able to use a wheelchair independently in the facility, and transferred with total dependence of two with a Hoyer (brand of full body mechanical lift). R2's care plan did not identify what size mechanical lift sling to use during transfers. R2's care plan did not identify what size mechanical lift sling to use for transfers. R2's Lift Mobility Status-V1 dated 1/8/26, completed by a registered nurse (RN), identified R2 was not bedfast, could not stand, pivot, or walk. R2 could tolerate a semi-reclined position and R2 will continue to use full lift with two staff assist for transfers. The assessment did not identify heigh, weight, nor the sling size R2 required for transfers. R4 R4's face sheet dated 4/29/26, identified diagnoses of spondylosis (degenerative changes to spine) without myelopathy (spinal cord compression) or radiculopathy (compression of spinal nerve root) lumbar (lower spine) region, muscle weakness, unsteadiness on feet, and spinal stenosis (narrowing of spinal canal). R4's admission MDS dated 4/16/26, identified R4 had no cognition issues. R4 required substantial assistance to roll, sit to lying, lying to sitting, sitting to standing and was dependent on staff to transfer from surfaces. R4 weighed 220 pounds and was 71 inches (5 feet 9 inches).	F0689	Continued from page 4 5. Facility alleges substantial compliance on 6/1/26	06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0689 SS = D	Continued from page 5 R4's Lift Mobility Status-V1 dated 4/12/26, completed by an RN identified R4 was not bedfast, could not stand, pivot, or walk. R4 could tolerate a semi-reclined position, weight was between 376-420 pounds (which was inconsistent with the MDS dated 4/16/26.) and required Hoyer (brand of mechanical lift). Further, the assessment did not identify which size sling R4 required. R4's ADL care plan dated 4/11/26, identified R4 was dependent for transfers. R4's care plan did not identify what size mechanical lift sling R4 required or what device to use for transfers. During an interview on 4/29/26 at 9:34 a.m., nursing assistant (NA)-B stated there were three different sizes for mechanical lift slings depending on how large the person was. On each lift sheet there is a label that says sizes and which one to use is based on weight. NAs choose the size based off that information; NA-B did not articulate height was also required to determine appropriate size. During an interview on 4/29/26 at 10:32 a.m., NA-C stated the nurse would determine sling size. On the sling it would say small, medium, large, or extra-large. NA's could find the information in the care plan. During an interview on 4/29/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated at admission the nurse completed an assessment on resident transfers. Sling sizing goes by resident weight and therapy determines sling size. LPN-A reviewed R4's care plan and verified the care plan did not identify mechanical lift sling size or what type of machine R4 needed to transfer. LPN-A reviewed R2's care plan and verified the care plan did not identify mechanical lift sling size. LPN-A stated the director of nursing (DON) or medical records complete the care plan, not the floor nurses. LPN-A would expect the sling sizes and what lift to use for residents would be in the care plan. During an interview on 4/29/26 at 10:03 a.m., certified occupational therapy assistant (COTA)-A stated nursing was in charge of sizing slings for residents that use mechanical lifts. Therapy did not make that determination. During an interview on 4/29/26 at 12:32 p.m., DON stated nursing assesses sling sizes for residents. The weight of the resident determines what sling size to use; DON did not articulate height was also required to determine appropriate sling size. The	F0689		06/01/2026

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F0689 SS = D	Continued from page 6 MDS or floor nurses would put the information in the resident care plan. DON stated it was not her expectation that mechanical lift sling sizes would be included in the care plans but that the information would be in a binder at the nurse's station. DON went to the nurses' station and took the NA binder and looked through it, there was no information about sling sizes in the NA binder. DON stated she would find an NA and ask how they know the sling sizes. DON went to NA-B who stated NA's decided sling size by looking in the storage closet by the office at the sling size guide and resident's weight.	F0689		06/01/2026
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to develop an individualized pain management plan for wound treatments and failed to provide pain management during wound treatment for 1 of 2 residents (R1) reviewed for pain management. Findings include: R1's face sheet dated 4/28/26, identified diagnoses of polyneuropathy (breakdown of nerves), fracture of unspecified part of neck of left femur (thigh bone), and polyosteoarthritis (degeneration of joints leading to pain and stiffness). R1's admission Minimum Data Set (MDS) dated 2/17/26, identified R1 had mild cognitive impairment. R1 had verbal behaviors directed towards others one to three days and would reject cares one to three days. R1 required supervision/touch assistance with dressing, and was independent with transferring, bed mobility, and moving surfaces. R1 was occasionally incontinent of urine and frequently incontinent of bowels. R1 was not at risk for developing pressure injuries and did not have pressure injuries. R1's care plan dated 4/22/26, identified R1 was on aspirin therapy. Interventions included to administer anticoagulation medication as ordered by physician.	F0697	1 Corrective action for affected residents: Resident #1 was assessed for pain meds were offered. 2.Identification of other residents at risk: The DON/designee audited all residents receiving wound care to ensure pain management interventions, and documentation are completed appropriately. No concerns noted. 3. Systemic changes implemented: Licensed nurses were re-educated on pain assessment, pain intervention before wound treatments, and individualized care planning. A wound care pain management monitoring tool was implemented with pain being assessed prior to the initiation of wound care. The DON/designee will conduct routine audits of residents receiving wound care to ensure compliance with pain management requirements weekly x 4 weeks and on-going as part of the IDT meeting. 4. Quality Assurance and Performance Improvement Program. QAPI was held on 5/18/2026 to review survey results and approve the education plan. Results of audits will be reviewed through the QAPI process for ongoing compliance monthly x 3 months. 5. Facility alleges substantial compliance on 6/1/26	06/01/2026

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F0697 SS = D	Continued from page 7 R1's care plan dated 4/22/26, identified R1 was on opioid pain medication related to fracture. The goal was for R1 to be free of any discomfort or adverse side effects from pain medication. Interventions included to administer analgesic medications as ordered by physician, monitor/document side effects and effectiveness every shift, for respiratory depression: monitor respiratory rate, depth, and effort after administration of pain medications, monitor for increased risk of falls, monitor/document/report as needed adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis (itchy skin), respiratory distress/decreased respirations, sedation, and urinary retention. Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain. R1's care plan did not address R1's acceptable level of pain. R1's care plan dated 2/12/26, identified R1 had chronic pain related to absence of toes on both feet, polyneuropathy, and gastroesophageal reflux disease. Interventions included R1's pain was aggravated by "neuropathy", pain was alleviated by Tylenol, Gabapentin, and rest. Monitor/record/report to nurse R1's complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from R1's past experience of pain. R1's care plan dated 4/7/26, identified R1 had pressure wounds. Although the care plan included the intervention to treat pain as per orders prior to treatment/turning etc to ensure comfort- there was no associated physician order that directed which analgesic should be administered or when prior to the wound treatment. R1's physician orders dated 4/29/26, included Aspirin 81 milligrams (mg) daily, Tylenol 1,000 mg every 6 hours as needed for moderate pain, Gabapentin 600 mg every 8 hours as needed for pain, Oxycodone 5 mg every 4 hours as needed for severe pain with a maximum daily does of 30 mg. R1's medication administration record (MAR) dated April 2026, identified non-pharmacological pain interventions: 1. Ice 2. Distraction 3. Rest. Effectiveness-Effective or Not Effective every day and night shift document non-pharmacological interventions tried alongside of medication for pain. Offer resident pain medications frequently. Every day and night shift.	F0697		06/01/2026

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F0697 SS = D	Continued from page 8 In review of R1's records there was no indication of a comprehensive assessment or treatment orders or care plan interventions that addressed R1's pain prevention during wound treatments. R1's MAR dated 4/30/26, identified Aspirin was given at 8:00 a.m. with a pain level identified at "6". The record revealed no indication non-pharmacological interventions were offered or attempted and no indication R1 was offered or administered Tylenol, Gabapentin, or Oxycodone. During an observation and interview on 4/30/26 at 11:49 a.m., licensed practical nurse (LPN)-A entered R1's room to complete a dressing change to R1's buttocks. R1 was lying on his back on the bed on top of an overlay air mattress. LPN-A opened R1's brief and noticed R1 had enlarged testicles, which LPN-A stated had not been enlarged the day before. LPN-A examined R1's testicles and asked R1 if it caused him pain. Registered nurse (RN)-A entered room and examined testicles. R1 stated it did not hurt when RN-A touched abdomen and testicles. R1 began to get upset and yell at LPN-A for taking so long to do the dressing change. R1 stated he was "cold and hurts". LPN-A and RN-A began to roll R1 to his right side and R1 yelled that they needed to lift his leg when they rolled him. LPN-A removed the dressing on R1's bottom and began cleaning the wound. R1 continued to yell that he was in pain and made noises "ooooooohhhhhhhm ahhhhhhhhh, mmmmmmmm and f*ck". R1 then screamed that it stung and that LPN-A needed to hurry up. LPN-A stated he would get R1 pain medication and R1 stated "oh, I'm gonna need it". During an interview on 4/30/26 at 3:26 p.m., nursing assistant (NA)-C stated R1 screamed in pain every time he was turned or repositioned. R1 had a lot of pain and NA-C would attempt to soothe him and explain what was going to calm him. NA-C stated she would report that R1 was in pain to the nurses and trained medication aides (TMA) every time she worked with R1. During an interview on 4/30/26 at 3:31 p.m., trained medication assistant (TMA)-C stated R1 was "quite stiff" and would yell every time he moved positions. During an interview on 4/30/26 at 2:38 p.m., TMA-B stated she only gave as needed pain medication if a resident asked for it or the nurse told her to give it. The nurse did not have to assess the resident prior to TMA-B administering the medication but the nurse would assess for effectiveness. TMA-B was assigned to pass medications to R1 on 4/30/26.	F0697		06/01/2026

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F0697 SS = D	Continued from page 9 During the morning medication pass TMA-B gave R1 aspirin and rated his pain at “6”. TMA-B did not notify LPN-A what R1’s pain level was. R1 did not ask for pain medication and he usually would. This afternoon, R1’s pain was at a “7” and LPN-A told TMA-B to give R1 Tylenol for pain. R1 asked for Gabapentin at that time also. During an interview on 4/30/26 at 2:35 p.m., LPN-A stated with a pain level of “6” “you can start with the lowest Aspirin or Tylenol if R1 could have it”. LPN-A stated if those interventions did not work then R1 could try Oxycodone. LPN-A stated “8” would be considered severe pain. LPN-A did not offer R1 pain medication prior to the dressing change “we had started already and I should have maybe given before” because R1 was in pain every time he was turned “he had aspirin this morning”. LPN-A stated R1 had rated his pain at “8”. After the dressing change was completed LPN-A asked TMA-B to give R1 pain medication and she gave Tylenol. After reviewing R1’s medication orders and the FACES pain scale, LPN-A stated R1 should have received Oxycodone for severe pain. LPN-A stated most of the time when he asked R1 about his pain he would be laying down and not in pain but when R1 moved that was when he was in pain. During an interview on 4/30/26 at 3:35 p.m., director of nursing (DON) stated R1 should have been offered pain medication when his pain was identified at “6”. DON would have expected LPN-A and RN-A to stop the dressing change when R1 voiced pain. DON stated staff are to utilize non-pharmacological interventions such as putting pillows under R1’s legs, calling R1’s daughter, and putting Western shows on the television prior to pain medication administration. R1 had returned from the hospital on 4/29/26, and prior to the hospitalization the facility had worked with the physician on R1’s pain and he had Oxycodone scheduled not just as needed. Staff should use pain scale or the FACES scale to determine level of pain. DON stated Tylenol would be an appropriate choice for pain level of “8”, start with the lowest medication first and move up. DON stated R1’s pain needed to be assessed and documented for the physician to review and determine if the medication should be scheduled or remain as needed. DON stated that a nurse must assess the resident prior to a TMA giving as needed medications. The facility FACES Pain Assessment Tood undated, identified the facility utilizes a numeric/faces pain assessment tool which combines a 0–10 numeric scale with corresponding facial expressions and	F0697		06/01/2026

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F0697 SS = D	Continued from page 10 severity categories. The scale defines 0 as no pain, 1–3 as mild, 4–6 as moderate, 7–9 as severe to very severe, and 10 as worst pain possible, and is intended to promote consistent identification and communication of pain levels. The facility 0-10 Scale of Pain Severity undated, identified severity and description of experience: 0-no pain “I have no pain”. 1-minimal “my pain is hardly noticeable”. 2-mild “I have a low level of pain. I am aware of my pain only when I pay attention to it”. 3-uncomfortable “My pain bothers me but I can ignore it most of the time”. 4-moderate “I am constantly aware of my pain but I can continue most activities”. 5-distracting “I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain”. 6-distressing “I think about my pain all of the time. I give up many activities because of my pain”. 7-unmanageable “I am in pain all the time. It keeps me from doing most activities”. 8-intense “my pain is so severe that it is hard to think of anything else. Talking and listening are difficult”. 9-severe “my pain is all that I can think about. I can barely talk or move because of the pain”. 10-unable to move “I am in bed and cant move due to my pain. I need someone to take me to the emergency room to get help for my pain”.	F0697		06/01/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	Corrective action for affected residents: Residents R1 and R2 were assessed and wound care practices were immediately reviewed. Staff involved received re-education on proper hand hygiene, infection control practices, and maintaining clean treatment surfaces. Education was provided to nurse providing R1 and R2 wound care on appropriate hand hygiene during wound care with understanding validated by clean dressing change competency	06/01/2026

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F0880 SS = D	Continued from page 11 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 11 2.Identification of other residents at risk: All residents receiving wound care services were reviewed for potential impact from the deficient practice. Clean dressing change competency was completed on licensed clinical staff by DON/designee on with all licensed staff having competency by 5/28/2026 any staff not having a competency by 5/28/26 will not be allowed to work until competency completed. 3. Systemic changes implemented: Licensed nurses and treatment staff received re-education on proper hand hygiene, infection prevention during wound care, and cleaning and disinfection of treatment surfaces and carts. Facility policies related to infection control and wound care practices were reinforced, and routine observation rounds will be conducted to ensure continued compliance with 2 staff being observed during wound care 3/week x 4 weeks, weekly x 4 weeks and monthly thereafter x 2 months or until substantial compliance is obtained. 4. Quality Assurance and Performance Improvement Program. QAPI was held on 5/18/2026 to review survey results and approve the education plan. Results of audits will be reviewed through the QAPI process for ongoing compliance monthly x 3 months. 5. Facility alleges substantial compliance on 6/1/26	06/01/2026

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F0880 SS = D	Continued from page 12 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene and failed to ensure clean surface are for wound supplies for 2 of 2 residents (R2, R1) reviewed for pressure ulcers. Findings include: R2's face sheet dated 4/28/26, identified diagnoses of paraplegia (paralysis to lower half of body), pressure ulcer stage 4 right buttock, pressure ulcer stage 4 left buttock, and pressure ulcer stage 4 of the sacral region. R2's comprehensive Minimum Data Set (MDS) dated 4/16/26, identified R2 had no cognition impairment. R2 had impairment to both sides of lower extremities, required staff assistance with dressing, turning, and transferring surfaces. R2 used a wheelchair for mobility. R2's care plan dated 11/1/25, identified R2 required enhanced barrier precautions (EBP) (use of gown and gloves during high contact interactions) related to open wounds, colostomy, and urinary catheter. Interventions included direct care staff to utilize gown and gloves for all personal care, monitor for signs/symptoms of infection. Document and properly report signs/symptoms of potential infections. Monitor psychosocial and mental well-being related to EBP. Document any changes and report any symptoms promptly. During an observation on 4/30/26 at 10:19 a.m., licensed practical nurse (LPN)-A entered R2's room wearing EBP. R2 was lying on an overlay mattress on his back in bed. LPN-A did not sanitize the work space prior to beginning wound care. LPN-A lowered R2's brief and began examining R2's penis with his gloved hands. LPN-A continued to wear the same gloves and turned around and grabbed 4 inch	F0880		06/01/2026

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F0880 SS = D	Continued from page 13 (in) by 4 in gauze from the gauze container. Using the same gloves, LPN-A wiped around the head of R2's penis. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A applied barrier cream to his gloved finger and wiped it around R2's penis. LPN-A removed gloves and put on a new pair without sanitizing hands. R2 rolled to his left side. LPN-A removed all three of R2's dressings. LPN-A removed gloves and applied a new pair without sanitizing his hands. LPN-A took gauze from the container, soaked it with a wound cleanser and placed the gauze inside the right pressure ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A took gauze from the container, soaked it with a wound cleanser and placed the gauze inside the left pressure ulcer. LPN-A removed more gauze from the container, soaked it, removed a glove and put a new one on without sanitizing his hands and put the gauze in the sacral ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A removed the gauze from all three wounds. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A applied wound cleanser to gauze and began wiping around right ulcer. LPN-A threw away the gauze and reached his hand into the gauze container and got more gauze. Applied wound cleanser to gauze and began wiping around left ulcer. LPN-A removed a glove, did not sanitize his hands, and applied a new glove. LPN-A grabbed more gauze from the container, soaked it in wound cleanser and wiped around the sacral and perineal region. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A opened a package of Calcium Alginate (highly absorbent material used to manage drainage and promote healing in wound care) and took a bandage scissors and cut the Calcium Alginate into three strips. LPN-A took a strip and placed it in the left ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. Took another strip and placed in the right wound. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A then took the final strip and placed it in the sacral wound. LPN-A began touching the Calcium Alginate that was in the left ulcer. LPN-A picked up a Mepilex (bordered foam dressing) and removed the sticky back piece. LPN-A then reached into the gauze container and grabbed some gauze. LPN-A wiped the gauze around the sacral and left ulcers. LPN-A applied Mepilex dressings to the ulcers. LPN-A removed gloves and adjusted R2 in bed. LPN-A took the full garbage and left room. LPN-A walked down the hallway and entered the utility room, threw garbage away and washed hands.	F0880		06/01/2026

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F0880 SS = D	Continued from page 14 R1 R1's significant change MDS dated 4/21/26, identified R1 had no cognitive impairment. R1 had a stage 3 pressure ulcer. R1's care plan dated 4/7/26, identified R1 had pressure wounds. Interventions included treat pain as per orders prior to treatment/turning etc. to ensure the residents comfort. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate. During an observation on 4/30/26 at 11:49 a.m., LPN-A entered R1's room wearing EBP and brought wound supplies into room to perform a dressing change to R1's ulcer. LPN-A set the supplies on the overbed table. LPN-A removed the tabs from R1's brief and pulled the brief down. R1's testicles were enlarged and LPN-A began examining them with his gloved hands. LPN-A took some gauze from the container and wiped around R1's penis and testicles. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A lifted the wound supplies into his hand and arm, took a sanitizing wipe, wiped down the overbed table, and placed the supplies back on the table. LPN-A opened Calcium Alginate. LPN-A removed gloves and applied a new pair without sanitizing hands. Registered nurse (RN)-A entered room wearing EBP to assist with dressing change. RN-A examined R1's penis and testicles, removed gloves and applied a new pair without sanitizing hands. LPN-A and RN-A rolled R1 to his right side. R1 was incontinent of bowels. LPN-A cleaned bowels. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A removed dressing from R1's sacral ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A sprayed wound cleanser onto gauze and cleaned ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A placed Calcium Alginate on wound bed, opened and placed Mepilex over ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. RN-A removed gloves and applied a new pair without sanitizing hands. RN-A applied cream to penis and removed gloves. LPN-A and RN-A boosted R1 in bed. LPN-A picked up wound supplies, washed overbed table, and left room. During an interview on 4/30/26 at 12:28 p.m., LPN-A stated when doing dressing changes he would sanitize his hands prior to the first glove application and when the dressing was completed.	F0880		06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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

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F0880 SS = D	Continued from page 15 LPN-A stated he should have cleaned the work surface prior to setting wound supplies on it for R2. During an interview on 4/30/26 at 3:35 p.m., director of nursing (DON) stated hands should be sanited before and after wound care is completed. DON expected the surface that the wound supplies would be placed on should be cleaned prior to putting wound supplies on it. The facility Hand Hygiene policy undated, identified the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to putting on gloves, and immediately after removing gloves. Hand hygiene should be completed when, during resident care, moving from a contaminated body site to a clean body sit	F0880		06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

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20000	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 4/28/26, 4/29/26, and 4/30/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H54001527C (2986920), H54001453C (2984647), H54001526C (2982999), and H54009440C (2962737). No orders were issued. Minnesota Department of Health is documenting the	20000		05/15/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

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20000	Continued from page 1 State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		05/15/2026