DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 26, 2025

Administrator

WABASSO RESTORATIVE CARE CENTER

660 MAPLE STREET

WABASSO, MN 56293

RE: CCN: 245400

Cycle Start Date: July 24, 2025

Dear Administrator:

On September 17, 2025, we notified you a remedy was imposed. On October 24, 2025, the Minnesota Departments 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 October 1, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 24, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 17, 2025, 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 October 24, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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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Electronically delivered

September 17, 2025

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

RE: CCN: 245400
Cycle Start Date: July 24, 2025

Dear Administrator:

We informed you that we may impose enforcement remedies.

On September 2, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 24, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 24, 2025. They will

also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 24, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 24, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, WABASSO RESTORATIVE CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 24, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 - Health Regulation Division staff and/or the Department of Public Safety,

State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 24, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file

electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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
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September 17, 2025

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

Re: Event ID: 1D4F16-H1

Dear Administrator:

The above facility survey was completed on September 2, 2025 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 09/02/2025

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 8/27/25, 8/28/25, and 9/2/25, 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 complaint was reviewed H54002890C (2597611,2597299, 2602770); H54002661C (2594749); and H54003142C (2601561) with a deficiency cited at F577, F600, and F609. 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		10/01/2025
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents,	F0577	The facility immediately gathered all survey results, complaint investigations, and plans of correction and placed them in a Survey Results Binder located at the front entrance for access by residents, families, visitors, and staff. Since all residents, families, visitors, and staff may be affected, the facility ensured the binder is available and accessible to everyone, with clear signage directing where documents can be reviewed. Policy reviewed and staff have been educated on the binder's location and access requirements. The Administrator or designee will audit the Survey Results Binder monthly for six months, then quarterly x 1, with results reported to QAPI for review and follow-up as needed.	10/01/2025

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 09/02/2025

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F0577 SS = C	Continued from page 1 and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure both recertification survey results, complaint investigations, and facility plans of correction were available for review. This had the potential to affect all forty-three (43) residents residing in the facility, as well as family, visitors, and staff. Findings include: R5's brief interview for mental status (BIMS) dated 8/11/25, indicated R5 had moderately impaired cognition. On 8/27/25 at 3:50 p.m., R5 indicated he would like to see the results of the surveys that the State Agency (SA) conducted however, did not know where to locate them. On 8/27/25 at 4:00 p.m., a binder titled facility survey results was located in a plastic wall file by the front entrance behind the resident council minutes. The survey results included in the binder consisted of the recertification survey results for 4/25/24, and complaint investigation results for 5/21/24, and 5/28/25. A review of Aspen Central Office (ACO-an online computerized federal document site which contains the surveys completed for facilities, including both recertification surveys, and complaint investigation) identified recertification surveys were completed on 6/29/23, 4/25/24, and 11/18/24. Additionally, complaint investigations were completed and noted to have	F0577		

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F0577 SS = C	Continued from page 2 citations issued on the following dates: 12/28/22, 3/23/23, 7/12/23, 7/26/23, 2/28/24, 5/21/24, 9/24/24, 12/24/24, and 5/28/25. The facility survey result binder lacked the following: recertification surveys completed 6/29/23, and 11/18/24; facility's plan of correction for 4/25/24; complaint surveys completed 12/28/22, 3/23/23, 7/12/23, 7/26/23, 2/28/24, 9/24/24, and 12/24/24; facility's plan of correction for 5/21/24. During an interview on 8/28/25 at 11:54 a.m., the corporate clinical care coordinator (CCCC) indicated the survey results were public knowledge and should contain all state agency surveys with facility plan of corrections. The CCCC verified the facility survey binder did not contain all the required surveys or facility plans of correction. During an interview on 9/2/25 at 4:39 p.m., the administrator was unable to locate the facilities survey binder however, indicated the residents take them and stated, “they [survey results] disappear as fast as we put them out”. A facility policy was requested for posting of survey results however, was not provided.	F0577		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to protect 1 of 1 resident (R1)	F0600	Immediately following the incident, R1 was assessed by nursing staff for physical and emotional harm, and also by the attending physician. R1 was offered counseling services and emotional support. R1 was placed on 15-minute checks, and a room change was offered, however declined by R1. To identify other residents who may be at risk, the facility conducted a thorough audit of all residents, with a care plan which includes physical or verbal aggression focus. Care plans were reviewed and updated accordingly. Systemic changes were implemented to prevent recurrence. Staff received re-education on abuse prevention and response protocols. The multidisciplinary team now reviews all aggression-related incidents daily (Monday–Friday) to ensure timely interventions. Random audits are conducted in smoking areas during the work week to monitor resident safety. In addition, environmental adjustments, including doorbell audits, were introduced to further enhance resident safety. To ensure ongoing compliance and effectiveness, the Director of Nursing or designee will conduct weekly	10/01/2025

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F0600 SS = D	Continued from page 3 from resident-to-resident physical abuse. Findings include: A Vulnerable Adult Maltreatment report submitted to the State Agency (SA) on 8/21/25 at 9:35 p.m., identified alleged physical abuse when it was reported that at approximately 8:00 a.m. that morning, R2 had pulled R1's hair, struck her in the back of the head, and pushed her wheelchair. R2 admitted that he had pulled R1's hair during a verbal altercation outside in the smoking area however, denied hitting or pushing R1. A Facility Reported Incident (FRI) submitted to the SA on 8/22/25 at 11:35 a.m., alleged abuse when R2 tugged R1's hair and hit her head while outside. The alleged abuse occurred on 8/21/25 at approximately 10:00 a.m. During an interview with R1 on 9/2/25 at 5:55 p.m., R1 indicated on 8/21/25 at approximately 8:00 a.m., R2 hit her in the back of the head, pulled her hair, and pushed her wheelchair into the fence in the smoking area. R1 stated, "I immediately got a headache and got a Tylenol". R1 further identified she told "several nursing staff immediately after it happened" however, could not remember who she had talked to. R1 identified the next day on 8/22/25, R2 scared her when he told her he was going to kill her. R1 stated she immediately called a family member to come and pick her up because she did not feel safe. R2 stated she discharged from the facility and was not going back. During an interview with family member (FM)-A on 9/2/25 at 5:30 p.m., FM-A stated R1 was "upset" when she called to report that R2 had "punched her in the back of the head and hit her head on the back of the fence". FM-A called the facility but did not get any one to answer so called the Sheriff's department to do a well check on R1 to assure her safety. FM-A stated the next morning, R1 called her again to request FM-A to pick her up from the facility immediately because she did not feel the facility was doing enough to protect her and that R2 had threatened her that morning. R1's admission Minimum Data Set (MDS) dated 7/18/25, indicated R1 had severe cognitive impairment and no behaviors. Identified R1 used a wheelchair for mobility and required substantial staff assist with dressing, transferring, bed mobility, and personal hygiene. A follow up brief interview for mental status on 8/22/25, indicated R1 had moderately impaired cognition. R1's Care Plan Report identified R1 had a potential for abuse due to current health condition that required assistance with activities of daily living (ADL)'s and cognition. Diagnoses included alcohol dependence,	F0600	Continued from page 3 audits of incident reports for a period of three months. These findings will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meetings. Staff adherence to abuse prevention protocols will be monitored through random interviews and observations weekly for three weeks then monthly for 2 months, with any non-compliance addressed through immediate corrective action and retraining.	

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F0600 SS = D	Continued from page 4 tobacco dependence, major depressive disorder and repaired fracture of femur and pelvis. R1's Medication Administration Record identified on 8/21/25, R1 complained of a pain level of ten (10) and received Acetaminophen 500 milligram (mg) two tablets at 8:02 a.m. R1's Discharge Assessment indicated R1 left the facility against medical advice (AMA) on 8/22/25 at 11:30 a.m. During an observation and interview on 8/28/25 at 10:01 a.m., R2 was lying in bed coloring and watching television. R2 stated, "she [R1] called me a [expletive] so I grabbed her by the scruff of the hair and shook her a little bit and then let her go". R2 further stated, "she [R1] must have been scared of me because she left the next day". R2 further indicated the staff talked to him the next day and had him sign a paper that he would agree to not have any further physical altercations and had not. R2's quarterly MDS dated 7/9/25, indicated R2 had intact cognition and no behaviors. Identified R2 had no upper extremity impairment however, had lower extremity impairment and used a manual wheelchair. R2 was independent wheeling his wheelchair. Diagnoses included paraplegia (paralysis of the legs and lower body), alcohol dependence, and adjustment disorder with mixed anxiety and depressed mood. R2's care plan updated 8/22/25, indicated R2 had a behavior problem as evidenced by previous episodes of yelling, throwing things, and alleged physical aggression. The care plan identified triggers as pain and disrespect. Facility incident report dated 8/17/25 at 1:15 p.m., identified R2 had a verbal altercation and made a threat of violence with an unidentified resident. The facility identified R2 had a decrease in a medication that caused R2 to have increased discomfort, and he became more short-tempered. The facility placed R2 on 30-minute checks for mood monitoring from 8/17/25 to 8/22/25. During an interview on 9/2/25 at 2:08 p.m., nursing assistant (NA)-A indicated she was working on 8/21/25 when the alleged incident occurred. Further identified R1 told her at approximately 8:00 a.m. that R2 had pulled her hair and punched her while outside in the smoking area. NA-A identified she told the assistant director of nursing and the charge nurse about the	F0600		

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WABASSO RESTORATIVE CARE CENTER	660 MAPLE STREET , WABASSO, Minnesota, 56293

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F0600 SS = D	Continued from page 5 allegation immediately after R1 reported it and they placed R1 and R2 on 15-minute checks. During an interview on 9/2/25 at 2:02 p.m., NA-B identified R1 reported that R2 had pulled her hair and punched or slapped her on the head. NA-B stated they started 15-minute checks on R1 and R2 for safety. During an interview on 9/2/25 at 2:36 p.m., NA-C indicated she was working the medication cart on 8/21/25 and R1 “was acting a little weird and a little distraught”. NA-C further identified at approximately 8:00 a.m., R1 complained that her head hurt and she wanted some Tylenol. During an interview on 9/2/25 at 2:42 p.m., NA-D indicated she was working on 8/21/25, when R1 reported that R2 had hit her and pulled her hair. During an interview on 8/28/25 at 2:15 p.m., licensed practical nurse (LPN)-A, indicated she was working on 8/21/25, as a charge nurse and did not recall any incident between R1 and R2 that occurred that day. LPN-A stated on 8/22/25, R1 was upset and reported she was leaving the facility because she was scared of R2. During an interview on 9/2/25 at 3:00 p.m., the director of nursing stated she was informed of the incident between R1 and R2 the day after it happened and described the incident as R2 “pulled or touched [R1’s] hair and she did not like it and was upset about it”. The facility implemented 15-minute checks on R1 and R2. During an interview on 9/2/25 at 11:34 a.m., the administrator identified she was aware of the incident that occurred between R1 and R2 and the facility implemented 15-minute checks on R1 and R2 to assure they were not outside in the smoking area at the same time. The Sheriff’s Office Incident Report dated 8/21/25 at 7:21 p.m., R1’s family member called to request a welfare check on R1 as R1 had reported R2 assaulted her. The sheriff’s deputy responded at 7:34 p.m. and R1 reported at 8 a.m. that morning, R2 pulled her hair, struck her in the back of the head, and pushed her wheelchair. The deputy informed staff of the situation and staff stated that they would keep R1 and R2 separated. Review of the facility's policy titled, Abuse, Neglect, and Exploitation last revised 4/25/25, indicated it was the policy of the facility to provide protections for	F0600		

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 09/02/2025

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F0600 SS = D	Continued from page 6 the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of property. Abuse was defined as the willful infliction of injury with resulting physical harm, pain, or mental anguish. Physical abuse included and was not limited to hitting, slapping, punching, biting, and kicking.	F0600		
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 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 document review, the facility failed to report an allegation of abuse timely to the State Agency (SA) for 1 of 1 resident (R1) reviewed for allegations of abuse. Findings include: A Facility Reported Incident (FRI) submitted to the State Agency (SA) on 8/22/25 at 11:35 a.m., alleged	F0609	Upon identification of the issue, the facility immediately submitted the required abuse report to the State Agency and notified the resident's responsible party. R1 was assessed for any physical or emotional harm, and appropriate support services were offered. The facility initiated a comprehensive review of all recent incident reports to ensure no other allegations were missed or delayed in reporting. Since all residents may be affected, the facility created a Rapid Response Panel to ensure potential abuse indicators are reviewed in accordance with DHS regulations. To address systemic gaps, the facility revised its Abuse Reporting Policy to clearly define timelines and responsibilities for reporting abuse allegations. All staff, including licensed nurses, certified nursing assistants, and department heads, received mandatory re-education on abuse identification, reporting protocols, and regulatory requirements. The training emphasized the importance of immediate reporting to both internal leadership and external agencies. To monitor ongoing compliance, the Director of Nursing or designee will conduct weekly audits of incident reports and abuse allegations for the next three months to verify timely reporting. Audit results will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings. Any identified delays will be addressed immediately with corrective action and retraining.	10/01/2025

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F0609 SS = D	Continued from page 7 abuse when R2 tugged R1's hair and hit her head while outside. The alleged abuse occurred on 8/21/25 at approximately 10:00 a.m. (Approximately 25 ½ hours prior to reporting to the SA). R1's admission Minimum Data Set (MDS) dated 7/18/25, indicated R1 had severe cognitive impairment and no behaviors. Identified R1 used a wheelchair for mobility and required substantial staff assist with dressing, transferring, bed mobility, and personal hygiene. A follow up brief interview for mental status on 8/22/25, indicated R1 had moderately impaired cognition. R1's Care Plan Report identified R1 had a potential for abuse due to current health condition that required assistance with activities of daily living (ADL)'s and impaired cognition. Diagnoses included alcohol dependence, tobacco dependence, major depressive disorder and repaired fracture of femur and pelvis. During an interview with R1 on 9/2/25 at 5:55 p.m., R1 indicated on 8/21/25 at approximately 8:00 a.m., R2 hit her in the back of the head, pulled her hair, and pushed her wheelchair into the fence in the smoking area. R1 stated, "I immediately got a headache and got a Tylenol". R1 further identified she told "several nursing staff immediately after it happened" but could not remember who she had talked to. R1 identified the next day (8/22/25), R2 threatened her again and she called a family member to come and pick her up. R2 stated she discharged from the facility and was not going back. R2's quarterly MDS dated 7/9/25, indicated R2 had intact cognition and no behaviors. Identified R2 had no upper extremity impairment, had lower extremity impairment and used a manual wheelchair. R2 was independent wheeling his wheelchair. Diagnoses included paraplegia (paralysis of the legs and lower body), alcohol dependence, and adjustment disorder with mixed anxiety and depressed mood. During an interview on 9/2/25 at 2:08 p.m., nursing assistant (NA)-A indicated she was working on 8/21/25, when the alleged incident occurred. NA-A stated at approximately 8:00 a.m., R1 reported that R2 had pulled her hair and punched her while outside in the smoking area. NA-A identified she told the assistant director of nursing and the charge nurse about the allegation immediately after R1 reported it and they placed R1 and R2 on 15-minute checks. During an interview on 9/2/25 at 11:34 a.m., the administrator indicated she was notified of the	F0609		

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F0609 SS = D	Continued from page 8 incident on 8/21/25, however, did not know about R2 hitting R1. The administrator verified the FRI was submitted late to the SA on 8/22/25, when she became aware of the hitting. The Sheriff's Office Incident Report dated 8/21/25 at 7:21 p.m., R1's family member called to request a welfare check on R1 as R1 had reported R2 assaulted her. The sheriff's deputy responded at 7:34 p.m. and identified that R1 reported at 8 a.m. that morning, R2 pulled her hair, struck her in the back of the head, and pushed her wheelchair. The deputy informed staff of the situation and staff stated that they would keep R1 and R2 separated. Approximately 16 hours prior to the FRI was submitted to the SA. Review of facility policy titled The Abuse, Neglect, and Exploitation Policy last revised 4/25/25, indicated the facility was to report all alleged violations to the administrator, state agency, adult protective services, and all other required agencies (law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation was made for events that caused the allegation to involve abuse or result in serious bodily injury.	F0609		