



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Submitted  
June 18, 2025

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

RE: CCN: 245400  
Cycle Start Date: May 28, 2025

Dear Administrator:

On May 28, 2025, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### REMOVAL OF IMMEDIATE JEOPARDY

On May 28, 2025, the situation of immediate jeopardy to potential health and safety cited at F600 - Free From Abuse and Neglect was removed. However, continued non-compliance remains at the lower scope and severity of D.

#### 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 3, 2025.

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

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The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 3, 2025, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 3, 2025, (42 CFR 488.417 (b)).

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.

### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Wabasso Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 28, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor RR  
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 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

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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 November 28, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

#### APPEAL RIGHTS DENIAL OF PAYMENT

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](mailto: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 Tamika Brown at (312) 353-1502. Information may also be emailed to [tamika.brown@cms.hhs.gov](mailto:tamika.brown@cms.hhs.gov).

#### APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

#### 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

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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](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,



Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697  
Email: sarah.lane@state.mn.us



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Electronically delivered  
June 18, 2025

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

Re: State Nursing Home Licensing Orders  
Event ID: SHZ811

Dear Administrator:

The above facility was surveyed on May 19, 2025 through May 28, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Lisa Krebs, Regional Operations Supervisor RR  
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

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697  
Email: sarah.lane@state.mn.us

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>WABASSO RESTORATIVE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 MAPLE STREET , WABASSO, Minnesota, 56293</b>	
(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	<p><b>INITIAL COMMENTS</b></p> <p>On 5/19/25 to 5/28/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.</p> <p>The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F600 began on 3/27/25 when three residents reported inappropriate behavior by R2.</p> <p>The administrator, and director of nursing (DON) were notified of the IJ on 5/22/25 at 4:10p.m. The IJ was removed on 5/28/25 at 11:09 a.m.</p> <p>The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/23/25 and 5/27/25.</p> <p>The following complaints were reviewed: H54005087C (MN00113142 and MN00113146 ); H54005627C(MN00113364); H54005867C (MN00113425) with a deficiencies cited at F600, F609, F610, F627, F699, and F740 .</p> <p>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.</p> <p>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.</p>	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect	F0600	1. R1 was immediately assessed by nursing and social services for psychological impact including risk of	07/16/2025

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
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<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>WABASSO RESTORATIVE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 MAPLE STREET , WABASSO, Minnesota, 56293</b>	
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F0600 SS = SQC-J	<p>Continued from page 1 CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation</p> <p>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.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, observation and document review, the facility failed to ensure adequate supervision and a comprehensive assessment was completed to help prevent resident to resident sexual abuse. As a result of the facilities failures an immediate jeopardy (IJ) situation was identified when resident (R2) wrote unwanted paper notes that were sexual in nature and hand delivered them to R1, resulting in psychosocial harm related to triggering symptoms of PTSD (Post-Traumatic stress disorder) derived from childhood sexual abuse and feelings of insecurity for 1 of 2 residents (R1) reviewed for abuse.</p> <p>The IJ began on 3/27/25 when three residents reported inappropriate behavior by R2, including writing notes that were sexual in natural and touching residents. The facility administrator and director of nursing (DON) were notified of the IJ on 5/22/25 at 4:10 p.m. The IJ was removed on 5/28/25 at 11:09 a.m., but non-compliance remained at the lower scope and severity of D.</p> <p>Findings include:</p> <p>A Vulnerable Adult Maltreatment Report submitted to the State Agency (SA) on 5/16/25 at 12:00 p.m., alleged abuse and neglect to R1 when R1 reported feeling unsafe at the facility due to R2 being sexually inappropriate, sexually harassing, and making unwanted sexual advances</p>	F0600	<p>Continued from page 1</p> <p>PTSD, behavioral changes, mood, cognitive status and trauma related to the alleged abuse. R1 was reassured of their right to safety and privacy. Emotional support services were offered, and counseling was made available with an appointment made on 5/22 in the morning with her mental health provider scheduled for 05/23 @ 11am. On 5/22 an appointment was made with mental health for 5/23 at 11am. Mental health provider was updated on 5/23 at 8a with survey findings. R1 will be comprehensively assessed by the licensed mental health care provider for necessary treatment/support and a coordinated care plan. Communication made to mental health provider to complete a capacity to consent assessment. R1 and R2s medical health providers were notified on 5/22 @ 6:09p and 6:11p with communication of incident. R1s primary confirmed receipt of facilitys communication. SSD had routine check-ins with R1 for therapeutic discussions on 5/22 and 5/23 and will continue per consult with R1s mental health care professionals to determine the frequency and the duration of the check-in (supportive services), which is Tuesdays, Thursdays and Saturday evenings. IDT meeting was held to address any changes needed in R1s environment or supervision on 5/22.</p> <p>2. All residents have the potential to be affected in this area.</p> <p>3. R2 was immediately separated from R1 and placed on a 15-minute checks. R2s care plan and behavior intervention plan were updated to include all written and verbal communications restricted in its entirety with R1. R1 is set up to be evaluated on 5/22 by behavioral health/mental health provider on 5/23 @ 11am and referred for additional support services. R2 was offered support services; however, R2 declined. All residents were assessed to ensure no other individuals were impacted by similar behaviors from R2 or others. All allegations of abuse will be immediately investigated and appropriate interventions implemented. Staff were instructed to monitor all resident interactions and report any unusual communications immediately. Abuse policy was reviewed and revised to specifically include inappropriate written/verbal communications between residents and resident-to-resident sexual harassment procedures. Mandatory in-service training conducted for all staff on 5/22, including definitions and examples of sexual abuse (including written communication), and mandated reporting procedures. All education and competency tests were completed on 5/22 by all staff. The education is produced by MN Dept of Human Services and</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>05/28/2025</b>
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F0600 SS = SQC-J	<p>Continued from page 2 by writing letters and talking about sexual desires R2 had with R1. Several of the female residents stated they did not feel safe in the facility because of R2's behaviors.</p> <p>A Nursing Home Incident Report (NHIR) submitted to the SA on 5/16/25 at 1:57 p.m., alleged abuse when a resident (R1) reported during resident council on 5/15/25 that they did not feel safe because a resident (R2) stares at them.</p> <p>R1</p> <p>R1's New Admission Information dated 10/15/24, indicated R1 had diagnoses of Alcoholic encephalopathy, Post Traumatic Stress Disorder (PTSD), anxiety, and depression. R1's cognition was confused, and behaviors were confused but pleasant. The form also identified R1 was independent with activities of daily living (ADLs). The facility was to provide occupational therapy (OT), speech therapy (ST), and substance abuse treatment. R1 was admitted with a commitment order (court ordered mandate to be involuntarily place in an institution for treatment or care). Additional information included R1 had poor cognition, very forgetful, needs reminders that R1 had completed tasks.</p> <p>R1's admission Trauma Informed Care History dated 10/16/24 identified R1 was molested as a child. Triggers that make it worse were indicated as "use to have a lot of them but overcame them with counseling."</p> <p>R1's care plan initiated on 10/16/24, identify a potential for ineffective coping related to PTSD and reported history of traumatic event(s) from her childhood attention seeking behavior of sexual comments towards men. Goal was to feel safe and enjoy daily activities of her choice for the next 90 days. Interventions included allow to express feeling, communicate with them that they are safe, it's not their fault, you are sorry this happened and you are glad they are alive; identify support system and us them as appropriate; and provide a safe therapeutic environment where they can regain control as needed. R1 is a smoker and can smoke unsupervised. R1 has impaired cognitive function/dementia or impaired thought processes related to Wernicke's encephalopathy (brain and memory disorder), diagnoses and BIMS (brief interview of mental status) score. Interventions</p>	F0600	<p>Continued from page 2 Office of Ombudsman for Long-Term Care and education and competency test on reporting of allegations per facility policy. The education was also printed out and several copies were placed in the employee breakroom. The Administrator called and left a message with the ombudsman on 5/22 requesting immediate education and Administrator left her cell phone number in the message. The phone call has not been returned as of 5/23 at 10:20a. The facility has a system in place on how capacity to consent is going to be determined with all residents upon admission who have a history of sexual related traumas and current residents and education given on capacity to consent.</p> <p>4. DON or designee will conduct weekly audits of resident interactions and written and verbal communications for 4 weeks, then monthly for 3 months. Results of audits will be reviewed during the monthly QAPI meeting to identify patterns or needs for further intervention. All allegations of abuse will be reviewed immediately by IDT and then brought to QAPI committee meetings.</p>	

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NAME OF PROVIDER OR SUPPLIER <b>WABASSO RESTORATIVE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 MAPLE STREET , WABASSO, Minnesota, 56293</b>	
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F0600 SS = SQC-J	<p>Continued from page 3 included administer medications, cue, reorient, and supervise as needed; has a pad of paper in her room to put information on for her to remember; and has a sign on the wall to remind her that her wallet is with her husband and nursing has her cigarettes. R1's safety is at risk and there is a potential for abuse due to anxiety, chemical dependency, current medical condition, use of medications and need for assistance with cares and mobility. Interventions were to remove R1 from potentially dangerous situations.</p> <p>R1's Preadmission Screening and Resident Review (PASARR) screening dated 11/11/24, identified serious mental disorder, intellectual disability or related disorder existed.</p> <p>R1's Vulnerability and Susceptibility to Abuse assessment dated 2/19/25, indicated R1 was at risk for abuse related to cognitive impairment, alcohol/substance abuse, physical impairment.</p> <p>R1's significant change Minimum Data Set (MDS) dated 3/12/25, indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver).</p> <p>R1's Montreal Cognitive Assessment (MoCA) dated 3/4/25, indicated R1 had higher mild cognitive impairment.</p> <p>R1's Cognitive care area assessment (CAA) dated 3/10/25, identified risk for psychosocial well-being changes d/t recent hospitalization and factors of cognitive loss and ETOH (alcohol) abuse. At risk for further clinical declines, re-hospitalization if psychosocial well-being is not addressed.</p> <p>R1's Nursing Note dated 5/4/25 at 2:24 a.m., identified R1 and another resident approached writer at 7:40 p.m., and stated that they did not feel safe as R2 was harassing them by calling them offensive names when they were out in the smoking area. R1 further stated that the "harassing" resident [R1] stays at his door and when they go out to smoke, he follows them. Writer request R1 to stay away from the other resident as much</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 4 as they could. Writer offered an alternative smoking area for the meantime and in the event [R1] wanted to go to the regular smoking area to inform staff so they could be with staff all the time. Law enforcement involved. Director of nursing DON was notified and social worker to be informed. (no other mention of feeling unsafe in the notes)</p> <p>R1's Resident Location charting dated 4/27/25, 4/28/25, and 4/29/25 indicate 15-minute checks for protection. (no other information given)</p> <p>R1's psychiatry Therapy note dated 5/23/25, identified R1 reported getting letters from a male resident a couple of months ago and have become inappropriate over time and R1 notified staff of this. R1 now feels uneasy around the person. R1 further reports feelings of unease like tension in her chest when wondering if she will see that person and brings up feelings like when she was sexually abused as a child. R1 feels she needs to watch her back and protect herself since reporting her concerns about the peer. R1 reports it is taking a long time to get to sleep and waking up 2-3 times a night. R1 requested to increase her session frequency to two times a week for additional support at this time.</p> <p>R1's record lacked indication a comprehensive assessment was completed to determine psychosocial harm, interventions put in place to ensure safety, supportive services provided, or monitoring systems for supervision and mood/behavior changes were implemented to keep R1 safe from ongoing abuse.</p> <p>R2</p> <p>R2's quarterly MDS dated 5/8/25, identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly.</p> <p>R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply).</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 5</p> <p>R2's care plan initiated 1/25/25 indicates potential for ineffective coping related to reported history of traumatic event no triggers noted. Interventions included allow to express feelings, provide a safe therapeutic environment where they can regain control as needed; prefers female caregivers; does not want male caregivers for intimate cares. R2 requires assist of staff with bed mobility, toileting, transferring, and dressing lower body. R2 does not ambulate. R2 is a smoker and can smoke unsupervised. R2 used psychotropic medications related to depression and anxiety. Interventions included monitor/record occurrence of target behavior symptoms of rapidly shifts between different emotions, self-isolation, sense of impending doom, and hyper-fixation. Target behavioral interventions is journalling, talk therapy, distractions/redirections, remind to focus on what is controllable, and drawing. R2 is at risk and there is a potential for abuse due to anxiety, and chemical dependency. Interventions include: ensure I am safe around others that might take advantage of my confusion, encourage participation in separate meaningful activity, provide positive reinforcement when resident handle conflicts appropriately.</p> <p>R2's care plan lacked updates or potential sexual behaviors toward others.</p> <p>R2's progress notes dated 3/27/25 at 4:28 p.m., three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed feeling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them [R1], who had shown interest in him. Education given to the resident, verbalize understanding.</p> <p>R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding.</p> <p>R2's 15-30-60 Minute Monitoring Flowsheet dated 5/3/25</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 6 and 5/4/25, identified R2 was on 15-minute checks for safety reasons, started 5/3/25 at 2:45 p.m. to 5/4/25 at 11:30 a.m. R2 flowsheet lacked monitoring on 5/4/25 between 11:45 a.m. to 6:00 p.m. then resumed on 5/4/25 at 6:00 p.m., with last entry at 5/5/25 at 5:45 a.m.</p> <p>R2's record lacked additional behavior management, assessments or monitoring to mitigate risk of R2's alleged sexual behaviors towards R1.</p> <p>During an interview on 5/19/25 at 1:42 p.m., the business office manager (BOM) indicated she attended the resident council meeting on 5/15/25 and concerns were expressed about feeling unsafe at the facility related to R2 writing some notes to R1 and R2 watching and waiting for R1 to go out to the smoking area and R1 did not want to be by R2. The BOM reported the ombudsman was in the meeting and was going to follow up on the concern and did report their concerns to the DON and administrator. The BOM denied having prior knowledge of the letters.</p> <p>During an observation and interview on 5/19/25 at 2:15 p.m., R2 identified he was in trouble at the facility because he had a relationship with R1 and wrote her some love notes. R1 decided she did not want them anymore; they called the "cops" and we were supposed to stay away from each other. Law enforcement returned on Friday 5/16/25 and talked to me again. R2 stated, "all the staff knew about it" and the social worker told R2 that he was "stalking" R1 but could not remember when that conversation occurred. R2 reported writing "love notes" to R1 for approximately two months.</p> <p>During observation and interview on 5/20/25 at 8:55 a.m., R1 stated she had concerns about her safety because of R2 saying "stuff to me like he likes me and started passing me some sexual notes". R1 indicated being married and would not consent to a relationship with R2. R1 further identified the notes started to get "disturbing" and showed staff the notes "a week or so ago, can't remember". R1 indicated R2 would usually approach her in the smoking area, which was unsupervised by staff.</p> <p>During an interview on 5/20/25 at 9:05 a.m., R4 indicated R2 was "obsessed" with R1 and would sit in the doorway and stare at her, write letters to R1, and play love songs for R1 to hear. R4 further indicated</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 7 about a month ago, R1 and R3 told the DON about the letters and the DON made copies of the letters and they moved R2 to a room even closer to R1. R4 indicated the DON told them they were all adults and needed to work it out.</p> <p>During an interview on 5/20/25 at 9:20 a.m., R3 indicated R2 "sexually harasses" R1 and has read the letters that R2 had written to R1, and they were sexual and graphic. R3 stated, "R2 is scaring the [expletive] out of her". R3 indicated the allegation was reported to the social worker and nursing staff about six weeks to two months ago but moved R2's room even closer to R1. R3 said after the resident council meeting on 5/15/25, R1 and R2 were to go to two different smoking areas.</p> <p>During an interview on 5/20/25 at 9:50 a.m., NA-B indicated the conflict between R1, R2, and R3 is an "everyday thing". NA-B indicated night shift had reported seeing R2 in R1's room and reported it to the charge nurse. NA-B identified R1 expressed concerns with the letters from R2 "a couple of weeks ago" that R1 continued to receive letters from R2 and that R1 wanted them stopped, stating R1 felt stalked. NA-B reported to the charge nurse. NA-B identified they were told to supervise the hallways as much as we can but there are no restrictions on what R1 and R2 can do but, R1 is good about not being in the same area as R2.</p> <p>During an interview on 5/20/25 at 10:15 a.m., R5 indicated being upset because of the sexual harassment to R1 by R2 and stated, "it has to stop". R5 reported she had read the letters and found them to be sexual harassment but not threatening. R5 further indicated R1 had expressed her concerns with the letters and given them to registered nurse (RN)-A and the DON about six weeks ago and the facility made copies of the letters but did nothing to help R1.</p> <p>During an interview at 5/20/25 at 10:30 a.m., RN-A indicated she was made aware of the letters to R1 written by R2 sometime in April. RN-A described the letters she read to be "kind letters, like you are beautiful, and want you to be my friend." RN-A identified she talked to R2, and he did not feel the letters were inappropriate for their relationship. RN-A stated R1 was concerned enough about the letters that she brought them to us and law enforcement was called a couple of times. RN-A identified she did not feel R1</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 8 had the capacity to consent and needed to "figure something out [related to the relationship between R1 and R2]".</p> <p>During an interview on 5/20/25 at 11:08 a.m., the director of nursing (DON) indicated she was aware that R1 and R2 had an off and on relationship that had been ongoing for a while. Indicated R1 has memory issues but R2 does not. The DON indicated R1 brought the letters to her back in "April sometime", did an investigation, interviewed both R1 and R2, and determined R1 "knows what she is doing" so did not report the concern to the State Agency. The DON was not sure how they determined R1's capacity to consent. The DON indicated she was not made aware of any further concerns about the letters until resident council meeting on 5/15/25. After the resident council meeting, implemented 15-minute checks on R1 and told staff to make sure R1 and R2 are not seen together.</p> <p>During an interview on 5/20/25 at 11:32 a.m., family member (FM-A) identified R1 calls her about eight times a day and had concerns about R1's safety and security related to the unwanted letters, treats, snacks, and gifts from R2. FM-A further indicated R1 had called her crying because the abusive situation is triggering R1's PTSD symptoms from earlier childhood trauma. FM-A indicated the facility has talked to R2 and told him to stop but, "it was just ramping it up". FM-A shared concerns that the facility was not following through with their safety plan because he was still writing R1 letters and handing them to her.</p> <p>During an interview on 5/20/25 at 1:04 p.m., the activity director (AD) reported R1 felt unsafe around R2 and received letters from in the past. The AD indicated the letters were given to management and grievances were written. The AD indicated the letters were given to the social worker and R2 did stop writing letters for a while.</p> <p>During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SW identified she was aware of a mutual relationship between R1 and R2 and described the relationship as R2 is "infatuated" and R1 "enjoys the attention". The SW further indicated R1 and R2 are close friends and two adults but their relationship "depends on the day". The SW did not know when the letters first started but did not think they had all</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 9 the letters because she felt the letters that were copied were "friendly" in nature with some drawings. The SW identified the letters were in a "soft file." The SW based R1's capacity to consent off the brief interview for mental status (BIMS) which indicated a score of seven which equated to severe cognitive impairment and "the totality of knowing [R1]". The SW indicated she felt R1 could make decisions "in the moment" but 5-6 hours later would not be confident in her choices.</p> <p>During a follow up interview on 5/22/25 at 11:05 a.m., R1 reported receiving letters from R2 for "at least a few months" and brought her concerns and the notes to staff at least twice before bringing her concerns to the resident council meeting with the ombudsman in attendance. R1 identified the first time she reported her concerns about the notes written by R2, she was told (by facility staff) they would talk to him; the second time she approached staff about the notes, she did not receive any follow up on what had happened. R2 continued to write, and hand deliver the notes to R1 in the designated smoking area or in the hallway. R1 stated, "I would hold my breath going down the hallway, hoping he didn't see me". R1 stated, "the sexual abuse PTSD really amped up and brought it back". R1 reported informing her counselor of the PTSD and the unwanted attention and the doctor was going to "look at adjusting one of my medications but don't know if that happened". R1 was tearful and continued to report trouble sleeping since the notes started as R1 worried about R2 coming into her room at night when the staff was not looking. R1 stated R2's notes made her feel "disgusting, unsettled, and disturbed". R1 indicated the letters from R2 stopped after the resident council meeting on 5/15/25.</p> <p>The letters provided by the facility are as follows:</p> <p>3/27/25: My Luv Bug, you are my favorite addiction Miss Lovely in every xxxxxx way. BTW: I love your tight tush. Yummy to my tummy. Any ways I'm leaving here when you leave becuz [unreadable] I need, want, and love will be gone when you depart my lady. I love you [R1]</p> <p>Undated letter: I just hope you know I am taking an onslaught of haters by expressing my affection for you "Lovely." I am about ready to tap out. It doesn't mean I don't love you, but I am gonna let off the gas pedal soon. I can only hope you still wanna lay in my arms</p>	F0600		

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<p>F0600 SS = SQC-J</p>	<p>Continued from page 10 someday. All night, All night.</p> <p>4/2/25: Baby I still love you [R1] always will. [phone number written] Last letter circled.</p> <p>Letters provided by R1:</p> <p>4/10/25 at 9:26 p.m.: [R1] I love you always [R2]. I will give U loyal love 4 a lifetime if I can trade u my heart for your beautiful body baby bunz.</p> <p>4/21/25 at 7:57 p.m.: Love [R2] I want 2 kiss you forever and a day [R1]! I will always love you. U lifted up baby</p> <p>4/23/25 at 9:56 p.m.: I want to kiss your smile smile. I'm falling 4 you [R1] badly. I love you so much I feel you in my bones baby. I want to kiss you forever.</p> <p>4/26/25 at 7:35 p.m.: 4 ever love [R2] I will never stop adoring you everything you do drives me crazy 4 you [R1] and I love you 4 it more.</p> <p>Undated: Happy May Day my lady. Good morning my lover and best friend you were so amazingly perfect to my eyes. I just longed to touch you everywhere on your baby silk smooth flawless skin. You allowing me to touch you and massage your back and legs gave me a soothing peace I need every day. You are my darling and will and always enjoy pleasuring you anywhere any day {R1}. [heart sign] R2</p> <p>Undated: Happy may day baby - to [R1] we need a night 2getherness. Good morning [R1] I love you more today than before. Thank you for letting me touch you and caress your [unreadable] last night. I need to touch you more. Your body is so silky smooth is soothing you know for me more than it probably is too you. Love [R2]</p> <p>Undated: Baby Bunz, you look so absolutely stunning today. I want to kiss you until me and you both feel loved. [R1] you look more beautiful than ever before. U make me wanna ... ..69 long ... ..until ... ..cream.</p>	<p>F0600</p>		

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F0600 SS = SQC-J	<p>Continued from page 11</p> <p>Undated: [R1} I love u and I know it! I have fallen 4 you [R1] 2 me through my eyes u are the most beautiful women I have ever had a soul connection with by far. No matter what happens you will never be forgotten and will always have a special piece of my [arrow drawn]. There is just something about you baby.</p> <p>Undated: Zangi.com(a private messaging app) [R2's number is listed]</p> <p>Undated: I feel better just being in love with you</p> <p>Undated: P.S ...I [heart drawn]U [R1]! I hope someday we can be alone so I can kiss and hold you until you feel my love.</p> <p>Undated: To my lady [R1] my lover, my lady, my friend, my woman, my wife, my life, my love, yours always [R2]</p> <p>Undated: I need you to know how I feel about you. Its not even funny you're the first and the last thought in my head every day even when we [unreadable] together, just cant get enough of you. The look on your face when you are telling me how you feel about me makes me about melt or when your pushing my buttons trying to be cute makes my head swim even though its frustrating as xxxx it doesn't bother me. The hardest part is trying to not let how I feel show on my face all day long. I selfish and want you all to myself for the remainder of the time we have together. I guess what Im really saying is that I love you and everything about you.</p> <p>Facility documents</p> <p>R1's Grievance Form dated 4/2/25, indicated R1 did not want letters from R2 anymore. The investigation summary identified the DON spoke with R2 about letter writing and R2 wrote his last letter. Attached to the grievance form was a letter written by R1 dated 4/2/25, indicated last letter with "baby, I still love you, always will" with phone numbers written on the note.</p> <p>A county sheriff's office Incident Report dated 5/3/25 at 8:15 p.m., indicated the sheriff's office received a 911 call indicated residents harassing each other and one feels unsafe. Residents were separated and advised</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 12 to leave each other alone. The residents involved were R1, R2, and R3.</p> <p>The facilities Resident Council Minutes dated 5/15/25, identified social services concerns were resident feelings of being stalked and harassed by other residents and social worker stretched thin (over worked).</p> <p>The facility's undated policy titled, Abuse, Neglect and Exploitation identified it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implanting written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will make efforts to ensure all resident are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.</p> <p>The facility's undated policy titled, Resident Right, identifies the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The resident has the right to voice grievances to the facility or other agency without discrimination or reprisal. Such grievance includes those with respect to care and treatment which has been furnished as well as that which has not been furnished; the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have.</p> <p>The immediacy of the IJ was removed on 5/28/25 at 11:09 a.m., when it was verified, the facility had implemented the following:</p> <p>1)</p> <p>R1 immediately assessed by nursing and social service staff for psychological impact related to PTSD,</p>	F0600		

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F0600 SS = SQC-J	Continued from page 13 behavioral changes, mood, and cognitive status.  2) R1 had an appointment over the phone with rural psychiatry services on 5/23/25 at 11:00 a.m.  3) R1 and R2 were placed on 15-minute checks by facility staff. R1's 15-minute checks were to monitor for signs of distress, anxiety, or change in behavior. R2's 15-minute checks were for behavior monitoring.  4) R1 reassured of right to safety and privacy.  5) R1 was offered emotional support services and a counseling session was scheduled for 5/23/25 at 11:00 a.m.  6) Mental health provider will be completing a capacity to consent. The facility is in the process of finding a provider that is able to complete this.  7) Primary care provider and rural psychiatry services were updated of the sexual abuse of R1 by R2 on 5/22/25.  8) Social service designee had routine check-in's with R1 on 5/22/25 and 5/23/25. Check-in's will continue on Tuesday, Thursday, and Saturday evenings.  9) IDT meeting held on 5/22/25 which included increased supervision for R1 and R2, ensure supervising staff are	F0600		

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F0600 SS = SQC-J	<p>Continued from page 14 briefed on relevant background and IJ findings, review of current living/social environment for safety and appropriateness, offer relocation to a different facility if resident wishes, remove or limit access to triggering individuals or settings where possible, remove or limit access to triggering individuals or settings where possible, counseling arranged to occur as needed, engage family or guardians where/when appropriate, engage commitment manager/relocation, worker/therapist/clergy when/where appropriate.</p> <p>10) R2's care plan and behavioral intervention plans updated to include all written and verbal communications with R1 would be monitored by staff to ensure appropriateness and maintain a respectful, safe environment.</p> <p>11) All residents were assessed to ensure no others were impacted by similar behavior from R2.</p> <p>12) Abuse policy was revised to include written/verbal communications and resident to resident sexual harassment procedures.</p> <p>13) Mandatory in-service training on 5/22/25, including definitions and examples of sexual abuse including written communications and mandated reporting.</p> <p>14) System in place to determine capacity to consent on admission for all residents.</p> <p>15) Weekly audits of resident interactions both written and verbal for 4 weeks, monthly for 3 months, and reviewed at quality assurance and performance improvement (QAPI) meetings.</p>	F0600		

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F0609 SS = D	<p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to report allegations of abuse timely to the State Agency for 1 of 1 resident (R1) reviewed for allegations of abuse and neglect. The allegations occurred on 3/27/25, 4/2/25, 4/27/25, 5/3/25, and 5/15/25.</p> <p>Findings include:</p> <p>A Vulnerable Adult Maltreatment Report submitted to the</p>	F0609	<p>1. All allegations involving R1 from 3/27/25, 4/2/25, 4/27/25, 5/3/25, and 5/15/25 have been reviewed and investigated. Any delayed reports have now been submitted to the State Agency. R1 remains safe with no ongoing risk. The staff members responsible have been re-educated.</p> <p>2. A full audit of Risk Management, grievance logs, and behavior monitoring notes from the last 30 days was conducted to ensure that all other allegations were reported timely to the State Agency. No other delays in reporting were identified at this time.</p> <p>3. "The facility's Abuse Reporting Policy has been reviewed and it includes the clarification of the 2-hour and 24-hour reporting requirements to the State Agency per federal and state regulations.</p> <p>"All nurses, social workers, and department heads received training on abuse allegation recognition, reporting timeframes, and documentation procedures.</p> <p>"A new internal reporting checklist has been implemented for allegations to ensure timely reporting and tracking.</p> <p>4. The DON or designee will audit all abuse allegation reports weekly for 4 weeks, then monthly for 1 month, to ensure reports are submitted within the required timeframes. Results of audits will be reported to the facility's Quality Assurance and Performance Improvement (QAPI) Committee monthly and action taken as needed.</p>	07/16/2025

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F0609 SS = D	<p>Continued from page 16</p> <p>State Agency (SA) on 5/16/25 at 12:00 p.m., alleged abuse and neglect to R1 when R1 reported feeling unsafe at the facility due to R2 being sexually inappropriate, sexually harassing, and making unwanted sexual advances by writing letters and talking about sexual desires that he had with R1. Several of the female resident stated they did not feel safe in the facility because of R2's behaviors. Residents stated that the Director of Nursing Services told the residents that she will "not be babysitting" and that they are all adults and that this other resident "[R2]" has the right to "Freedom of Speech". After [R1] reported her concerns to staff they moved "[R2]" closer to her room which makes her even more uncomfortable. Several of the other resident's report that "[R2]" is also stealing things from them out of their rooms. The residents report that nothing is done by staff to stop these things from occurring.</p> <p>A Nursing Home Incident Report (NHIR) submitted to the SA on 5/16/25 at 1:57 p.m., alleged abuse when a resident (R1) reports during resident council on 5/15/25 that they did not feel safe because a resident (R2) stares at them. The report further indicated the ombudsmen was onsite and told the facility they were mandated reporters. Administrator was notified 5/15/25 at 1:16 p.m.</p> <p>R1's significant change Minimum Data Set (MDS) assessment dated 3/12/25, indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver).</p> <p>R1's Vulnerability and Susceptibility to Abuse assessment dated 2/19/25, indicated R1 was at risk for abuse related to cognitive impairment, alcohol/substance abuse, physical impairment.</p> <p>R2's quarterly MDS assessment dated 5/8/25, identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly.</p>	F0609		

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F0609 SS = D	<p>Continued from page 17</p> <p>R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply).</p> <p>R2's progress notes dated 3/27/25 at 4:28 p.m., three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed felling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding.</p> <p>A facility Grievance Form submitted by R1 dated 4/2/25, indicated R1 did not want letters from R2 anymore. The investigation summary identified the DON spoke with R2 about letter writing and R2 wrote his last letter. Attached to the grievance form was a letter written by R1 dated 4/2/25, indicated last letter with "baby, I still love you, always will" with phone numbers written on the note.</p> <p>R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding.</p> <p>A county sheriff's office Incident Report dated 5/3/25 at 8:15 p.m., the sheriff's office received a 911 call indicated residents harassing each other and one feels unsafe. Residents were separated and advised to leave each other alone. The residents involved were R1, R2, and R3.</p> <p>The facilities Resident Council Minutes dated 5/15/25, identified social services concerns were resident feelings of being stalked and harassed by other residents.</p> <p>During an interview on 5/20/25 at 11:08 a.m., the director of nursing (DON) indicated she was aware that</p>	F0609		

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F0609 SS = D	<p>Continued from page 18</p> <p>R1 and R2 had an off and on relationship that had been ongoing for a while. Indicated R1 has memory issues but R2 does not. The DON indicated R1 brought the letters to her back in "April sometime", did an investigation, interviewed both R1 and R2, and determined R1 "knows what she is doing" so did not report the concern to the State Agency. The DON was not sure how they determined R1's capacity to consent.</p> <p>During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SW identified she was aware of a mutual relationship between R1 and R2 and described the relationship as R2 is "infatuated" and R1 "enjoys the attention". The SW further indicated R1 and R2 are close friends and two adults but their relationship "depends on the day". The SW did not know when the letters first started but did not think they had all the letters because she felt the letters that were copied were "friendly" in nature with some drawings. The SSD and administrator denied awareness of the 5/3/25 incident and verified they did not report any of the allegations to the SA.</p> <p>The facility's undated Abuse, Neglect and Exploitation policy identified it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implanting written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will make efforts to ensure all resident are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The policy further directs reporting of all alleged violations to the administrator, state agency, adult protective services, and all other required agencies within specified timeframes: immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p>	F0609		
F0610 SS = D	<p>Investigate/Prevent/Correct Alleged Violation</p> <p>CFR(s): 483.12(c)(2)-(4)</p>	F0610	1. R1 was assessed for physical/emotional well-being, protective interventions were put in place, and the physician and family were notified.	07/16/2025

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F0610 SS = D	<p>Continued from page 19</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to thoroughly investigate and protect residents for an allegation of sexual abuse for 1 of 3 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>A Vulnerable Adult Maltreatment Report submitted to the State Agency (SA) on 5/16/25 at 12:00 p.m., alleged abuse and neglect to R1 when R1 reported feeling unsafe at the facility due to R2 being sexually inappropriate, sexually harassing, and making unwanted sexual advances by writing letters and talking about sexual desires that he had with R1. Several of the female resident stated they did not feel safe in the facility because of R2's behaviors. Residents stated that the Director of Nursing Services told the residents that she will "not be babysitting" and that they are all adults and that this other resident "[R2]" has the right to "Freedom of Speech". After [R1] reported her concerns to staff they moved "[R2]" closer to her room which makes her even more uncomfortable. Several of the other resident's report that "[R2]" is also stealing things from them out of their rooms. The residents report that nothing is done by staff to stop these things from occurring.</p>	F0610	<p>Continued from page 19</p> <p>2. A 30-day review of grievances, logs, behavioral notes, and Risk Management completed. No other concerns were identified. Residents with similar vulnerabilities were reassessed for safety and protection measures.</p> <p>3. Abuse investigation policy was revised. Department Heads and all licenses nurses were re-educated on abuse protocols, trauma-informed care, and immediate protection steps.</p> <p>4. The Administrator or designee will continue to discuss incidents in standup with process and results of investigations. An audit of investigations monthly x 3 months for completion and resolution. Results will be reviewed in QAPI to identify trends and ensure compliance.</p>	

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F0610 SS = D	<p>Continued from page 20</p> <p>A Nursing Home Incident Report (NHIR) submitted to the SA on 5/16/25 at 1:57 p.m., alleged abuse when a resident (R1) reports during resident council on 5/15/25 that they did not feel safe because a resident (R2) stares at them. The report further indicated the ombudsmen was onsite and told the facility they were mandated reporters. Administrator was notified 5/15/25 at 1:16 p.m.</p> <p>R1's significant change Minimum Data Set (MDS) assessment dated 3/12/25, indicated severe cognitive impairment and diagnoses of Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver).</p> <p>R2's quarterly MDS dated 5/8/25, indicated moderately impaired cognition with verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly. R2's diagnosis list includes emotional lability, alcohol use, depression, and anxiety disorder.</p> <p>R2's progress notes dated 3/27/25 at 16:28 (4:28 p.m.), three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed feeling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding.</p> <p>The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings.</p> <p>A facility Grievance Form submitted by R1 dated 4/2/25, indicated R1 did not want letters from R2 anymore. The investigation summary identified the DON spoke with R2 about letter writing and R2 wrote his last letter. Attached to the grievance form was a letter written by R1 dated 4/2/25, indicated last letter with "baby, I still love you, always will" with phone numbers written</p>	F0610		

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F0610 SS = D	<p>Continued from page 21 on the note.</p> <p>R1 provided the following letters to registered nurse (RN)-A and the director of nursing (DON):</p> <p>3/27/25: My Luv Bug, you are my favorite addiction Miss Lovely in every [expletive] way. BTW: I love your tight tush. Yummy to my tummy. Any ways I'm leaving here when you leave becuz [unreadable] I need, want, and love will be gone when you depart my lady. I love you [R1]</p> <p>Undated letter: I just hope you know I am taking an onslaught of haters by expressing my affection for you "Lovely." I am about ready to tap out. It doesn't mean I don't love you, but I am gonna let of the gas pedal soon. I can only hope you still wanna lay in my arms someday. All night, All night.</p> <p>4/2/25: Baby I still love you [R1] always will. [phone number written] Last letter circled.</p> <p>The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings.</p> <p>R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding.</p> <p>The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings.</p> <p>A county sheriff's office Incident Report dated 5/3/25 at 8:15 p.m., the sheriff's office received a 911 call indicated residents harassing each other and one feels unsafe. Residents were separated and advised to leave each other alone. The residents involved were R1, R2,</p>	F0610		

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<p>F0610 SS = D</p>	<p>Continued from page 22 and R3.</p> <p>The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings.</p> <p>The facilities Resident Council Minutes dated 5/15/25, identified social services concerns were resident feelings of being stalked and harassed by other residents.</p> <p>The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation.</p> <p>R1 continued to receive letters from R2 on 4/10/25, 4/21/25, 4/23/25, 4/26/25, and nine undated letters after submitting the facility grievance form on 4/2/25.</p> <p>During an interview on 5/20/25 at 10:20 a.m., registered nurse (RN)-A identified R1 had concerns about letters that she was receiving from R2 and provided the letters to her in "April sometime". RN-A identified she notified the administrator at that time. RN-A indicated they interviewed a few of the residents but determined the letters to be "kind letters" and talked to R2 about the letter writing. RN-A denied seeing any sexual letters. RN-A denied having documentation of the interviews.</p> <p>During an interview on 5/20/25 at 11:08 a.m., the director of nursing (DON) indicated she was aware of the letters "back in April sometime". R1 and R2 were interviewed but did not have documentation of the interviews or evidence of a thorough investigation. The DON indicated the investigation concluded R1 "knows what she is doing" but did not know how that was determined. The DON also indicated R1 was put on 15-minute checks "over the weekend" but did not know where the documentation was.</p> <p>During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SSD indicated she was aware of some of the letters R1 had received from R2 but felt</p>	<p>F0610</p>		

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F0610 SS = D	Continued from page 23 the letters had been "friendship in nature" and contained some drawings. The SSD did acknowledge receiving a grievance from R1 regarding the letters in April. The SSD and the administrator both stated they were not aware of the sheriff's department being dispatched to the facility on 5/3/24 related to reported harassment among R1, R2, and R3 but that the DON was notified. The documentation's and timelines of the investigations were requested related to the letters, but the SSD only provided copies of three letters from a "soft file." The administrator did not have any further information.  The facility's undated Abuse, Neglect and Exploitation policy directed an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation, identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause and providing complete and thorough documentation of the investigation. Protection of the resident: The facility will make efforts to ensure all resident are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: responding immediately to protect the alleged victim and the integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and others; room or staffing changes if necessary, to protect the resident(s) from the alleged perpetrator; protection from retaliation; providing emotional support and counseling to the resident during and after the investigation, as needed; revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.	F0610		
F0627 SS = D	Inappropriate Discharge  CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)  §483.15(c) Transfer and discharge-  §483.15(c)(1) Facility requirements-	F0627	1. R2 was discharged on 05/23/2025. The facility immediately reviewed the discharge for compliance. Documentation was evaluated for appropriateness and the Discharge Transfer Notice form (42 CFR 483.15) was completed and no signature line(s) were noted.  2. All residents have the potential for risk. No	07/16/2025

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F0627 SS = D	<p>Continued from page 24</p> <p>§483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-</p> <p>(A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>(B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>(C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;</p> <p>(D)The health of individuals in the facility would otherwise be endangered;</p> <p>(E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F)The facility ceases to operate.</p> <p>§483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is</p>	F0627	<p>Continued from page 24 additional concerns were identified. All planned discharges moving forward are now reviewed for regulatory compliance.</p> <p>3. Discharge policy was reviewed. Staff involved in discharge planning were re-educated on 42 CFR §483.15 and facility procedures.</p> <p>4. The Social Services Director or designee will audit 100% of discharges weekly x 4 weeks, then monthly x 1 month. Audit results will be reviewed during QAPI meetings. Immediate corrective action will be taken if deficiencies are found.</p>	

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F0627 SS = D	<p>Continued from page 25 documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i)Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>§483.15(c)(7) Orientation for transfer or discharge.</p> <p>A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.</p> <p>§483.15(e)(1) Permitting residents to return to facility.</p> <p>A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.</p> <p>(i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-</p> <p>(A) Requires the services provided by the facility; and</p> <p>(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services</p>	F0627		

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F0627 SS = D	<p>Continued from page 26</p> <p>(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.</p> <p>§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.</p> <p>§483.21(c)(1) Discharge Planning Process</p> <p>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-</p> <p>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.</p> <p>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.</p> <p>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.</p> <p>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.</p> <p>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.</p>	F0627		

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F0627 SS = D	<p>Continued from page 27</p> <p>(vi) Address the resident's goals of care and treatment preferences.</p> <p>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.</p> <p>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.</p> <p>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>§483.21(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the</p>	F0627		

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F0627 SS = D	<p>Continued from page 28</p> <p>resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide 1 of 2 residents (R2) with choices for discharge, right to an appeal process, ability to stay at facility during an appeal process, review and take into account substance use disorder and mental health diagnoses that would impair judgement on the decision to transfer, and allow the resident time to process the discharge prior to discharging.</p> <p>R2's face sheet dated 5/23/25, identified diagnoses of emotional lability (tendency to shift rapidly and dramatically between different emotional states), alcohol use, cognitive communication deficit (challenges with language comprehension, expression, reasoning, attention, memory, and organization), depression, anxiety disorder, and osteonecrosis (death of the bone due to lack of blood supply) to right and left femur.</p> <p>R2's quarterly Minimum Data Set (MDS) assessment dated 5/8/25, identified R2 had moderately impaired cognition, no hallucinations or delusions, and had verbal behaviors directed towards others one to three days weekly and behavioral symptoms not directed at others one to three days weekly. R2 required assist of staff with bed mobility, toileting, transferring, and dressing lower body. R2 does not ambulate.</p> <p>R2's care plan dated 1/25/25, identified ineffective coping related to reported history of traumatic event with no triggers noted. Interventions included to allow R2 to express feelings, provide a safe, therapeutic environment to regain control as needed, R2 preferred female caregivers and did not want male caregivers for intimate cares. A focus dated 1/29/25, identified R2 had a behavior problem of story telling and embellishing the truth. Interventions included to discuss the behavior, explain/reinforce why behavior is inappropriate or unacceptable. On 5/22/25, an intervention of 15-minute safety checks for behavior monitoring was initiated. A focus dated 1/27/25,</p>	F0627		

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F0627 SS = D	<p>Continued from page 29 identified R2 wished to return to his prior living arrangements when able to discharge, interventions included to evaluate and discuss the prognosis for independent or assisted living, no additional interventions were identified past 1/27/25.</p> <p>R2's Trauma Informed Care History dated 1/27/25, identified traumata history from physical abuse. The response to triggers that make things worse was, "not really" and the Lord and prayer helped R2 manage.</p> <p>R2's psychosocial care area assessment (CAA) dated 1/27/25, identified R2 was at risk for psychosocial wellbeing changes due to recent hospitalization and factors noted in worksheet. At risk for further rehospitalization if psychosocial well-being not addressed. Care plan to address psychosocial wellbeing and strategies to reduce and manage risk. No behaviors.</p> <p>R2's Treatment Administration Record (TAR) dated 5/1/25 to 5/31/25, identified targeted behaviors included negative statements, isolating self, sad, crying, and anxiety.</p> <p>R2's progress note dated 4/27/25 at 4:51 p.m., identified R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R2 was interviewed and identified that sexual behavior occurred with R1. R1's safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. Director of Nursing (DON) and social worker notified.</p> <p>R2's progress note dated 5/3/25 at 2:35 p.m., identified a conflict between R2 and another resident had occurred in the designated smoking area. The residents were separated and educated on observing facility rules and were advised to remain apart from each other for the safety of themselves and other residents. Conflict de-escalated.</p> <p>R2's progress note dated 5/4/25 at 2:47 p.m., identified R2 talked with law enforcement for "allegation" raised by another resident that R2 was harassing them while they were outside smoking. R2 is on 15-minute checks from a prior incident and was educated to inform staff when he went outside to smoke</p>	F0627		

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F0627 SS = D	<p>Continued from page 30 and not go outside when the other resident was outside. DON and social worker notified.</p> <p>R2's progress note dated 5/22/25 at 8:36 p.m., identified R2 had exhibited a pattern of writing notes directed toward a female peer. Due to concerns regarding boundary issues and to promote a safe, respectful environment, R2's care plan has been updated to obtain approval from charge nurse or designated staff member before sharing written communication with female residents. Additionally, all interpersonal interactions with the female residents will be monitored by staff. R2 was informed of this change and provided education regarding appropriate social boundaries. Additionally, R2 remains on 15-minute safety checks for behavioral monitoring. R2 agreed and verbalized understanding of the education provided.</p> <p>R2's progress note dated 5/23/25 at 3:00 p.m., identified: discussed with R2 that the referral to a sister facility had been accepted and a transfer is now possible. R2 expressed understanding and agreed to the transfer. R2 inquired about the timeline and was informed the transfer could occur today. R2 consented to a same day move. Staff offered assistance with packing; R2 accepted and requested that staff use the suitcase located in his closet. Discharge orders obtained from R2's primary care physician and transfer coordination is underway.</p> <p>R2's progress note dated 5/23/25 at 3:39 p.m., identified R2 discharged to sister facility around 3:30 p.m. R2 got a ride through the facility's transportation. R2 used a wheelchair, declined a vital sign check, is alert and orientated. Sent medications and medication sheet with the driver.</p> <p>R2's visual check sheet every 15 minutes dated 5/22/25, identified the checks began on 5/22/25 at 5:45 p.m. and ended on 5/23/25 at 4:00 p.m. with discharge.</p> <p>The discharge/transfer notice dated 5/23/25, identified this notice was to notify of the transfer or discharge to the sister facility. The box was checked that R2 requested the transfer or discharge with the reason to be closer to surgery site/fresh start. The notice was signed by the administrator on 5/23/25.</p>	F0627		

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F0627 SS = D	<p>Continued from page 31</p> <p>During an interview on 5/27/25 at 11:54 a.m., registered nurse (RN)-A stated the DON had asked her to talk to R2 and see if he would transfer to the sister facility as they had accepted him as a transfer. R2 agreed to the transfer but made a comment that he would like to return once another resident discharged from this facility. RN-A stated that would be something that would have to be discussed with the interdisciplinary team (IDT).</p> <p>During a phone interview on 5/27/25 at 12:18 a.m., regional Ombudsman (RO)-A stated she was unaware that R2 had discharged to another facility until she received an email from the DON on 5/27/25. If this was a facility initiated discharge the Ombudsman must be contacted immediately and R2 has the right to appeal and remain where he is at during the appeal process. If R2 agreed with the transfer/discharge he should have signed the form that he agreed to the discharge.</p> <p>During a phone interview on 5/27/25 at 12:28 p.m., R2 stated registered nurse (RN)-A came to his room and said maintenance worker (MW)-A was getting the bus to transfer to the sister facility and nursing assistant (NA)-A and NA-C packed his belongings up and he was in the bus in a matter of 10-12 minutes time. The NA's threw out a note pad that had passwords on it during the process, and R2 is unable to use his phone until he can purchase more minutes to change his phone number. The facility got rid of me. They said I could have better care at the new facility. They said the "higher-ups" decided but R2 was not allowed to discuss it with them and when R2 asked if he had to leave, they told him "Yeah, in a certain way" so R2 believed them. R2 asked to return to the facility when certain residents discharged. Something does not feel right when they get you out of there as fast as they can like Caesar washing his hands from Jesus Christ, and it came from the administrator. R2 stated the facility got him to verbally say he would move and if he did not like it, they could hopefully help him return but did not let him talk to an advocate. Now that R2 is at the current facility, he wants to go back. This is a real nursing home and R2 does not feel he belongs at it. There are rules in place at the current facility that are not in place at the facility. R2 feels penned up at the current facility. R2 cried and has been crying in his room and feeling very depressed since the transfer. R2 keeps waking up from sleep and realizing that it is not a dream, and he is not at the facility he wants to be at. R2 stated his medical appointments are now 45 minutes farther to get too.</p>	F0627		

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F0627 SS = D	<p>Continued from page 32</p> <p>During an interview on 5/27/25 at 2:07 p.m., DON stated social service designee (SSD)-A initiated discharge for R2 and sent the referral to the sister facility and thought it occurred a couple of days prior to R2's discharge. Both R1 and R2 were aware that they may be discharged to a sister facility. The discharge notice was completed on 5/23/25 and sent to the Ombudsman on 5/27/25 after it was found on SSD-A's desk. The doctor was aware of the referrals sent and gave the order to discharge to the sister facility.</p> <p>During a phone interview on 5/27/25 at 2:16 p.m., DON-B, from the sister facility, stated she received an email referral for R2 on 5/23/25 at 1:55 p.m. and that was the first contact she had about R2 transferring to the facility. The information came from SSD-A and DON. DON had stated the facility needed placement for R2. DON-B stated DON and SSD-A did not provide information about R2's sexual abuse allegations but she was aware through working for the same company. R2 was antsy about being at the new facility on 5/23/25 after he arrived but DON-B had talked through the transfer with him. Verification of emails identified SSD-A sent an email on 5/23/25 at 1:55 p.m. that included R2's face sheet and progress notes, at 1:57 a second email from SSD included R2's care plan, and at 2:57 p.m. DON sent paperwork including order summary from emergency department, discharge summary, physician visit, and doctor note from 5/12/25 visit.</p> <p>During an interview on 5/28/25 at 2:36 p.m., MW-A stated he was informed at approximately 2:40 p.m. on 5/23/25, about R2 discharging to a sister facility because R1 felt unsafe with R2 at the facility. The transfer happened very suddenly and MW-A transported R2 to the sister facility around 3:00 p.m. During the transport, R2 was not in his normal mood, no big smile on his face, very monotone and emotionless, not reacting as he normally would to MW-A.</p> <p>During a phone interview on 5/28/25 at 3:42 p.m., SSD-A stated she had left the facility for the day, without access to the building or her email around 1:00 p.m. on 5/23/25. SSD-A did not have any part of the discharge preparing or planning for R2 and had not had a conversation with R2 about discharging. SSD-A did not send emails or have communication with the sister facility about R2's transfer.</p>	F0627		

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F0627 SS = D	<p>Continued from page 33</p> <p>During an interview on 5/28/25 at 3:04 p.m., Administrator stated R1 and R2 were both offered discharge to other facilities. R1 said no to the discharge. R2 was upset about being accused of sexual abuse from R1 and the 15-minute checks on him that were put in place and wanted a fresh start. R2 approached the possibility of being transferred to the SSD-A. The sister facility was 39 miles from the current facility and would be closer to R2's surgery location (88 miles from sister facility). Administrator was unable to articulate other facilities that R2 was offered for relocation. R2 did not sign the discharge form and was pretty upset during the relocation process. It was a big change in 1.5 hours for R2. R2 stated he wanted to return to the facility. The physician was notified and gave orders to discharge to the sister facility but was not made aware of the reason for the discharge. The Ombudsman was not notified of the discharge until 5/27/25.</p> <p>During a follow-up phone interview on 5/28/25 at 4:15 p.m., RN-A stated she was told a referral had been sent to the sister facility earlier during the week before 5/23/25. RN-A attended all the IDT meetings but was unsure if discharging R2 to the sister facility was discussed. RN-A told R2 he could transfer that day (5/23/25) and that it was closer to doctor appointments and that the facility could pack his belongings. R2 had talked about it being a fresh start at a different facility. R2's demeanor to the discharge appeared like he was frustrated.</p> <p>The facility's undated Resident Right policy, identifies the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The resident has the right to voice grievances to the facility or other agency without discrimination or reprisal. Such grievance includes those with respect to care and treatment which has been furnished as well as that which has not been furnished; the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have.</p> <p>During a return phone call on 6/6/25 at 10:14 a.m. from 5/28/25 at 11:40 a.m., family friend (FF)-A stated R2 has contacted her since being at the new facility. R2</p>	F0627		

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F0627 SS = D	<p>Continued from page 34 made statements that he was being left at the facility to die and voiced frustration of not seeing any type of future for himself.</p> <p>The facility Transfer and Discharge policy dated 4/21/25, identified it is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances.</p> <p>Once admitted, the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: necessary for the residents welfare, residents needs cannot be met, safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.</p> <p>The facilities transfer/discharge notice will be provided to the resident and residents representative and include: specific reason for the transfer, effective date of discharge, specific location to which the resident is to be transferred/discharged, an explanation of the appeal rights to the State, for residents with mental illness or related disability the notice will include the name, mailing and email addresses and phone number of the state agency responsible for protection and advocacy of these populations.</p> <p>Generally, the notice must be provided at least 30 days prior to the transfer or discharge of the resident. Exemptions to the 30-day requirement apply when: health/safety of individuals in the facility would be endangered due to clinical or behavioral status of the resident, urgent medical needs, resident has not resided at the facility for 30 days. In these exceptional cases, the notice must be provided to the resident, resident representative and LTC Ombudsman as soon as practicable before the transfer or discharge.</p>	F0627		
F0699 SS = D	<p>Trauma Informed Care</p> <p>CFR(s): 483.25(m)</p> <p>§483.25(m) Trauma-informed care</p> <p>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of</p>	F0699	<p>1. Care plans for R1 and R2 were immediately reviewed and updated to include individualized trauma-informed interventions based on each residents PTSD diagnosis and history. Staff were informed of the updates, and interventions were implemented.</p> <p>2. A facility-wide audit was completed to identify all residents with PTSD diagnosis. Their care plans were</p>	07/16/2025

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F0699 SS = D	<p>Continued from page 35 practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, observation and record review, the facility failed to implement trauma-informed care for 2 of 3 residents (R1, R2) identified with a diagnosis of post-traumatic stress disorder (PTSD) reviewed for PTSD-related care.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS) assessment dated 3/12/25, indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver).</p> <p>R1's admission Trauma Informed Care History dated 10/16/24 identified R1 was molested as a child. Triggers that make it worse were indicated as "use to have a lot of them but overcame them with counseling."</p> <p>R1's care plan initiated on 10/16/24, identify a potential for ineffective coping related to PTSD and reported history of traumatic event(s) from her childhood attention seeking behavior of sexual comments towards men. Goal was to feel safe and enjoy daily activities of her choice for the next 90 days. Interventions included allow to express feeling, communicate with them that they are safe, it's not their fault, you are sorry this happened and you are glad they are alive; identify support system and us them as appropriate; and provide a safe therapeutic environment where they can regain control as needed.</p> <p>R1's care plan, initiated 10/16/24, did not contain updated interventions for PTSD-related triggers, symptoms, or interventions.</p> <p>R1's Nursing Note dated 5/4/25 at 02:24 (2:24 a.m.) identified R1 and another resident approached writer at 7:40 p.m., and stated that they did not feel safe as R2</p>	F0699	<p>Continued from page 35 reviewed and updated as needed to reflect trauma-informed interventions.</p> <p>3. The facility reviewed its policy on trauma-informed. Nursing, social services, and direct care staff received education on trauma-informed principles and care planning specific to PTSD.</p> <p>4. The DON or designee will audit 5 care plans weekly x 4 weeks, then monthly x 1 month to ensure trauma-informed care is addressed for applicable residents. Results will be reviewed in QAPI, and corrective action taken as needed.</p>	

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F0699 SS = D	<p>Continued from page 36 was harassing them by calling them offensive names when they were out in the smoking area. R1 further stated that the "harassing" resident [R2] stays at his door and when they go out to smoke, he follows them. Writer request R1 to say away from the other resident as much as they could. Writer offered an alternative smoking area for the meantime and in the event [R1] wanted to go to the regular smoking area to inform staff so they could be with staff all the time. Law enforcement involved. Director of nursing DON was notified and social worker to be informed. There were no further notes related to monitoring for symptoms of PTSD symptoms.</p> <p>R1's record lacked indication a comprehensive assessment was completed to determine psychosocial harm, interventions were put in place to ensure safety, supportive services were provided, or monitoring systems for supervision and mood/behavior changes were implemented to keep R1 safe, recognize potential exacerbation of PTSD from ongoing abuse, and re-assess or review triggers that may be stressors or prompt recall of previous traumatic event.</p> <p>R2's quarterly MDS assessment dated 5/8/25, identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly.</p> <p>R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply).</p> <p>R2's psychosocial care area assessment (CAA) dated 1/27/25, identified R1 was at risk for psychosocial wellbeing changes due to recent hospitalization and factors noted in worksheet. At risk for further re-hospitalization if psychosocial well-being not addressed. Care plan to address psychosocial wellbeing and strategies to reduce and manage risk. No behaviors.</p> <p>R2's Trauma Informed Care History dated 1/27/25, indicated traumatic history included being beat up and kicked in the ribs. The response to triggers that make things worse was, "not really" and the lord and prayer helped R2 manage.</p>	F0699		

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F0699 SS = D	<p>Continued from page 37</p> <p>R2's Psychiatry Provider Note dated 2/11/25, indicated R2's trauma history included sexual abuse as a child by a family member.</p> <p>R2's care plan initiated 1/25/25, indicates potential for ineffective coping related to reported history of traumatic event no triggers noted. Interventions included allow to express feelings, provide a safe therapeutic environment where they can regain control as needed; prefers female caregivers; does not want male caregivers for intimate cares. Did not include care plan updates, potential sexual behaviors toward others.</p> <p>R2's progress notes dated 3/27/25 at 4:28 p.m., three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed felling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding.</p> <p>R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding.</p> <p>R2's Treatment Administration Record dated 5/1/25 to 5/31/25, indicated targeted behaviors included negative statements, isolating self, sad, crying, and anxiety.</p> <p>R2's record lacked indication behavior management or monitoring was implemented to mitigate risk of R2's identified sexual behaviors towards R1. Further lacked identification of assessment of need for or implementation of supervision or monitoring of the potential for re-triggering PTSD related to childhood sexual abuse.</p>	F0699		

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F0699 SS = D	<p>Continued from page 38</p> <p>During observation and interview on 5/20/25 at 8:55 a.m., R1 stated she had concerns about her safety because of R2 saying "stuff to me like he likes me and started passing me some sexual notes". R1 indicated being married and would not consent to a relationship with R2. R1 further identified the notes started to get "disturbing" and showed staff the notes. R1 indicated R2 would usually approach her in the smoking area, which was unsupervised by staff.</p> <p>During an interview on 5/20/25 at 11:32 a.m., family member (FM-A) identified R1 calls her about eight times a day and had concerns about R1's safety and security related to the unwanted letters, treats, snacks, and gifts from R2. FM-A further indicated R1 had called her crying because the abusive situation is triggering R1's PTSD symptoms from earlier childhood trauma. FM-A indicated the facility has talked to R2 and told him to stop but, "it was just ramping it up". FM-A shared concerns that the facility was not following through with their safety plan because he was still writing R1 letters and handing them to her.</p> <p>During an interview on 5/20/25 at 11:58 a.m., the director of nursing (DON) stated a Trauma Informed Care Assessment is completed upon admission and take information from progress notes, provider notes and care plan interventions to meet the resident needs. The DON further identified the social service designee is responsible for completing the assessments and care planning interventions.</p> <p>During an observation and interview on 5/20/25 at 2:15 p.m., R2 was lying on the bed and identified he was in trouble at the facility because he had a relationship with R1 and wrote her some love notes. R1 decided she did not want them anymore; they called the "cops", and we were supposed to stay away from each other. Law enforcement returned on Friday 5/16/25 and talked to me again. R2 stated, "all the staff knew about it" and the social worker told R2 that he was "stalking" R1 but could not remember when that conversation occurred. R2 reported writing "love notes" to R1 for approximately two months. R2 identified he has been "shunned" by the staff and feels the need to "alienate" due to the harassment he was receiving by the staff and other residents because of the letters he wrote to R1.</p> <p>During a follow up interview on 5/22/25 at 11:05 a.m., R1 reported receiving letters from R2 for "at least a</p>	F0699		

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F0699 SS = D	<p>Continued from page 39 few months" and brought her concerns and the notes to staff at least twice before bringing her concerns to the resident council meeting with the ombudsman in attendance. R1 identified the first time she reported her concerns about the notes written by R2, she was told (by facility staff) they would talk to him; the second time she approached staff about the notes, she did not receive any follow up on what had happened. R2 continued to write, and hand deliver the notes to R1 in the designated smoking area or in the hallway. R1 stated, "I would hold my breath going down the hallway, hoping he didn't see me". R1 stated, "the sexual abuse PTSD really amped up and brought it back". R1 reported informing her counselor of the PTSD and the unwanted attention and the doctor was going to "look at adjusting one of my medications but don't know if that happened". R1 was tearful and continued to report trouble sleeping since the notes started as R1 worried about R2 coming into her room at night when the staff was not looking. R1 stated R2's notes made her feel "disgusting, unsettled, and disturbed". R1 indicated the letters from R2 stopped after the resident council meeting on 5/15/25.</p> <p>1.</p> <p>The facility policy Trauma Informed Care undated, identified the facility would provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. The facility will work to facilitate the principles of trauma informed care which include:</p> <p>a.</p> <p>Safety - Ensuring residents have a sense of emotional and physical safety.</p> <p>b.</p> <p>Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.</p>	F0699		

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F0699 SS = D	Continued from page 40  c.  Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals.  d.  Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care.  e.  Empowerment, voice, and choice - Ensuring that resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths.  The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to:  f.  Experiencing a lack of privacy or confinement in a crowded or small space.  g.  Exposure to loud noises, or bright/flashing lights.  h.  Certain sights, such as objects that are associated with their abuser.	F0699		

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F0699 SS = D	Continued from page 41 i.  Sounds, smells, and physical touch.  Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.  The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.  In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.	F0699		
F0710 SS = D	Resident's Care Supervised by a Physician  CFR(s): 483.30(a)(1)(2)  §483.30 Physician Services  A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.  §483.30(a) Physician Supervision.  The facility must ensure that-  §483.30(a)(1) The medical care of each resident is supervised by a physician;  §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable.	F0710	1. Physician documentation for R1s visit has been requested from the medical physician and will be added to the medical record once received.  2. All residents have the potential to be affected.  3. Staff were educated on ensuring physician visit documentation is received. A tracking log was implemented to verify all routine physician visits are documented.  4. DON/designee will audit visit documentation monthly x 6 months. Results will be reviewed in QAPI.	07/16/2025

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F0710 SS = D	<p>Continued from page 42</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure residents who were seen during routine physician visits every 30-60-90 days had physician documentation in the medical record for 1 of 1 (R1) resident, reviewed during the extended survey.</p> <p>Findings include:</p> <p>R1's significant change MDS dated 3/12/25; indicated severe impaired cognition; diagnoses of anxiety, depression, post traumatic stress disorder (PTSD). Required supervision with walking greater than 150 feet and set up for shower/bathe. Took antidepressants.</p> <p>R1's medical record identified R1 had physician visits on 10/29/24, 11/18/24, 2/6/25, 3/18/25, and 4/23/25. R1's medical record lacked documentation of routine 60-90-day routine visits from 11/18/24 to 2/6/25.</p> <p>During an interview on 5/29/25 at 11:05 a.m., director of nursing (DON) stated the physician saw the resident and signed the physician orders but did not know why he did not write a note. DON verified with physician that he saw resident, knew he had to write a note but did not remember why he did not.</p> <p>Facility undated policy titled "Physician visits and Physician Delegation", indicated:</p> <p>a. See resident within 30 days of admission to the facility.</p> <p>b. The resident must be seen at least once every 30 calendar days for the first 90 days after admission and at least every 60 days thereafter.</p> <p>h. At the option of the physician, required visits in SNF's, after the initial visit, may alternate between personal visits by the physician and visits by a non-physician provider, which is acting within their scope of practice.</p>	F0710		
F0740 SS = D	Behavioral Health Services	F0740	1. Comprehensive assessments and person-centered care	07/16/2025

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F0740 SS = D	<p>Continued from page 43</p> <p>CFR(s): 483.40</p> <p>§483.40 Behavioral health services.</p> <p>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, observation and document review, the facility failed to implement comprehensive assessment and person-centered planning to ensure residents individualized behavioral health needs were met for 2 of 2 residents (R1, R2) reviewed for behavioral health services.</p> <p>Findings include:</p> <p>R1's New Admission Information dated 10/15/24, indicated R1 had diagnoses of Alcoholic encephalopathy, Post Traumatic Stress Disorder (PTSD), anxiety, and depression. R1's cognition was confused, and behaviors were confused but pleasant. The form also identified R1 was independent with activities of daily living (ADL'S). The facility was to provide occupational therapy (OT), speech therapy (ST), and substance abuse treatment. R1 was admitted with a commitment order (court ordered mandate to be involuntarily place in an institution for treatment or care). Additional information included R1 had poor cognition, very forgetful, needs reminders that R1 had completed tasks.</p> <p>R1's significant change Minimum Data Set (MDS) assessment dated 3/12/25, indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver).</p> <p>R1's admission Trauma Informed Care History dated</p>	F0740	<p>Continued from page 43</p> <p>plans were reviewed and revised for R1 and R2 to address their individual behavioral health needs.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Interdisciplinary team (IDT) members and licensed staff will receive education on care planning and person-centered interventions related to trauma. The resident's mental health provider documentation is reviewed, as applicable, for care plan additions and support. This will include identification of triggers, prevention of identified triggers, and interventions of triggers when applicable documented to the CPs. The social services and nursing departments, when reviewing R1 and R2 care plans, ensured interventions specific to the residents.</p> <p>4. The Director of Nursing (DON) or designee will audit 3 care plans weekly x 4 weeks, then monthly x 2 months, to ensure individualized planning is in place. Results of audits will be reviewed during monthly QA meetings. Any trends or issues identified will result in additional education and immediate correction.</p>	

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F0740 SS = D	<p>Continued from page 44 10/16/24 identified R1 was molested as a child. Triggers that make it worse were indicated as "use to have a lot of them but overcame them with counseling."</p> <p>R1's care plan initiated on 10/16/24, identified the following:</p> <p>"</p> <p>A potential for ineffective coping related to PTSD and reported history of traumatic event(s) from her childhood attention seeking behavior of sexual comments towards men. Goal was to feel safe and enjoy daily activities of her choice for the next 90 days. Interventions included allow to express feeling, communicate with them that they are safe, it's not their fault, you are sorry this happened and you are glad they are alive; identify support system and us them as appropriate; and provide a safe therapeutic environment where they can regain control as needed.</p> <p>"</p> <p>R1 has impaired cognitive function/dementia or impaired thought processes related to Wernicke's encephalopathy diagnoses and brief interview of mental status (BIMS) score. Interventions included administer medications, cue, reorient, and supervise as needed.</p> <p>"</p> <p>R1's safety is at risk and there is a potential for abuse due to anxiety, chemical dependency, current medical condition, use of medications and need for assistance with cares and mobility. Interventions were to remove R1 from potentially dangerous situations.</p> <p>"</p> <p>R1 had a substance abuse/dependence of substances as evidenced by diagnoses of alcohol and cannabis [abuse]. Goal was to complete assessment with licensed alcohol and drug counselor (LADC) within 30 days and comply with commitment requirements while in care. Interventions listed as encourage to identify self-stabilizing activities during group activities; staff will assess vital signs, mental status, and physical symptoms if substance use is suspected or identified; contact R1's physician and follow order</p>	F0740		

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F0740 SS = D	<p>Continued from page 45 provided; and engage in therapeutic groups four times weekly to express/explore sobriety.</p> <p>"</p> <p>R1 has a psychosocial well-being problem related to being away from her children with interventions identified as assist/encourage support her to set realistic goals; encourage participation from resident who depends on others to make own decisions; increase communication between resident/family/caregivers about care and living environment. Explain all procedures, treatments, medications, results of labs/tests, condition, all changes, rules, and options.</p> <p>R1's care plan lacked evidence the facility identified R1's responses to stressors and utilize person-centered interventions developed by the IDT to support R1 and did not review and revise behavioral health care plans that had not been effective and when R1 had a change in condition related to the ongoing abuse.</p> <p>R1's Nursing Note dated 5/4/25 at 2:24 a.m., identified R1 and another resident approached writer at 7:40 p.m., and stated that they did not feel safe as R2 was harassing them by calling them offensive names when they were out in the smoking area. R1 further stated that the "harassing" resident [R1] stays at his door and when they go out to smoke, he follows them. Writer request R1 to say away from the other resident as much as they could. Writer offered an alternative smoking area for the meantime and in the event [R1] wanted to go to the regular smoking area to inform staff so they could be with staff all the time. Law enforcement involved. Director of nursing DON was notified and social worker to be informed.</p> <p>R1' s psychiatry Therapy note dated 5/23/25, identified R1 reported getting letters from a male resident a couple of months ago and have become inappropriate over time and R1 notified staff of this. R1 now feels uneasy around the person. R1 further reports feelings of unease like tension in her chest when wondering if she will see that person and brings up feelings like when she was sexually abused as a child. R1 feels she needs to watch her back and protect herself since reporting her concerns about the peer. R1 reports it is taking a long time to get to sleep and waking up 2-3 times a night. R1 requested to increase her session frequency to two times a week for additional support at this</p>	F0740		

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F0740 SS = D	<p>Continued from page 46 time.</p> <p>R1's record lacked indication a comprehensive assessment was completed to determine psychosocial harm, interventions were put in place to ensure safety, supportive services were provided, or monitoring systems for supervision and mood/behavior changes were implemented to keep R1 safe from ongoing abuse.</p> <p>During observation and interview on 5/20/25 at 8:55 a.m., R1 stated she had concerns about her safety because of R2 saying "stuff to me like he likes me and started passing me some sexual notes". R1 indicated being married and would not consent to a relationship with R2. R1 further identified the notes started to get "disturbing" and showed staff the notes "a week or so ago, can't remember". R1 indicated R2 would usually approach her in the smoking area, which was unsupervised by staff.</p> <p>During an interview on 5/20/25 at 11:32 a.m., family member (FM-A) identified R1 calls her about eight times a day and had concerns about R1's safety and security related to the unwanted letters, treats, snacks, and gifts from R2. FM-A further indicated R1 had called her crying because the abusive situation is triggering R1's PTSD symptoms from earlier childhood trauma. FM-A indicated the facility has talked to R2 and told him to stop but, "it was just ramping it up". FM-A shared concerns that the facility was not following through with their safety plan because he was still writing R1 letters and handing them to her.</p> <p>R2</p> <p>R2's quarterly MDS assessment dated 5/8/25, identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly.</p> <p>R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply).</p>	F0740		

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F0740 SS = D	<p>Continued from page 47</p> <p>R2's progress notes dated 3/27/25 at 16:28 (4:28 p.m.), three female residents [R1, R3, and unknown discharged resident] approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed feeling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding.</p> <p>R2's Nursing Note dated 4/27/25 at 16:51 (4:51 p.m.), R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding.</p> <p>During an observation and interview on 5/20/25 at 2:15 p.m., R2 identified he was in trouble at the facility because he had a relationship with R1 and wrote her some love notes. R1 decided she did not want them anymore; they called the "cops", and we were supposed to stay away from each other. Law enforcement returned on Friday 5/16/25 and talked to me again. R2 stated, "all the staff knew about it" and the social worker told R2 that he was "stalking" R1 but could not remember when that conversation occurred. R2 reported writing "love notes" to R1 for approximately two months.</p> <p>During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SSD identified she was aware of a mutual relationship between R1 and R2 and described the relationship as R2 is "infatuated" and R1 "enjoys the attention". The SSD further indicated R1 and R2 are close friends and two adults but their relationship "depends on the day". The SSD did not know when the letters first started but did not think they had all the letters because she felt the letters that were copied were "friendly" in nature with some drawings. based R1's capacity to consent off the brief interview for mental status (BIMS) which indicated a score of seven which equated to severe cognitive impairment and "the totality of knowing [R1]". The SW indicated she felt R1 could make decisions "in the moment" but 5-6 hours later would not be confident in her choices. The</p>	F0740		

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F0740 SS = D	<p>Continued from page 48 SSD stated R1 received talk therapy once a month and received psychiatry care but denied awareness of R1's increased PTSD symptoms.</p> <p>During a follow up interview on 5/22/25 at 11:05 a.m., R1 reported receiving letters from R2 for "at least a few months" and brought her concerns and the notes to staff at least twice before bringing her concerns to the resident council meeting with the ombudsman in attendance. R1 identified the first time she reported her concerns about the notes written by R2, she was told (by facility staff) they would talk to him; the second time she approached staff about the notes, she did not receive any follow up on what had happened. R2 continued to write, and hand deliver the notes to R1 in the designated smoking area or in the hallway. R1 stated, "I would hold my breath going down the hallway, hoping he didn't see me". R1 stated, "the sexual abuse PTSD really amped up and brought it back". R1 reported informing her counselor of the PTSD and the unwanted attention and the doctor was going to "look at adjusting one of my medications but don't know if that happened". R1 was tearful and continued to report trouble sleeping since the notes started as R1 worried about R2 coming into her room at night when the staff was not looking. R1 stated R2's notes made her feel "disgusting, unsettled, and disturbed". R1 indicated the letters from R2 stopped after the resident council meeting on 5/15/25. R1 further denied any further action or offers of emotional support by facility staff during the ongoing abuse further identifying the facility staff made R1 feel like it was her "fault" [ the abuse occurred]."</p> <p>The facility policy Trauma Informed Care undated, identified the facility would provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. The facility will work to facilitate the principles of trauma informed care which include:</p> <p>a.</p> <p>Safety - Ensuring residents have a sense of emotional</p>	F0740		

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F0740 SS = D	Continued from page 49 and physical safety.  b.  Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.  c.  Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals.  d.  Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care.  e.  Empowerment, voice, and choice - Ensuring that resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths.  The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to:  f.  Experiencing a lack of privacy or confinement in a crowded or small space.  g.	F0740		

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F0740 SS = D	Continued from page 50 Exposure to loud noises, or bright/flashing lights.  h. Certain sights, such as objects that are associated with their abuser.  i. Sounds, smells, and physical touch.  Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.  The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.  In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.  The facility did not provide any additional policies related to behavioral health services.	F0740		
F0838 SS = C	Facility Assessment  CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5)  §483.71 Facility assessment.  The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this	F0838	1. The Facility Assessment (FA) was reviewed, and it includes care needs related to PTSD. Staffing levels for social services were reviewed.  2. All residents with PTSD were identified. Their care plans were reviewed and updated as applicable to reflect trauma-informed approaches.  3. The FA was reviewed and reflects current resident needs and appropriate staffing. The IDT received education on maintaining the FA with behavioral health	07/16/2025

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F0838 SS = C	<p>Continued from page 51 assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.</p> <p>§483.71(a) The facility assessment must address or include the following:</p> <p>§483.71(a)(1) The facility's resident population, including, but not limited to:</p> <p>(i) Both the number of residents and the facility's resident capacity;</p> <p>(ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;</p> <p>(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;</p> <p>(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and</p> <p>(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.</p> <p>§483.71(a)(2) The facility's resources, including but not limited to the following:</p> <p>(i) All buildings and/or other physical structures and vehicles;</p> <p>(ii) Equipment (medical and non- medical);</p> <p>(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;</p> <p>(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;</p>	F0838	<p>Continued from page 51 considerations.</p> <p>4. The FA will be reviewed with any significant change in QAPI.</p>	

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F0838 SS = C	<p>Continued from page 52</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).</p> <p>§ 483.71(b) In conducting the facility assessment, the facility must ensure:</p> <p>§ 483.71(b)(1) Active involvement of the following participants in the process:</p> <p>(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and</p> <p>(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.</p> <p>(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.</p> <p>§483.71(c) The facility must use this facility assessment to:</p> <p>§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).</p> <p>§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.</p> <p>§483.71(c)(3) Consider specific staffing needs for each</p>	F0838		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>WABASSO RESTORATIVE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 MAPLE STREET , WABASSO, Minnesota, 56293</b>	
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F0838 SS = C	<p>Continued from page 53 shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.</p> <p>§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.</p> <p>§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to identify specific care or practices necessary to meet identified care needs regarding post-traumatic stress disorder (PTSD). This had the potential to affect all residents currently residing in the facility with a diagnosis or history of PTSD. Furthermore, the facility failed to implement 1 of 1 facility assessment (FA) and ensure the identified number of staff deemed required to provide social services to residents had been maintained. The number of social services designee (SSD) was equal to 1 full time position.</p> <p>Findings include:</p> <p>The FA, dated 4/2025, indicated the purpose of the assessment was to identify the care required by the resident population using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments. Resident feedback and Community resources facilitates the development of a personalized plan of care for each resident. The facility dose have a specialty of providing Outpatient Chemical Dependency Treatment. This has the impact of making typical resident of this facility to be younger and more mobile. The services offered for mental health and behavior indicated management of the medical conditions and medication related issues causing psychiatric symptoms and behaviors, identify and implement interventions to help support individual with issues such as dealing with anxiety, care of someone with</p>	F0838		

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F0838 SS = C	<p>Continued from page 54 cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder (PTSD), other psychiatric diagnoses, intellectual or developmental disabilities. The facility tries to adhere to the following plan for the basic number of staff; the department's daily staff, except for the manager's positions: Social Services Designee (SSD)- 1 FT.</p> <p>During an interview on 5/28/25 at 3:04 p.m., administrator stated the SSD is divided between two facilities about equal time and felt the time SSD put in at the facility was sufficient.</p> <p>Review of the undated facility policy titled Facility Assessment, indicated a facility assessment is conducted and documented to determine what resources are necessary to care for their residents competently during both day-to-day operations and the purpose was to establish responsibilities and procedures for the facility assessment process Furthermore, the policy indicated the administrator is responsible for ensuring the completion of the FA and maintaining all documents that pertain to the assessment. The administrator serves as the leader of the FA process, or may designate someone to lead the process. The assessment included a detailed review of the care required by the resident population using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments.</p>	F0838		

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 5/19/25 to 5/28/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	Continued from page 1  The following complaints were reviewed: H54005087C (MN00113142 and MN00113146 ); H54005627C(MN00113364); H54005867C (MN00113425) with a licensing orders issued at 1290 and 1925.  Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.  You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01 , available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.  PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
21285	Admission Orders and Physician Evaluations  CFR(s): MN Rule 4658.0710 Subp. 2  Subp. 2. Admission orders. A nursing home must have physician orders for a resident's admission and immediate care at the time of admission.  This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21285	Corrected.	07/16/2025

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21285	<p>Continued from page 2</p> <p>Based on interview and document review, the facility failed to ensure residents who were seen during routine physician visits every 30-60-90 days had physician documentation in the medical record for 1 of 1 (R1) resident, reviewed during the extended survey.</p> <p>Findings include:</p> <p>R1's significant change MDS dated 3/12/25; indicated severe impaired cognition; diagnoses of anxiety, depression, post traumatic stress disorder (PTSD). Required supervision with walking greater than 150 feet and set up for shower/bathe. Took antidepressants.</p> <p>R1's medical record identified R1 had physician visits on 10/29/24, 11/18/24, 2/6/25, 3/18/25, and 4/23/25. R1's medical record lacked documentation of routine 60-90-day routine visits from 11/18/24 to 2/6/25.</p> <p>During an interview on 5/29/25 at 11:05 a.m., director of nursing (DON) stated the physician saw the resident and signed the physician orders but did not know why he did not write a note. DON verified with physician that he saw resident, knew he had to write a note but did not remember why he did not.</p> <p>Facility undated policy titled "Physician visits and Physician Delegation", indicated:</p> <p>a. See resident within 30 days of admission to the facility.</p> <p>b. The resident must be seen at least once every 30 calendar days for the first 90 days after admission and at least every 60 days thereafter.</p> <p>h. At the option of the physician, required visits in SNF's, after the initial visit, may alternate between personal visits by the physician and visits by a non-physician provider, which is acting within their scope of practice.</p> <p>SUGGESTED METHOD OF CORRECTION:</p>	21285		

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21285	<p>Continued from page 3</p> <p>The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff obtain the needed orders/guidance after physician visits. In addition the facility could ensure a procedure to ensure resident's orders are carried out as ordered.</p> <p>The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.</p> <p>The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21285		
21925	<p>Patients &amp; Residents of HC Fac. Bill of Rights</p> <p>CFR(s): MN St. Statute 144.651 Subd. 29</p> <p>Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide 1 of 2 residents (R2) with choices for discharge, right to an appeal process, ability to stay at facility during an appeal process, review and take into account substance use disorder and mental</p>	21925	Corrected.	07/16/2025

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21925	<p>Continued from page 4 health diagnoses that would impair judgement on the decision to transfer, and allow the resident time to process the discharge prior to discharging.</p> <p>R2's face sheet dated 5/23/25, identified diagnoses of emotional lability (tendency to shift rapidly and dramatically between different emotional states), alcohol use, cognitive communication deficit (challenges with language comprehension, expression, reasoning, attention, memory, and organization), depression, anxiety disorder, and osteonecrosis (death of the bone due to lack of blood supply) to right and left femur.</p> <p>R2's quarterly Minimum Data Set (MDS) assessment dated 5/8/25, identified R2 had moderately impaired cognition, no hallucinations or delusions, and had verbal behaviors directed towards others one to three days weekly and behavioral symptoms not directed at others one to three days weekly. R2 required assist of staff with bed mobility, toileting, transferring, and dressing lower body. R2 does not ambulate.</p> <p>R2's care plan dated 1/25/25, identified ineffective coping related to reported history of traumatic event with no triggers noted. Interventions included to allow R2 to express feelings, provide a safe, therapeutic environment to regain control as needed, R2 preferred female caregivers and did not want male caregivers for intimate cares. A focus dated 1/29/25, identified R2 had a behavior problem of story telling and embellishing the truth. Interventions included to discuss the behavior, explain/reinforce why behavior is inappropriate or unacceptable. On 5/22/25, an intervention of 15-minute safety checks for behavior monitoring was initiated. A focus dated 1/27/25, identified R2 wished to return to his prior living arrangements when able to discharge, interventions included to evaluate and discuss the prognosis for independent or assisted living, no additional interventions were identified past 1/27/25.</p> <p>R2's Trauma Informed Care History dated 1/27/25, identified traumata history from physical abuse. The response to triggers that make things worse was, "not really" and the Lord and prayer helped R2 manage.</p> <p>R2's psychosocial care area assessment (CAA) dated 1/27/25, identified R2 was at risk for psychosocial</p>	21925		

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21925	<p>Continued from page 5 wellbeing changes due to recent hospitalization and factors noted in worksheet. At risk for further rehospitalization if psychosocial well-being not addressed. Care plan to address psychosocial wellbeing and strategies to reduce and manage risk. No behaviors.</p> <p>R2's Treatment Administration Record (TAR) dated 5/1/25 to 5/31/25, identified targeted behaviors included negative statements, isolating self, sad, crying, and anxiety.</p> <p>R2's progress note dated 4/27/25 at 4:51 p.m., identified R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R2 was interviewed and identified that sexual behavior occurred with R1. R1's safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. Director of Nursing (DON) and social worker notified.</p> <p>R2's progress note dated 5/3/25 at 2:35 p.m., identified a conflict between R2 and another resident had occurred in the designated smoking area. The residents were separated and educated on observing facility rules and were advised to remain apart from each other for the safety of themselves and other residents. Conflict de-escalated.</p> <p>R2's progress note dated 5/4/25 at 2:47 p.m., identified R2 talked with law enforcement for "allegation" raised by another resident that R2 was harassing them while they were outside smoking. R2 is on 15-minute checks from a prior incident and was educated to inform staff when he went outside to smoke and not go outside when the other resident was outside. DON and social worker notified.</p> <p>R2's progress note dated 5/22/25 at 8:36 p.m., identified R2 had exhibited a pattern of writing notes directed toward a female peer. Due to concerns regarding boundary issues and to promote a safe, respectful environment, R2's care plan has been updated to obtain approval from charge nurse or designated staff member before sharing written communication with female residents. Additionally, all interpersonal interactions with the female residents will be monitored by staff. R2 was informed of this change and provided education regarding appropriate social</p>	21925		

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21925	<p>Continued from page 6 boundaries. Additionally, R2 remains on 15-minute safety checks for behavioral monitoring. R2 agreed and verbalized understanding of the education provided.</p> <p>R2's progress note dated 5/23/25 at 3:00 p.m., identified: discussed with R2 that the referral to a sister facility had been accepted and a transfer is now possible. R2 expressed understanding and agreed to the transfer. R2 inquired about the timeline and was informed the transfer could occur today. R2 consented to a same day move. Staff offered assistance with packing; R2 accepted and requested that staff use the suitcase located in his closet. Discharge orders obtained from R2's primary care physician and transfer coordination is underway.</p> <p>R2's progress note dated 5/23/25 at 3:39 p.m., identified R2 discharged to sister facility around 3:30 p.m. R2 got a ride through the facility's transportation. R2 used a wheelchair, declined a vital sign check, is alert and orientated. Sent medications and medication sheet with the driver.</p> <p>R2's visual check sheet every 15 minutes dated 5/22/25, identified the checks began on 5/22/25 at 5:45 p.m. and ended on 5/23/25 at 4:00 p.m. with discharge.</p> <p>The discharge/transfer notice dated 5/23/25, identified this notice was to notify of the transfer or discharge to the sister facility. The box was checked that R2 requested the transfer or discharge with the reason to be closer to surgery site/fresh start. The notice was signed by the administrator on 5/23/25.</p> <p>During an interview on 5/27/25 at 11:54 a.m., registered nurse (RN)-A stated the DON had asked her to talk to R2 and see if he would transfer to the sister facility as they had accepted him as a transfer. R2 agreed to the transfer but made a comment that he would like to return once another resident discharged from this facility. RN-A stated that would be something that would have to be discussed with the interdisciplinary team (IDT).</p> <p>During a phone interview on 5/27/25 at 12:18 a.m., regional Ombudsman (RO)-A stated she was unaware that R2 had discharged to another facility until she received an email from the DON on 5/27/25. If this was</p>	21925		

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21925	<p>Continued from page 7 a facility initiated discharge the Ombudsman must be contacted immediately and R2 has the right to appeal and remain where he is at during the appeal process. If R2 agreed with the transfer/discharge he should have signed the form that he agreed to the discharge.</p> <p>During a phone interview on 5/27/25 at 12:28 p.m., R2 stated registered nurse (RN)-A came to his room and said maintenance worker (MW)-A was getting the bus to transfer to the sister facility and nursing assistant (NA)-A and NA-C packed his belongings up and he was in the bus in a matter of 10-12 minutes time. The NA's threw out a note pad that had passwords on it during the process, and R2 is unable to use his phone until he can purchase more minutes to change his phone number. The facility got rid of me. They said I could have better care at the new facility. They said the "higher-ups" decided but R2 was not allowed to discuss it with them and when R2 asked if he had to leave, they told him "Yeah, in a certain way" so R2 believed them. R2 asked to return to the facility when certain residents discharged. Something does not feel right when they get you out of there as fast as they can like Caesar washing his hands from Jesus Christ, and it came from the administrator. R2 stated the facility got him to verbally say he would move and if he did not like it, they could hopefully help him return but did not let him talk to an advocate. Now that R2 is at the current facility, he wants to go back. This is a real nursing home and R2 does not feel he belongs at it. There are rules in place at the current facility that are not in place at the facility. R2 feels penned up at the current facility. R2 cried and has been crying in his room and feeling very depressed since the transfer. R2 keeps waking up from sleep and realizing that it is not a dream, and he is not at the facility he wants to be at. R2 stated his medical appointments are now 45 minutes farther to get too.</p> <p>During an interview on 5/27/25 at 2:07 p.m., DON stated social service designee (SSD)-A initiated discharge for R2 and sent the referral to the sister facility and thought it occurred a couple of days prior to R2's discharge. Both R1 and R2 were aware that they may be discharged to a sister facility. The discharge notice was completed on 5/23/25 and sent to the Ombudsman on 5/27/25 after it was found on SSD-A's desk. The doctor was aware of the referrals sent and gave the order to discharge to the sister facility.</p> <p>During a phone interview on 5/27/25 at 2:16 p.m.,</p>	21925		

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21925	<p>Continued from page 8</p> <p>DON-B, from the sister facility, stated she received an email referral for R2 on 5/23/25 at 1:55 p.m. and that was the first contact she had about R2 transferring to the facility. The information came from SSD-A and DON. DON had stated the facility needed placement for R2. DON-B stated DON and SSD-A did not provide information about R2's sexual abuse allegations but she was aware through working for the same company. R2 was antsy about being at the new facility on 5/23/25 after he arrived but DON-B had talked through the transfer with him. Verification of emails identified SSD-A sent an email on 5/23/25 at 1:55 p.m. that included R2's face sheet and progress notes, at 1:57 a second email from SSD included R2's care plan, and at 2:57 p.m. DON sent paperwork including order summary from emergency department, discharge summary, physician visit, and doctor note from 5/12/25 visit.</p> <p>During an interview on 5/28/25 at 2:36 p.m., MW-A stated he was informed at approximately 2:40 p.m. on 5/23/25, about R2 discharging to a sister facility because R1 felt unsafe with R2 at the facility. The transfer happened very suddenly and MW-A transported R2 to the sister facility around 3:00 p.m. During the transport, R2 was not in his normal mood, no big smile on his face, very monotone and emotionless, not reacting as he normally would to MW-A.</p> <p>During a phone interview on 5/28/25 at 3:42 p.m., SSD-A stated she had left the facility for the day, without access to the building or her email around 1:00 p.m. on 5/23/25. SSD-A did not have any part of the discharge preparing or planning for R2 and had not had a conversation with R2 about discharging. SSD-A did not send emails or have communication with the sister facility about R2's transfer.</p> <p>During an interview on 5/28/25 at 3:04 p.m., Administrator stated R1 and R2 were both offered discharge to other facilities. R1 said no to the discharge. R2 was upset about being accused of sexual abuse from R1 and the 15-minute checks on him that were put in place and wanted a fresh start. R2 approached the possibility of being transferred to the SSD-A. The sister facility was 39 miles from the current facility and would be closer to R2's surgery location (88 miles from sister facility). Administrator was unable to articulate other facilities that R2 was offered for relocation. R2 did not sign the discharge form and was pretty upset during the relocation process. It was a big change in 1.5 hours for R2. R2 stated he wanted to</p>	21925		

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21925	<p>Continued from page 9 return to the facility. The physician was notified and gave orders to discharge to the sister facility but was not made aware of the reason for the discharge. The Ombudsman was not notified of the discharge until 5/27/25.</p> <p>During a follow-up phone interview on 5/28/25 at 4:15 p.m., RN-A stated she was told a referral had been sent to the sister facility earlier during the week before 5/23/25. RN-A attended all the IDT meetings but was unsure if discharging R2 to the sister facility was discussed. RN-A told R2 he could transfer that day (5/23/25) and that it was closer to doctor appointments and that the facility could pack his belongings. R2 had talked about it being a fresh start at a different facility. R2's demeanor to the discharge appeared like he was frustrated.</p> <p>The facility's undated Resident Right policy, identifies the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The resident has the right to voice grievances to the facility or other agency without discrimination or reprisal. Such grievance includes those with respect to care and treatment which has been furnished as well as that which has not been furnished; the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have.</p> <p>During a return phone call on 6/6/25 at 10:14 a.m. from 5/28/25 at 11:40 a.m., family friend (FF)-A stated R2 has contacted her since being at the new facility. R2 made statements that he was being left at the facility to die and voiced frustration of not seeing any type of future for himself.</p> <p>The facility Transfer and Discharge policy dated 4/21/25, identified it is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances.</p> <p>Once admitted, the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: necessary</p>	21925		

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21925	<p>Continued from page 10 for the residents welfare, residents needs cannot be met, safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.</p> <p>The facilities transfer/discharge notice will be provided to the resident and residents representative and include: specific reason for the transfer, effective date of discharge, specific location to which the resident is to be transferred/discharged, an explanation of the appeal rights to the State, for residents with mental illness or related disability the notice will include the name, mailing and email addresses and phone number of the state agency responsible for protection and advocacy of these populations.</p> <p>Generally, the notice must be provided at least 30 days prior to the transfer or discharge of the resident. Exemptions to the 30-day requirement apply when: health/safety of individuals in the facility would be endangered due to clinical or behavioral status of the resident, urgent medical needs, resident has not resided at the facility for 30 days. In these exceptional cases, the notice must be provided to the resident, resident representative and LTC Ombudsman as soon as practicable before the transfer or discharge.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days</p>	21925		