



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 26, 2025

Administrator

WABASSO RESTORATIVE CARE CENTER

660 MAPLE STREET

WABASSO, MN 56293

RE: CCN: 245400

Cycle Start Date: July 24, 2025

Dear Administrator:

On September 17, 2025, we notified you a remedy was imposed. On October 24, 2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 1, 2025.

As authorized by CMS the remedy of:

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

In our letter of September 17, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 24, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a small dot above the 'i' in Downing.

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



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December 26, 2025

Administrator

WABASSO RESTORATIVE CARE CENTER

660 MAPLE STREET
WABASSO, MN 56293

Re: Reinspection Results
Event ID: 1D1A71-H2

Dear Administrator:

On October 24, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 24, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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September 16, 2025

Administrator

Tuff Memorial Home

505 EAST 4TH STREET
HILLS, MN 56138

RE: CCN:245548

Cycle Start Date: August 27, 2025

Dear Administrator:

On August 27, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

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

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

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

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be

acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed.

Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 26, 2025(three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 26, 2026(six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145

St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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



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September 16, 2025

Administrator
Tuff Memorial Home
505 EAST 4TH STREET
HILLS, MN 56138

Re: State Nursing Home Licensing Orders

Event ID: 1D0DFC-H1

Dear Administrator:

The above facility survey was completed on August 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>On 7/23/25 & 7/24/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H54005587C (MN00113251), with deficiencies cited at F552, F580, F585, F657, F684, and F755.</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		09/10/2025
F0552 SS = D	<p>Right to be Informed/Make Treatment Decisions</p> <p>CFR(s): 483.10(c)(1)(4)(5)</p> <p>§483.10(c) Planning and Implementing Care.</p> <p>The resident has the right to be informed of, and participate in, his or her treatment, including:</p> <p>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.</p>	F0552	<p>F552 (D)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure residents were informed of medication changes for 1 of 3 residents (R1) reviewed for pharmacy services.</p> <p>1. Immediate Correction: Staff reviewed resident's order summary with R1, new physician orders reviewed. Resident made aware of changes and staff addressed questions/concerns at that time. Order summary signed and dated by resident and staff member 8/21/2025.</p> <p>2. All residents have the potential to be affected in this area.</p>	09/10/2025

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025
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F0552 SS = D	<p>Continued from page 1</p> <p>§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure residents were informed of medication changes for 1 of 3 residents (R1) reviewed for pharmacy services.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 7/5/25, indicated R1 had diagnoses including fracture of shaft of left femur (broken thigh bone), anxiety disorder, and opioid dependence. R1 received scheduled and as needed (PRN) pain medication and took opioid medication. R1 had intact cognition, understood others, and made herself understood.</p> <p>R1's physician order dated 6/12/25, was for oxycodone hydrochloride (HCl) (an opioid medication used to treat moderate to severe pain) oral tablet 5 milligrams (mg) with direction to give 5 mg by mouth every eight hours as needed for pain related to fracture of shaft of left femur. The order was discontinued on 6/24/25.</p> <p>R1's medication administration record (MAR) dated 6/1/25 through 6/30/25, identified the 5 mg PRN oxycodone order was last administered on 6/24/25 at 7:13 a.m.</p> <p>R1's provider note dated 6/24/25, indicated R1 was seen by nurse practitioner (NP)-A. The medication list included oxycodone HCl 5 mg oral tablet, give 5 mg by mouth every eight hours as needed for pain. The note indicated R1 was seen for evaluation of anemia. The plan for left femur fracture included "oxycodone" and "stable." It did not indicate R1's oxycodone dose was changed from 5 mg to 1.5 mg or R1 was informed of this medication change.</p> <p>R1's physician order dated 6/24/25, was for oxycodone HCl oral tablet 5 mg with direction to give 2.5 mg by mouth every eight hours as needed for pain related to fracture of shaft of left femur.</p> <p>R1's MAR dated 6/1/25 through 6/30/25, identified the 2.5 mg PRN oxycodone order was first administered on 6/24/25 at 3:20 p.m.</p>	F0552	<p>Continued from page 1</p> <p>3. Staff Education: All staff members will undergo re-education regarding residents' rights and the right to know about any changes in medications or treatments. Policy Review: The facility's Residents rights policy will be reviewed and revised by 9/10/2025 to ensure it adequately addresses residents' right to be informed. The revised policy will be communicated to all nursing staff and residents by 9/10/2025. Staff were educated on 8/6/2025 and again, by 9/10/2025 on policy of resident rights and changes to medications and treatments.</p> <p>4. All residents will be notified and educated on any changes to residents' medications. ADON or designee will complete random audit of any medication changes during provider rounds and resident notification weekly, for 4 weeks and then once a month for 3 months. The Quality Assurance and Performance Improvement (QAPI) committee will review compliance with the established system to ensure ongoing compliance and adjust as necessary.</p>	

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F0552 SS = D	<p>Continued from page 2</p> <p>R1's progress note dated 6/24/25 written by the assistant director of nursing (ADON), indicated R1's provider decreased her oxycodone from 5 mg to 2.5 mg every eight hours as needed. The note did not include evidence that R1 was notified of this change.</p> <p>During an interview on 7/23/25 at 11:23 a.m., R1 stated she had previously taken 2.5 mg of oxycodone but had increased pain because of her broken left femur and NP-A had increased her oxycodone to 5 mg every eight hours as needed. R1 stated that one day recently "all of a sudden" the evening nurse told her there had been a change in her oxycodone when she requested it, R1 said what are you talking about, and the nurse informed her the oxycodone had been decreased again to 2.5 mg. R1 stated she had a change in her medication and the evening nurse informed her, but NP-A had not discussed it with her nor other facility staff. In a follow-up interview at 5:03 p.m., R1 stated this made her feel very upset because she had been having increased pain and NP-A decreased her oxycodone but didn't come tell her and hadn't mentioned decreasing it when she had seen him. She spoke to him about it a few days later along with the ADON and was very upset. It made her feel disrespected, uninformed, and like her pain was invalidated. She felt like this wasn't proper and a patient shouldn't have their medications changed without being told.</p> <p>During an interview on 7/23/25 at 2:26 p.m., the ADON stated when a provider changed a medication order, nursing staff needed to tell the resident about the medication change. This notification would be documented in a progress note. The ADON usually went on rounds with NP-A and he would discuss changes with residents during his visit. The ADON confirmed R1's oxycodone order was changed from 5 mg to 2.5 mg every eight hours as needed on 6/24/25, and confirmed this change was not identified in NP-A's note dated 6/24/25. The ADON stated she did not see documentation indicating R1 was informed of this medication change. The ADON stated standard of practice was for residents to be informed of changes in care and treatment. It was important for resident to be informed so they were aware and they had the right to be informed.</p> <p>During an interview on 7/23/25 at 12:33 p.m., the director of nursing (DON) stated NP-A usually did rounds before changing any medications. There should be a note from the provider and a progress note from whoever input the medication order, including documentation that a resident was notified of a medication change. The DON stated the provider was responsible for notifying the residents of medication</p>	F0552		

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F0552 SS = D	Continued from page 3 changes and explaining signs and symptoms they may experience and effects that could happen related to the change. During a follow-up interview at 3:26 p.m., the DON stated it was not in NP-A's note dated 6/24/25 that he was changing R1's oxycodone. She did not see evidence elsewhere that R1 was notified of the change or documentation of why the medication was decreased. Residents needed to be notified of changes because they needed to be involved in their care, know what they were taking, and had a right to be informed and notified. The DON stated she would get upset if she was a resident and her pain medication was decreased without being informed. Facility policy titled Medication Administration dated 6/12/24, indicated medications were administered by licensed nurses or legally authorized staff as ordered by the physician and in accordance with professional standards of practice. Facility policy titled Resident Rights dated 2025, indicated the facility would ensure all direct and indirect care staff members would be educated on the rights of residents and the responsibility of the facility to properly care for its residents. Resident rights included planning an implementing care, "the resident has the right to be informed of, and participate in, his or her treatment." This included "the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to... the right to be informed, in advance, of changes to the plan of care."	F0552		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F0580	F580 (D): This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the resident's physician of multiple missed administrations of an opioid pain medication for 1 of 3 residents (R1) reviewed for pharmacy services. 1. Immediate action(s) taken for the resident(s) found to have been affected include: R1's MAR was reviewed by DON or designee to determine if any missed administrations occurred since July 24, 2025. R1 did not receive 2 medications on 8/13. R1's provider was notified of medications that were missed on 8/13, on 8/28/2025. Resident was interviewed on 8/28 about the 2 missed medications, acknowledged missed medication and discussion with staff member.	09/10/2025

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NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293	
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F0580 SS = D	<p>Continued from page 4</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15)</p> <p>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to notify the resident's physician of multiple missed administrations of an opioid pain medication for 1 of 3 residents (R1) reviewed for pharmacy services.</p> <p>Findings include:</p> <p>R1's facesheet dated 7/24/25, indicated she had diagnoses including fracture of shaft of left femur (broken thigh bone), opioid dependence, neuralgia (pain</p>	F0580	<p>Continued from page 4</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that any resident receiving prescribed medications or treatments could be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Clinical staff education was provided on 8/6/2025 and again by 9/10/2025 regarding documentation in MAR of medication not available. A form was implemented to track missed medication, notification of provider, education provided to resident and assessment of resident due to missed medication.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not reoccur:</p> <p>Random audits will be performed by DON or designee daily for 4 weeks, then weekly for 4 weeks, then monthly for 2 months. The Quality Assurance and Performance Improvement (QAPI) committee will review compliance with the established system to ensure ongoing compliance and adjust as necessary.</p>	

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F0580 SS = D	<p>Continued from page 5 caused by nerve damage or irritation) and neuritis (nerve inflammation), osteoarthritis of left knee, and fibromyalgia (chronic condition causing wide-spread pain throughout the body).</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 7/5/25, indicated R1 received scheduled and as needed (PRN) pain medication, took opioid medication, and had intact cognition.</p> <p>R1's physician order dated 1/14/25, was for methadone hydrochloride (HCl) (an opioid pain medication used to treat severe pain) oral tablet 5 milligrams (mg). It directed, give 0.5 tablet (2.5 mg) by mouth two times a day for pain.</p> <p>R1's medication administration record (MAR) dated March 2025 and corresponding administration progress notes for the Methadone were reviewed. The record included the following:</p> <ul style="list-style-type: none"> - 3/9/25 at 8:00 a.m., charted as code "9" indicating other/see progress notes; corresponding administration progress note at 7:14 a.m. identified "NO SUPPLY." - 3/9/25 at 8:00 p.m., charted as code "9"; corresponding administration progress note at 7:22 p.m. identified "On back order." - 3/10/25 at 8:00 a.m., charted as code "9"; corresponding administration progress note at 7:19 a.m. identified "ON BACK ORDER" - 3/10/25 at 8:00 p.m., charted as code "9"; corresponding administration progress note at 8:58 p.m. was struck out with strike out reason of "Declined Order" and strike out date of 3/10/25 at 8:01 p.m. Additional note at 9:01 p.m. initiated however without additional information. - 3/11/25 at 8:00 a.m., charted as administered, R1's record did not include a corresponding administration note that could be identified for the morning dose. - 3/11/25 at 8:00 p.m., charted as administered. - 3/11/25 at 8:00 p.m. a second time, charted as code "9". Administration progress note at 7:06 p.m. included "NO MED- on back order." Additional note at 9:57 p.m. did not include additional information. <p>Review of facility narcotics logbook entry number 16 identified the page was for tracking R1's methadone 5</p>	F0580		

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F0580 SS = D	<p>Continued from page 6 mg with direction to give half tablet two times a day. The last entry was dated 3/8/25 at 7:20 p.m. with amount on hand of one, amount used of one, and amount left of zero.</p> <p>Review of facility narcotics logbook entry number 38 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The first entry was dated 3/11/25 with no time and indicated 60 tablets were received. The following entry indicated the first administration of the new supply of medication was on 3/11/25 at 9:55 p.m.</p> <p>Review of R1's progress notes did not identify notification of R1's physician regarding the missed administrations of methadone from 3/9/25 through 3/11/25.</p> <p>Email dated Sunday 3/9/25 at 3:30 p.m., provided to the surveyor was from nurse practitioner (NP)-A to the facility's nursing email account in response to an email sent from the nursing account on 3/9/25 at 2:25 p.m. Email from the nursing account included, "Methadone is on backorder and [R1] is running out of it very soon. Is it possible to order something else as we wait for the back order?" The email did not identify the author. NP-A's emailed response included, "I can switch to something for [R1] and will talk to her Tuesday." The facility's email did not identify that R1's supply of methadone had already run out with last dose administered on 3/8/25 at the 8:00 p.m. as documented in the MAR and narcotics logbook. No further emails or replies regarding R1's methadone were identified and provided to the surveyor by the facility.</p> <p>During an interview on 7/23/25 at 12:33 p.m., the director of nursing (DON) stated if a medication was not available staff should call the provider who would give an order for an alternative medication or order to hold the unavailable medication. Notification of the provider would be documented in the MAR progress notes or in emails. If there was no supply of a medication, staff should call the provider. In a follow-up interview at 3:26 p.m., the DON reviewed R1's MAR and narcotic book logs and confirmed R1 missed doses of her methadone twice on 3/9/25, twice on 3/10/25, and the morning of 3/11/25. The DON confirmed the email to NP-A dated 3/9/25 did not identify R1 had no supply of methadone and did not identify the 8:00 a.m. administration that day was missed. The DON stated she did not see documentation R1's provider was notified her methadone was unavailable and not given from 3/9/25 through 3/11/25.</p>	F0580		

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F0580 SS = D	Continued from page 7 During an interview on 7/24/25 at 11:57 a.m., NP-A stated he was part of the primary care team for all residents at the facility along with a medical doctor. NP-A believed R1's methadone had been on backorder with the pharmacy previously. He did not remember being notified but assumed it would have been via email. He did not recall being notified that R1 was "actually out of" the methadone, and if it was not in the email dated 3/9/25 provided by the surveyor for his review, then he did not know that he was otherwise notified. Notification would be identified in an email or a note in R1's chart and if not there, he doubted he was notified. His expectation was that he would have been notified R1 was out of methadone and scheduled administrations were not given. Typically, he would increase a resident's other pain medications or find an alternative temporarily until the medication was available. R1 would have increased pain without the methadone and NP-A would have increased R1's other pain medication, oxycodone, while the methadone was on back order to bridge the gap. Facility policy titled Medication Errors dated 2025, identified a medication error was the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications, or accepted professional standards and principles which apply to professionals providing services. Factors indicating errors in medication administration included medication not administered in accordance with the prescriber's order including example of medication omission. If a medication error occurred, a nurse was to assess and examine the resident's condition and notify the physician or health care practitioner as soon as possible.	F0580		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F0585	F585(D) Grievances REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure resident grievances were provided with a written response for 2 of 4 residents (R1, R3) reviewed for grievances. Resident R1 has been provided with a formal response to their respective grievances, including findings, and actions taken to prevent recurrence. Resident was also offered a chance to ask questions regarding the response.	09/10/2025

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F0585 SS = D	<p>Continued from page 8</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or</p>	F0585	<p>Continued from page 8</p> <p>Any resident who submitted a grievance within the past 60 days are affected. All grievances received in the past 60 days were reviewed by 9/9/2025 with resident initiating the grievance.</p> <p>All staff have been educated on the updated grievance policy, with emphasis on: Timely and appropriate investigation of grievances. providing and documenting responses, respecting residents' rights to voice concerns, initial training was completed on 8/6 as well as follow up training completed by 9/9/2025.</p> <p>The social worker or designee will perform random weekly audits new grievances for 1 month and monthly for 3 months, verifying that the grievance process is complete and response was discussed with resident. Findings will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee. Ongoing compliance will be reviewed quarterly through the QAPI process to determine if additional corrective measures are needed.</p>	

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F0585 SS = D	<p>Continued from page 9 misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure resident grievances were provided with a written response for 2 of 4 residents (R1, R3) reviewed for grievances.</p> <p>Findings include:</p> <p>R1's face sheet dated 6/24/25, identified diagnoses of depression (a mood disorder that causes persistent sadness) and anxiety (an emotion that causes feelings of fear, dread, and unease).</p> <p>R1's quarterly Minimum Data Set (MDS) dated 7/5/25, identified R1 was cognitively intact and had no behaviors.</p> <p>During an interview on 7/23/25 at 11:23 a.m., R1 stated the week prior she had completed two different grievance forms about concerns with two staff members. One of the grievances was regarding a staff member performing wound care on a resident in a public area and not performing proper hand hygiene. The second grievance was about a staff member with body odor and</p>	F0585		

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F0585 SS = D	<p>Continued from page 10 being on their personal cell phone for an extended period, while they were supposed to be working. R1 had given one of the grievances to an unidentified staff member to place on the social worker's desk, and the other grievance form was given to the assistant director of nursing (ADON). R1 further stated that the ADON had spoken with her regarding the grievance of the staff member performing wound care in a public area, however she never received a written response from the facility on what was done about it. R1 also stated she had not received a written response to the filed grievance about a staff member with body odor/being on their phone while working.</p> <p>Review of the facility grievances from May 2025 through July 2025, only identified one grievance form had been filed by R1.</p> <p>Review of a facility Grievance Form dated 7/16/25. Identified R1 had voiced concerns about a nurse that completed wound care on another resident at the nursing station and did not performing hand hygiene. The investigation indicated staff was observed doing wound care and giving insulin by the nursing station. Education had been done previously, and staff member was given a written discipline on 7/16/25. Plan of resolution was staff was educated to do all cares and insulin in resident's room or in a private area and verbalized understanding. Follow up on R1's 7/16/25 grievance form was left blank.</p> <p>R3's face sheet dated 7/24/25, identified diagnoses of generalized anxiety disorder, explosive disorder (a mental disorder characterized by explosive outbursts of anger/violence), and affective mood disorder (a serious mental illness that causes persistent and intense changes in mood, energy, and behavior).</p> <p>R3's significant change MDS dated 4/23/25, identified R1 was cognitively intact and had no behaviors.</p> <p>Review of a facility Grievance Form dated 6/12/25, identified R1 had voiced concerns about an inheritance check he was supposed to have received, and the business office manager would not give him his check. Investigation summary was that R3 did not receive any inheritance check and only received a direct express card in his account. Plan of resolution was to talk to psychiatry about the episodes and continue to monitor. Follow up was to change medication regime and continue to see psychiatry.</p> <p>During an interview on 7/23/25 at 10:45 a.m., R3 stated</p>	F0585		

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F0585 SS = D	<p>Continued from page 11</p> <p>he filled out a grievance form last month regarding an inheritance check that he was supposed to have received, however, had not received it. R3 further stated he had not heard or received a written response on what the facility found out about his inheritance check, and "I guess it is none of my business on what was found out about what they did." R3 said there is a stereotype in the facility, that the people that live here do not even have enough memory to recall what was told to the facility and that is why we do not get a response.</p> <p>During an interview on 7/24/25 at 8:33 a.m., long term care ombudsman (OMB) stated she attends the monthly resident council meetings and the concerns from the residents each month continue to be the same, that their grievances that they file always go "unanswered". Residents will fill out the grievance forms, turn them in, however, do not get a response from the facility on the resolution. OMB stated she had requested from the administrator on how the grievances are managed in the facility and requested the grievance policy, however, did not get a response from the administrator.</p> <p>During an interview on 7/24/25 at 11:55 a.m., administrator stated that all grievances from residents are to be responded to within five business days, however, the grievances that R1 and R3 filed did not identify a date/time or copy of the written response regarding their grievances. Administrator further stated she will be adding a signature line on the current grievance forms where the resident can sign/date the form from now on and this will ensure the facility has documentation that the resident being informed of the resolution of the filed grievance and can use this to provide the resident with written response.</p> <p>Review of the facility's Resident and Family Grievances Policy dated 11/18/24, identified the following: In accordance with the resident's right to obtain a written decision regarding his or her grievance, the grievance official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:</p> <ul style="list-style-type: none"> -The date the grievance was received. -The steps taken to investigate the grievance. -A summary of the pertinent findings or conclusions regarding the resident's concern(s). 	F0585		

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F0585 SS = D	Continued from page 12 -A statement as to whether the grievance was confirmed or not confirmed. -Any corrective action taken or to be taken by the facility as a result of the grievance. -The date the written decision was issued.	F0585		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be: (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for wake-up and/or medication administration times for 1 of 4 residents (R4) who demonstrated new behaviors when her medications were not provided in accordance with her preferences.	F0657	F-Tags: F657(D) Care Plan Timing and Revision. This requirement is not met as evidence by Based on observation, interview, and document review the facility failed to revise the care plan for wake-up and/or medication administration times for 1 of 4 residents (R4) who demonstrated new behaviors when her medications were not provided in accordance with her preferences. The care plan for Resident R4 was immediately reviewed and updated to reflect her preferences regarding wake-up and medication administration times. Nursing, pharmacy, and direct care staff were notified of the revision, and medication administration times have been adjusted to align with the resident's stated preferences and needs. All residents in the facility have the potential to be impacted. All Residents were interviewed by 9/9/2025 on their waking and medication administration times. Nurses and TMAs were trained on 8/6/2025, and a follow up training was provided before 9/9/2025, on the importance of individualized care planning, including honoring resident preferences for medication timing and daily routines. Individualized care planning will be included in orientation for all new clinical staff. The Director of Nursing (DON), or designee will randomly audit active care plans weekly for 4 weeks, then monthly for 3 months, focusing on resident preferences for wake-up and medication administration times. The Quality Assurance and Performance Improvement (QAPI) committee will review compliance with the established system to ensure ongoing compliance and adjust as necessary.	09/10/2025

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F0657 SS = D	<p>Continued from page 13</p> <p>Findings include</p> <p>R4's face sheet dated 7/24/25, identified diagnoses of anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear) , borderline personality disorder (a mental disorder characterized by unstable moods and behaviors), and delusional disorder (a serious mental disorder where a person cannot tell what is real from what is imaginary).</p> <p>R4's annual Minimum Data Set (MDS) dated 4/19/25, identified moderate cognitive impairment and no behaviors.</p> <p>During an observation on 7/23/25 at 11:29 a.m., R4 was in the day room standing next to the medication cart talking in a loud voice to trained medication aide (TMA)-A, "I want my medications, it is my right to get my medications that are prescribed." R4 further began saying no staff came in and woke her up to take her medications today and "why are you not giving them to me." Clinical registered nurse consultant (CRNC) informed R4 that her meds could not be given to her because it was beyond the time limit, and staff needed to follow the doctor's orders. R4 then began hitting her fist on the chair in the dayroom yelling "I need my medications, and it is a state law for you to give them to me." R4 continued to state, "I need my medications, and it is my right to get them." R4 was pacing up and down the hallway during this time and continued to return to the medication cart multiple times. CRNC then placed a phone call to the on-call physician and obtained an order to administer R4's morning medications. Once R4 had received her medications she began to speak in a normal tone and then began asking staff to get a lunch ready for her to take to an outside appointment in a normal tone.</p> <p>In review of R4's current care plan it did not address her preferences for wake-up times and/or preferences to be woken up for her morning medications.</p> <p>During an interview on 7/23/25 at 12:07 p.m., TMA-A stated she attempted to go into R4's room three times that day, however R4 was sleeping each time, so she signed them off in the medication administration record as not given due to R4 sleeping. When R4 came to her around 11:20 a.m., she requested her morning medication, however when she told her it was too late for me to give them to her R4 became upset and began yelling.</p>	F0657		

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F0657 SS = D	<p>Continued from page 14</p> <p>During an interview on 7/23/25 at 12:30 p.m., TMA-D stated R4 will normally get up around 9:00 to 9:30 a.m. daily, and when she is due to get her meds, if R4 is still in bed she will go in and “gently” wake her up, and tell her tell her it is time for her morning medications and she will take her pills and then go back to sleep if she wants to. “That is how she like to take her pills, and it seems to work for her.”</p> <p>During an interview on 7/24/25 at 10:15 a.m., R4 stated that she normally gets up around 9:00 a.m., however, sometimes she likes to sleep longer, and, on those days, most staff will wake her up and tell her it is time for her morning medication, then she will wake up and take her pills and then go back to sleep. “It is my right to get my medication, and it is their job to make sure I get it on time.” R4 stated the facility told her that they have fixed it now and will be ensuring they will be giving her medication the way she likes to receive it now</p> <p>During an interview on 7/24/25 at 11:37 a.m. registered nurse (RN)-B stated R4's focus behavior care plan that outlined her medication administration preferences had not been created and updated until 7/23/25 after R4 been upset for not being woken up for her morning medications. RN-B stated she participates in the care planning process for R4 but was not aware of R4's preferences regarding her medication administration.</p> <p>During an interview on 7/23/25 at 2:51 p.m., director of nursing (DON) stated R4's behavior that occurred in the morning regarding not getting her medications, was not a normal behavior for her and was “out of the ordinary”. R4 likes to sleep in and will always get her medications late and thought it had been care planned for her choices but was uncertain if R4's care plan was reflective of this.</p> <p>Review of the facility's Comprehensive Care Plan policy dated, 4/21/25, identified the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.</p>	F0657		
F0684 SS = D	<p>Quality of Care</p> <p>CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p>	F0684	<p>F684</p> <p>This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to</p>	09/10/2025

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F0684 SS = D	<p>Continued from page 15</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure a resident was appropriately assessed and monitored for potential effects of an opioid pain medication that was not administered as ordered for two and a half days for 1 of 3 residents (R1) reviewed for pharmacy services.</p> <p>Findings include:</p> <p>R1's facesheet dated 7/24/25, indicated she had diagnoses including fracture of shaft of left femur (broken thigh bone), opioid dependence, neuralgia (pain caused by nerve damage or irritation) and neuritis (nerve inflammation), generalized anxiety disorder, insomnia, other muscle spasm, osteoarthritis of left knee, and fibromyalgia (chronic condition causing wide-spread pain throughout the body).</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 7/5/25, indicated R1 received scheduled and as needed (PRN) pain medication, took opioid medication, and had intact cognition.</p> <p>R1's care plan focus dated 8/6/24, identified R1 had pain related to muscle spasms, left femur fracture, migraine, hammer toe, fibromyalgia, and osteoarthritis of left knee. Interventions included: monitor/record/report to nurse resident complaints of pain or requests for pain treatment dated 8/6/24, monitor/document for side effects of pain medication dated 8/11/24, non-pharmacological pain interventions dated 4/17/25, and opioid side effect monitoring dated 4/27/25.</p> <p>R1's physician order dated 1/14/25, was for methadone hydrochloride (HCl) (an opioid medication used to severe pain) oral tablet 5 milligrams (mg). It directed, give 0.5 tablet (2.5 mg) by mouth two times a day for pain.</p> <p>Review of facility narcotics logbook entry number 16 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day.</p>	F0684	<p>Continued from page 15</p> <p>ensure a resident was appropriately assessed and monitored for potential effects of an opioid pain medication that was not administered as ordered for two and a half days for 1 of 3 residents (R1) reviewed for pharmacy services.</p> <p>Immediate action</p> <p>Staff will immediately review residents' current medication with R1 and address any questions or concerns R1 has.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The Facility determined all residents that take opioid medications have potential to be affected. All residents receiving opioid medications were identified by an audit, these residents's MARS were reviewed for missing opioid medication administration between July 24 and August 28. Residents impacted were informed by 8/28/2025.</p> <p>Staff education:</p> <p>Staff education was provided on 8/6/25 and follow-up training was provided before 9/9/2025, regarding documentation in MAR of medication not available. A form was implemented to track missed medication, notification of provider, education provided to resident and assessment of resident due to missed medication.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not reoccur:</p> <p>Medication audits of unavailable medications are being done daily for 1 month, weekly for 1 month, and then monthly for 3 months. The Quality Assurance and Performance Improvement (QAPI) committee will review compliance with the established system to ensure ongoing compliance and adjust as necessary</p>	

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F0684 SS = D	<p>Continued from page 16 The last entry was dated 3/8/25 at 7:20 p.m. with amount on hand of one, amount used of one, and amount left of zero.</p> <p>R1's medication administration record (MAR) dated March 2025 and corresponding administration progress notes for the Methadone were reviewed. The record included the following:</p> <ul style="list-style-type: none"> - 3/9/25 at 8:00 a.m., charted as code "9" indicating other/see progress notes; corresponding administration progress note at 7:14 a.m. identified "NO SUPPLY." - 3/9/25 at 8:00 p.m., charted as code "9"; corresponding administration progress note at 7:22 p.m. identified "On back order." - 3/10/25 at 8:00 a.m., charted as code "9"; corresponding administration progress note at 7:19 a.m. identified "ON BACK ORDER" - 3/10/25 at 8:00 p.m., charted as code "9"; corresponding administration progress note at 8:58 p.m. was struck out with strike out reason of "Declined Order" and strike out date of 3/10/25 at 8:01 p.m. Additional note at 9:01 p.m. initiated however without additional information. - 3/11/25 at 8:00 a.m., charted as administered, R1's record did not include a corresponding administration note that could be identified for the morning dose. - 3/11/25 at 8:00 p.m., charted as administered. - 3/11/25 at 8:00 p.m. a second time, charted as code "9". Administration progress note at 7:06 p.m. included "NO MED- on back order." Additional note at 9:57 p.m. did not include additional information. <p>Review of R1's progress notes dated 3/9/25 through 3/11/25 did not identify additional notes regarding R1's missed administrations of methadone or related assessment and monitoring.</p> <p>Review of R1's assessments dated 3/9/25 through 3/11/25 did not identify any completed assessments.</p> <p>R1's vital signs section in the electronic health record (EHR) dated 3/9/25 through 3/11/25 included the following:</p>	F0684		

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F0684 SS = D	<p>Continued from page 17</p> <p>- Pain levels (on scale of one to 10) on 3/9/25: 0, 7, 3, 5, 3, 6, 8, and 5.</p> <p>- Pain levels (on scale of one to 10) on 3/10/25: 9, 5, 8, 8, 6, 6, 8, 6, 8, 9, and 5.</p> <p>- Pain levels (on scale of one to 10) on 3/11/25: 7, 8, 8, 3, 8, 3, 8, and 4.</p> <p>Vital signs did not include any associated recorded blood pressure, oxygen saturation level, heart rate, respiratory rate, or temperature.</p> <p>During an interview on 7/23/25 at 11:23 a.m., R1 stated there was a time about four months ago when she did not receive her methadone for about two days, she took it twice a day and thought she had missed maybe six doses. She took the medication for pain. During a continued interview at 5:03 p.m., R1 stated when she did not receive her methadone, she felt like she was crawling out of her skin, had increased pain, increased irritability, sweatiness, restlessness, sleeplessness, and "definitely" felt like she was having withdrawal. She informed staff that she was having increased pain, but stated staff did not monitor her more than usual or take her vital signs to identify an increase in her pain levels.</p> <p>During an interview on 7/23/25 at 4:40 p.m., licensed practical nurse (LPN)-A stated R1 had previously run out of methadone for a few days, and he thought the facility ran out of supply and it was back-ordered at the pharmacy. If a medication was not available to be given as ordered, he would notify the provider for direction. For missed administrations of methadone, LPN-A would monitor for withdrawals, take vital signs, and inform the provider that they did not have the medication. Specific monitoring would include watching for things like shakes, is someone in pain, headaches, changes in vital signs, and sweatiness. LPN-A stated he didn't think he knew what type of vital sign changes might be seen. LPN-A did not recall what monitoring or assessment he completed for R1 when he was unable to administer her methadone, but documentation would be in progress notes he and did not recall how her pain level seemed.</p> <p>During an interview on 7/24/25 at 8:13 a.m., registered nurse (RN)-A stated for a resident who did not receive methadone, she would check for signs of withdrawal, vital signs, gait imbalances, shaking, sweating, temperature or pulse changes, nausea, ask how the resident was feeling, and notify the doctor. RN-A was not sure how often vital signs should be checked, but</p>	F0684		

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F0684 SS = D	<p>Continued from page 18 if someone was having symptoms, she would probably check every hour or two. Pulse, respirations, and blood pressure could be elevated along with nausea, sweatiness, throwing up, and headache. This would be documented in assessments or progress notes with vitals in the vitals sign section of the EHR. She would monitor pain by asking a resident how their pain was on a scale of one to 10. For a resident not receiving ordered methadone for pain the frequency of pain assessments would depend on how the resident was doing.</p> <p>During an interview on 7/28/25 at 5:00 p.m., the facility's consultant pharmacist (CP) stated methadone affected opioid receptors and altered a person's perception of and response to pain. Methadone was a class II-controlled substance so was considered a high-risk medication. The medication had a high inter-patient variability, it could affect people differently and had a narrow therapeutic index when combined with other drugs for pain. She noted the impact of not taking prescribed methadone for two and a half days would probably be increased pain with the potential for vital sign changes like increased blood pressure. If someone did not receive methadone for a few days they could experience withdrawal symptoms or cravings. The medication should kick back in a few hours after being restarted but took three to five days to reach its peak level for someone who took the medication continuously.</p> <p>During an interview on 7/24/25 at 11:57 a.m., nurse practitioner (NP)-A stated he did not remember being notified R1 had run out of and not received methadone for two and a half days. He would expect R1 to have been assessed and monitored for pain and vital signs changes. He thought the chance of R1 experiencing withdrawal was minimal because she took other narcotics and did not take the methadone for treatment of substance abuse. He noted the missed methadone could result in increased blood pressure or pulse and would expect pain monitoring and vital signs to be taken at least every shift while R1 was without methadone. The absence of recorded vital signs for R1 when her methadone was not administered was not in line with his expectations.</p> <p>During an interview on 7/23/25 at 3:26 p.m., the director of nursing (DON) confirmed documentation showed R1's methadone was given on 3/8/25 at 7:20 p.m. and not administered again until the night of 3/11/25 after the narcotic logbook indicated the medication was received from the pharmacy. The DON stated not receiving methadone for two and a half days could have an impact of withdrawal, side effects, and increased</p>	F0684		

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F0684 SS = D	Continued from page 19 pain. She stated staff should have monitored R1 for withdrawals, vital signs, if her pain was increasing, and notified the doctor as needed. The DON identified pain monitoring was completed in the MAR as pain assessments were done when R1's other pain medications were administered, and staff would have assessed her during that period for where the pain was and if it was increasing. The DON identified MAR documentation of pain included a numerical pain scale rating. The DON was unable to identify additional evidence R1 was monitored for potential withdrawal, side effects, or vital signs when her scheduled methadone was not administered. Facility policy titled Medication Errors dated 2025, noted factors indicating errors in medication administration included medication administered not in accordance with provider's orders which included medication omission. If a medication error occurred, nurses were to: assess and examine the resident's condition and notify the physician or health care practitioner as soon as possible; monitor and document the resident's condition, including response to medical treatment or nursing interventions; and document actions taken in the medical record.	F0684		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F0755	F755 (D) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available to be administered in accordance with physician orders and failed to identify and report a medication error for 1 of 3 (R1) residents reviewed for pharmacy services. 1. Immediate Correction: Nursing staff will address the issue regarding R1 missing medication with that resident, encouraging her to tell Nurses if she doesn't receive a medication. 2. All residents who have medications prescribed to them have the potential to be affected in this area. resident's MAR's reviewed to ensure medications were administered according to physician's orders. If medications were not available medication error reports were completed in EHR and physician notified? Were medication carts audited to ensure all medications	09/10/2025

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<p>F0755 SS = D</p>	<p>Continued from page 20</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure medications were available to be administered in accordance with physician orders and failed to identify and report a medication error for 1 of 3 (R1) residents reviewed for pharmacy services.</p> <p>Findings include:</p> <p>R1's facesheet dated 7/24/25, indicated she had diagnoses including fracture of shaft of left femur (broken thigh bone), opioid dependence, neuralgia (pain caused by nerve damage or irritation) and neuritis (nerve inflammation), generalized anxiety disorder, insomnia, other muscle spasm, osteoarthritis of left knee, and fibromyalgia (chronic condition causing wide-spread pain throughout the body).</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 7/5/25, indicated . R1 received scheduled and as needed (PRN) pain medication, took opioid medication, and had intact cognition.</p> <p>R1's physician order dated 1/14/25, was for methadone hydrochloride (HCl) (an opioid medication used to severe pain) oral tablet 5 milligrams (mg). It directed, give 0.5 tablet (2.5 mg) by mouth two times a day for pain.</p> <p>R1's medication administration record (MAR) dated March 2025 in conjunction with administration notes, included the following documentation for administrations of the ordered methadone:</p> <p>- 3/9/25 at 8:00 a.m., charted as code "9" indicating other/see progress notes; corresponding administration progress note at 7:14 a.m. identified "NO SUPPLY."</p> <p>- 3/9/25 at 8:00 p.m., charted as code "9"; corresponding administration progress note at 7:22 p.m.</p>	<p>F0755</p>	<p>Continued from page 20 were available per physician order by 9/9/2025.</p> <p>3. Staff Education: All nurses and TMA's received education regarding the facility's medication availability procedure and reporting of medication error procedures on 8/6/25 and follow-up training was provided before 9/10/2025. The facility's medication error policy was reviewed and revised to ensure it adequately addresses definitions of medication errors and how to proceed.</p> <p>4. DON or designee will complete random audits regarding medication errors, medication availability daily for 4 weeks then once a week for 1 month and then once a month for 3 months. The Quality Assurance and Performance Improvement (QAPI) committee will review compliance with the established system to ensure ongoing compliance and adjust as necessary.</p>	

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F0755 SS = D	<p>Continued from page 21 identified "On back order.</p> <p>- 3/10/25 at 8:00 a.m., charted as code "9"; corresponding administration progress note at 7:19 a.m. identified "ON BACK ORDER"</p> <p>- 3/10/25 at 8:00 p.m., charted as code "9"; corresponding administration progress note at 8:58 p.m. was struck out with strike out reason of "Declined Order" and strike out date of 3/10/25 at 8:01 p.m. Additional note at 9:01 p.m. initiated however without additional information.</p> <p>- 3/11/25 at 8:00 a.m., charted as administered, R1's record did not include a corresponding administration note that could be identified for the morning dose.</p> <p>- 3/11/25 at 8:00 p.m., charted as administered.</p> <p>- 3/11/25 at 8:00 p.m. a second time, charted as code "9". Administration progress note at 7:06 p.m. included "NO MED- on back order." Additional note at 9:57 p.m. did not include additional information.</p> <p>Review of facility narcotics logbook entry number 16 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The last entry was dated 3/8/25 at 7:20 p.m. with amount on hand of one, amount used of one, and amount left of zero.</p> <p>Review of facility narcotics logbook entry number 38 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The first entry was dated 3/11/25 with no time and indicated 60 tablets were received. The following entry indicated the first administration of the new supply of medication was on 3/11/25 at 9:55 p.m.</p> <p>In an email dated 7/24/25 at 2:30 p.m., the administrator noted there were no facility medication errors for the month of March 2025.</p> <p>During an interview on 7/23/25 at 11:23 a.m., R1 stated there was a time about four months ago when she did not receive her methadone for about two days, she took it twice a day and thought she had missed maybe six doses. She took the medication for pain. During a continued interview at 5:03 p.m., R1 stated when she did not receive her methadone, she felt like she was crawling out of her skin, had increased pain, increased irritability, sweatiness, restlessness, sleeplessness, and felt like she was having withdrawal.</p>	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	<p>Continued from page 22</p> <p>During an interview on 7/23/25 at 12:07 p.m., trained medication assistant (TMA)-A stated if a medication was scheduled for administration but not available, she would see if it was in the facility's medication bank. If it wasn't there, she would call the pharmacy. She was not sure if it was a medication error if a medication administration was missed because the medication was unavailable.</p> <p>During an interview on 7/23/25 at 4:40 p.m., licensed practical nurse (LPN)-A stated if a medication was back ordered the provider should be notified. He remembered R1 had previously run out of her methadone and it was on backorder at the pharmacy. He did not recall if he had notified R1's provider of this or followed up when he was unable to administer R1's methadone as ordered. When asked if a provider order was needed to hold a medication if it was unavailable for administration, he stated he had never seen or been told that. He was not sure if it was a medication error if a dose of a medication was missed without a provider order to hold it.</p> <p>During an interview on 7/23/25 at 3:04 p.m., pharmacy general manager (PM) at the facility's pharmacy stated methadone was not currently and had not previously been stocked in the facility's medication bank. PM noted the pharmacy first received a refill request for R1's methadone on 2/25/25 and had notified the facility the medication was out of stock due to a national shortage and requested the provider change to an alternative form or medication. The notification was sent again on 3/4/25 when a second refill request was made. PA did not see any response from the facility or order for an alternative. The methadone was back in stock at the pharmacy on 3/11/25 and delivered to the facility that evening.</p> <p>During an interview on 7/23/25 at 12:33 p.m., the director of nursing (DON) stated if a medication was not available for administration, staff would check the medication bank. If it was not there, staff would call the pharmacy. If it was backordered at the pharmacy, staff would notify the provider to get an order to hold the medication or an alternative medication to administer. If there was no supply of a medication, staff should call the provider because they needed an order to hold it and needed to let the provider know the resident didn't receive it. If staff did not have an order to hold the medication and the medication was not administered, this was a medication error. Medications were to be administered according to provider orders. In a continued interview at 3:26 p.m.,</p>	F0755		

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F0755 SS = D	<p>Continued from page 23 the DON reviewed R1's MAR and narcotic book logs and confirmed R1 missed doses of her methadone twice on 3/9/25, twice on 3/10/25, and the morning of 3/11/25. She did not think R1's provider was notified of the missed administrations or gave an order to hold it and was unable to identify evidence of this. She stated this was a medication error because R1 did not receive her methadone as ordered and confirmed it was not identified and reported as such.</p> <p>During an interview on 7/24/25, nurse practitioner (NP)-A stated he was part of R1's primary care team. He believed R1's methadone had been on backorder with the pharmacy previously, but did not remember being notified R1 was out of methadone. His expectation was that he would have been notified R1 was out of methadone and scheduled administrations were not given. Typically, he would increase a resident's other pain medications or find an alternative temporarily until the medication was available. R1 would have increased pain without the methadone and NP-A would have increased R1's other pain medication, oxycodone, while the methadone was on back order to bridge the gap.</p> <p>Facility policy titled Medication Administration dated 6/12/24, identified medication were administered by licensed nurses, or other staff who are legally authorized to do so in this state, as order by the physician and in accordance with professional standards of practice. The policy explanation section directed to administer medication as ordered in accordance with manufacturer specifications.</p> <p>Facility policy titled Medication Errors dated 2025, identified the facility would ensure medications were administered according to physician's orders. A medication error was the observed or identified preparation or administration of medications or biologicals which was not in accordance with the prescriber's order; manufacturer's specifications, or accepted professional standards and principles which apply to professionals providing services. Factors indicating errors in medication administration included medication not administered in accordance with the prescriber's order including example of medication omission. If a medication error occurred, a nurse was to assess and examine the resident's condition and notify the physician or health care practitioner as soon as possible. Nurses were also to report the incident to the appropriate supervisor and complete the incident or occurrence report.</p>	F0755		