

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 17, 2021

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

RE: CCN: 245400

Cycle Start Date: December 28, 2020

Dear Administrator:

On December 31, 2020, we informed you that we may impose enforcement remedies.

On May 4, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

#### **REMEDIES**

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

• Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 28, 2021, will remain in effect.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

#### NURSE AIDE TRAINING PROHIBITION

As we notified you in our letter of December 31, 2020, 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), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 28, 2021 since your facility didn't come into compliance by March 28, 2020. This does not apply to or affect any previously imposed NATCEP loss.

### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

#### DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 28, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

#### APPEAL RIGHTS

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

### Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 17, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: M9PI11

#### Dear Administrator:

The above facility was surveyed on April 30, 2021 through May 4, 2021 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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:

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504 Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu Fishe Downing

Licensing and Certification Program Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 06/07/2021 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C B. WING 00949 05/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO RESTORATIVE CARE CENTER WABASSO, MN 56293 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*ATTENTION\*\*\*\*\* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been

corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

### **INITIAL COMMENTS:**

On 4/30/21 through 5/4/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 05/20/21

Electronically Signed

M9PI11 If continuation sheet 1 of 15

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Minnesota Department of Health

STATE FORM 6899 M9PI11 If continuation sheet 2 of 15

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Minnesota Department of Health STATE FORM

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	by: Based on interview facility failed to proving for 1 of antipsychotic medicincreased behavior	and document review, the vide appropriate behavior 1 resident (R1) receiving cation (Seroquel) with s, resulting in an episode of d schizophrenia and inpatient nt.		Completed		
	Findings include:					
	R1's 1/4/21, admission Minimum Data Set (MDS) identified he had moderate cognitive impairment. R1 had diagnoses of Wernicke's encephalopathy (acute neurological disorder caused by a thiamine deficiency induced by alcoholism resulting in delirium, confusion, and memory disturbances), anxiety, major depression and low thyroid and alcohol dependence with withdrawal delirium. R1's Care Area Assessment identified he required supervision on the unit. R1 had expectations to discharge back to the community after completing chemical dependency treatment.					
	administration reco administered Seroc (anti-psychotic) twic beginning 3/19/21, (anti-depressant) a venlafaxine 225 mg depression, buspire hour nicotine patch gum hourly as need abuse, and Melator insomnia.	ysicians orders and medication rd (MAR) identified he was quel 25 milligrams (mg) be daily for major depression Trazodone 50 mg to bedtime for insomnia, godaily (anti-depressant) for one twice daily for anxiety, a 24 (14 micrograms), Nicorette ded, a multivitamin for alcoholonin 3 mg at bedtime for				

Minnesota Department of Health

STATE FORM M9PI11 If continuation sheet 4 of 15

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21540	boundaries when it staff related to his NR1 had been found female resident's rounfound accusation items or access to certain informatic aggression towards were set regarding expectations. Staff 1) Administer his mhim with appropriat interacting, explain behaviors were inaunacceptable, intermonitor behaviors. and attempt to dete and document thos causes. R1 also ha Wernicke's enceph anxiety. Staff were ordered and monitor effects and effectives 3) Arrange for a psindicated. 4) Monitor, docume signs or symptoms hopelessness, anxieating, verbalizing in anxious or health-round the region of the plan and monie effects or behaviors. Interview on 4/30/2 aide (NA)-C identification in the specially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and monie effects or behaviors had but especially in the staff of the plan and t	f physical and verbally comes to other residents and Vernicke's encephalopathy. Iurking out side of another om. He had a history of its of staff not allowing him.  In R1 had a history of its male staff when boundaries behavioral management and were to: edications as ordered, assist elemethods of coping and and reinforce why his oppropriate and/or evene as necessary, and 2) Monitor behavior episodes elemented to the underlying cause elemented behaviors and potential depression due to his alopathy, depression, and to administer medications as or for and document side eness. Each consult and follow up as ent, and report as needed any of depression, including ety, sadness, insomnia, not negative statements, repetitive elated complaints, tearfulness, ation staff had followed the tored for medication side	21540			

Minnesota Department of Health

STATE FORM 6899 M9PI11 If continuation sheet 5 of 15

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	record and the pap When staff charted behaviors at that m others they may ha shift. There was no completed for the n up the sheets".	er monthly chartir each shift, they c oment, and not d ve observed thro paper behavioral	only charted ocumented ughout their I charting				
	Interview on 4/30/2 nurse (RN)-B identiand had been work was unsure what st made aware of R1's was in the ER and very cooperative wi interaction she had or symptoms of pa	fied she was new ing there about a aff charted on R1 s escalating beha was on a 72 hr ho th her and the lim with him, he sho	to the facility week. RN-B . She was viors. R1 old. He was nited wed no signs				
	R1's progress note: 1) Between 4/8/21 is behaviors documer 2) On 4/25/21 at 4:1 paranoid. R1 report him". R1 had writte and was keeping a were encouraged to staff were there to 13) On 4/25/21 at 8:1 been pacing severa with a batch of paplooked distressed". most of the time. Sin his concerns. He to stressed because of issues. He declined and legal challenge asked if he had any denied. A report wo worker to address is continue to monitor.	and 4/24/21, there and 4/24/21, there and in progress in 22 p.m., R1 was in the death of the control of the con	notes. noted to be t nice to s of all staff ies. Staff reassure him er him". noted to have m his room Pad. R1" o himself R1 to find out as so her legal cific financial R1 was m which he le social ff were to				

Minnesota Department of Health

Minnesota Department of Health

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WABASS	SO RESTORATIVE CA	ARE CENTER	LE STREET			
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	his concerns so the	ey could be addressed by the				
	care team.					
	4) On 4/27/21 at 4:	55 a.m., staff noted R1 went to				
	sleep at around 10	a.m. on 4/26/21, and woke up				
	at 0430.					
		2:08 p.m., R1 met with the				
		egistered nurse (RN)-A. R1				
		top posting messages on				
		ok page and his own personal				
		formed R1 if he had specific				
		uld speak to himself or nursing				
		d be addressed. R1 became				
		e had not been "getting any				
		trator advised R1 any of his g to his stay and care related				
		be addressed if he voiced				
		as reminded of specific				
		us concerns he had and the				
		R1 said "I have never been				
		n when I had issues with my				
		sident was informed that he				
		er, staff were not authorized to				
		panking accounts. R1 became				
	verbally aggressive	and started yelling. Staff				
		not to yell. R1 stated " I do not				
		This conversation is over. I do				
		anybody. I am getting out of				
		strator informed R1 he was his				
		arty and could make his own				
		if he felt that he wanted to				
		to do so. The admin requested				
		e, that R1 would provide the red date of discharge and				
		vas going to discharged to. R1				
		left. A few minutes later, R1				
		ommons area and started				
		told to leave today. R1, RN-A				
		ector of nursing (IDON)				
		atement was not true. RN-A				
		y had told R1 earlier. R1 was				

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Minnesc	<u>ita Department of He</u>	ealth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D WING		C	
		00949	B. WING		05/0	4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
TV/ UVIE OF 1	TO VIDEN ON OUT EIEN			717(12, 211 OODE		
WABASS	SO RESTORATIVE CA	ARE CENTER	LE STREET	_		
		WABASS	O, MN 5629	3		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIERO I)		
21540	Continued From pa	ige 7	21540			
	•					
		ner for privacy with the				
	administrator and F	RN-A. administrator and RN to				
	the meeting room for	or privacy so other residents				
		R1 left to go to his room while				
		nented they would continue to				
	monitor.	•				
	6) On 4/28/21 at 1:	31, staff documented earlier				
	,	e the nurse was making				
		scharge another resident from				
		standing outside of that				
		hen staff asked him what he				
		d he was "protecting the				
		ed the female resident (R14) if				
		esent. R14 stated "I don't know				
		ere" Staff asked him to move				
	away from the door					
		2:30 a.m., R1 was noted to				
		e his evening medications. R1				
		o stay up all night" and the				
		o him "any good". R1 then				
		m and started telling staff he				
	filed a lawsuit agair					
	administrator and the	he IDON. R1 further stated,				
	"These guys are go	oing to jail that is where they				
	belong!. I have don	e lawsuits all my life. That is				
	how I earned my liv	ring. This facility is going to pay	,			
		Me and my familywe have				
		have hired a lawyer for this				
		thut this place down and have				
		also advised staff they better				
		facility since the State was				
		the facility following his				
		staff to give him the resident's				
		plice to get him out of the				
		en the phone and called the				
	police.	on the phone and called the				
		1: 02 a m staff advised the				
		): 02 a.m., staff advised the				
		tor of the situation regarding				
		ed to be refusing medications				
	and threatening sta	ff. Staff noted there was a				

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STATE FORM 6899 If continuation sheet 8 of 15 M9PI11

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
71112 1 27111	or connection	BEITTH TOTALION MONBER.	A. BUILDING:			
		00949	B. WING		05/0	) 4/ <b>2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WABAS	SO RESTORATIVE CA	RE CENTER	LE STREET O, MN 56293	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	concern of potential building. Staff then outside resources for resources for resources encourage hour hold for further inpatient mental her some difference of the following increased of the following increased behaviors schizophrenia. Here increased verbal arrection was ever and R1 to the local recommendation for currently in the ER. There was no mention in the following behaviors related to was also no indicate obtain R1 any mental discontinued relate part of a gradual do Another request was ever received indication staff had provider, notifying behaviors and the massessment. There had actually assess behaviors since betaviors since betaviors since betaviors since betaviors in the following staff had provider in the following sent the massessment.	Il harm to others in the reached out to different for mental health. Those ged the facility to seek a 72 revaluation and possible alth services.  39 p.m., staff documented R1 stoday by the medical director aff was not allowed to remain rounds. R1 had been having streated to paranoid had been behaving with and physical aggression. After ds an order was written to all emergency room (ER) with a part of the facility attempted to the facility as made 4/27/21. No response by the provider. There was no ever attempted to call the MD-A about R1's increased need for a medical was also no indication staff sed and monitored R1's ginning his Seroquel on MD-A on the fax to R1's	21540			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						<u> </u>
		00949	B. WING			, 4/2021
		00949			03/0	4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
WADAO	O DECTORATIVE OA	660 MAP	LE STREET			
WABA5	SO RESTORATIVE CA	WABASS	O, MN 5629	3		
(V4) ID	QI IMMA DV QTA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	)NI	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
21540	Continued From pa	ugo 9	21540			
21340	Continued i Tom pa	ige 9	21340			
	R1's physician note	es and faxes identified on:				
	1) 1/12/21, nurse pi	ractitioner (NP)-A identified R1				
	was admitted to the	hospital in December 2020				
		eck was performed after R1				
	missed work for 4 c	days. R1 was found lying in				
	bed, delusional, we	ak, and confused. R1's				
	alcohol level was ne	egative and it was thought he				
	was going through	withdrawals. Neuropsychiatric				
	testing was perform	ned on 12/9/20 where it was				
	determined R1 had	no capacity to make his own				
	decisions. Given the	e acute nature of his				
	presentation to the	hospital, it was recommended				
	he have repeat test	ting performed after 60 to 90				
	days of sobriety.	<b>5</b> .				
	2) 2/3/21 and again	on 2/16/21, the order to get				
		peated by NP-A each visit.				
	There were no nota	ations identified in the medical				
	record that identifie	d staff had followed up on the				
		why it had not been				
		ied if the order was needed or				
	able to be obtained					
	3) 4/7/21, NP-A sav	wR1 and noted R1 was				
	oriented to person a	and place. He was very				
		ifficulty remembering				
		occurred immediately prior. He				
	does often repeat of	questions. Thought processes				
		ech was fluent and clear,				
		, and his insight was fair. R1				
		itted for chemical dependency				
		had started classes. He				
		nory impairment. Follow-up				
		testing had been requested,				
	but was unlikely the					
		were to continue medications				
		ccupational therapy for				
		g. R1 had a mood disorder due				
		ical conditions with depressive				
		xperienced significant losses				
		f his job recently due to				
		ner was fighting cancer. R1				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			`
		00949	B. WING	<del></del>	05/0	, 14/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WABASS	O RESTORATIVE CA	RE CENTER	LE STREET O, MN 56293	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	reported ongoing in mention NP-A was behaviors of R1 lea paranoid schizophr 4) 4/8/21, MD-A dis neurodiagnostic tes provided.  There was no indicated in the Electric of the E	somnia. There was no made aware of escalating ding to his diagnosis of				

Minnesota Department of Health

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00949	B. WING			C 0 <b>4/2021</b>
	PROVIDER OR SUPPLIER SO RESTORATIVE CA	BE CENTER 660 MAPI	DRESS, CITY, S LE STREET O, MN 56293	STATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21540	charted, during thei documentation wou accurately and doci his increasing beha per shift. Most of the to nursing staff verbout of the ton the nursing staff verbout of the ton the nursing staff verbout of the ton the nurse staff verbout of the ton the nurses verbally. We write notes and the and throw it away". Was known to be "obehaviors increased seemed to escalate 4/28/21. NA-B identification of the shift and would chabe the havior at that moother behaviors the throughout the shift communication body pertinent information residents had appocondition by a blank. R1's electronic behavior and paranoia had so discharge on 4/29/21 identification of the communication behavior and paranoia had so discharge on 4/29/21. No pages for each resident. The pages for the dates 4/27/21. No pages for the dates 4/27/21, followed by documented, it was	r shift. She agreed the ald not reflect R1's behaviors umentation lacked evidence of viors as staff only charted 1 x e time behaviors were passed bally and not documented.  ment review on 5/03/21 at a Behaviors were passed to A-B stated R1 would "write and en rip them into tiny pieces He was very paranoid and bsessed" with R14. R1's ad since his admission and e once R14 was discharged on tified staff documented 1 x per rt only if a resident had a ment she charted, not for any y may have observed and the ok was lacking any real and the section or an "ok".  avior charting from 4/8/21 artified staff had continuously rs, although R1's behaviors teadily increased up to his	21540			

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
					С	
		00949	B. WING		05/0	4/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WABAS	SO RESTORATIVE CA	RE CENTER	.E STREET O, MN 5629:	3		
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21540	O Continued From page 12		21540			
	Interview and docu IDON and administ requested to have a facility did not provi as the facility "does facility does have a provide psychiatric used her. The IDOI The facility was loo telehealth provider. were not document electronic medical eversions staff were unaware staff were unaware of his menta facility he had been was not diagnosed until he was seen be to the ER. Both agred book staff used for missing days, and in notes to pass off in IDON agreed staff increased behavior started on and contanti-psychotic medistrict monitoring.  Review of the curred Prescribing Information the staff of the curred Prescribing Information the staff of the curred Prescribing Information the curred Prescribing Information the staff of the curred Prescribing Information the curred Prescribing Information the staff of the curred Prescribing Information the curr	ment review on 5/3/21 with the rator identified the IDON R1's Seroquel be discontinued "justifiable diagnosis". The de R1 with mental health visits n't have one currently". The telehealth provider who could services, but they haven't N could not recall her name. king at bringing on another Both agreed R1's behaviors ed appropriately in the record or the paper monthly to also fill out. The IDON was n't filling out appropriate. R1's family member was I health. She advised the "dealing with it for years". R1 with paranoid schizophrenia y the MD the day he was sent eed the daily communication report was incomplete, nad no behaviors or other report to oncoming staff. The had not monitored R1's when s were noted, or when he was inued to receive and cation Seroquel, requiring  ent, undated Seroquel ation identified all patients antidepressants for any emonitored appropriately and r clinical worsening, sual changes in behavior, e initial few months of a apy, or at times of dose reases or decreases. The				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
711101 12/114	OF CONTRACTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00949	B. WING		05/0	) 4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WABAS	SO RESTORATIVE CA	RECENTER	LE STREET O, MN 56293	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	following symptoms attacks, insomnia, aggressiveness, im (psychomotor restlemania, have been with antidepressant disorder as well as psychiatric and nor caregivers of patier antidepressants for other indications, b non-psychiatric, shoto monitor patients agitation, irritability, and the other sympas the emergence such symptoms improviders. Such moobservation by fam  Review of the Febr Services policy idersigns of emotional receive services an individual needs and who do not display been diagnosed with psychosocial adjust post-traumatic street behavioral disturbation a specific clinical pattern unavoidable recognizing change psychological distresinterventions that a diagnosis and appromonitor those intervention. The	s, anxiety, agitation, panic rritability, hostility, pulsivity, akathisia essness), hypomania, and reported in adults being treated its for major depressive for other indications, both apsychiatric. Families and ints being treated with major depressive disorder or				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.25.1143.		С	
		00949	B. WING	·	05/0	4/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WABAS	SO RESTORATIVE CA	RF CFNTFR	.E STREET O, MN 5629:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Review of the Marce Condition policy ide help identify individe having acute change stay. Direct care starecognizing subtle is resident like increase communicate these MD will help identify combinations that a consequences that changes in condition about acute change collect pertinent described by the contact respond in a timely problems or change Staff were to contact additional guidance not receive a timely There was no indicate reviewed yearly for SUGGESTED MET administrator, direct consulting pharmact policies and proced medication usage at DON or designee, a could audit medicate to ensure compliant.	ch 2018, Acute Changes in entified the physician was to uals with a significant risk for use of condition during their aff were to be trained in out significant changes in the sed agitation and how to e changes to the nurse. The y medications and medication are associated with adverse could cause significant in. Before contacting the MD as of condition, staff were to tails to report to the physician. Bet the MD. The MD was to manner to notification of as in condition and status. It the medical director for and consultation if they do y or appropriate response. The ation the policy had been appropriateness.  THOD OF CORRECTION: The tor of nursing (DON) and consultation is the sist could review and revise larges for proper monitoring of and potential side effects. The along with the pharmacist, tion reviews on a regular basis	21540			

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PRINTED: 06/07/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245400	B. WING			C <b>05/04/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER	I			TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0 1/2021
WABASS	O RESTORATIVE CA	ARE CENTER			60 MAPLE STREET VABASSO, MN 56293		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
F 000	INITIAL COMMEN	TS	F 0	000			
	abbreviated survey Your facility was for with the requirement	h 5/4/21, a standard was conducted at your facility. und to be NOT in compliance hts of 42 CFR 483, Subpart B, ong Term Care Facilities.					
	SUBSTANTIATED: MN72322, MN7228 deficiencies cited a	plaints were found to be H5400028C (MN72275, B7, and MN72336) with t F689, F743, and F758. and 1933) with a deficiency cited at					
		plaints were found to be ED: H5400030C (MN72023).					
		f correction (POC) will serve of compliance upon the otance.					
	signature is not req page of the CMS-2	nrolled in ePOC, your juired at the bottom of the first 567 form. Your electronic POC will be used as bliance.					
F 689 SS=E	onsite revisit of you validate substantial regulations has been free of Accident Ha	azards/Supervision/Devices	F 6	889			5/24/21
	as free of accident	nsure that - resident environment remains hazards as is possible; and					NO DATE
LABORATOR'	LDIRECTOR'S OR PROVIL	DER/SUPPLIER REPRESENTATIVE'S SIGN	VALUKE		TITLE		(X6) DATE

Electronically Signed 05/20/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245400	B. WING			04/ <b>2021</b>
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO		J-1/2021
				660 MAPLE STREET		
WABASS	SO RESTORATIVE C	ARE CENTER		WABASSO, MN 56293		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From p	age 1	F 6	89		
	supervision and as accidents. This REQUIREME by: Based on observareview, the facility assess, and imme of 1 resident (R3) with attempted eloof cannabis oil. Thall 10 of 26 residents (R6, R7, R8, R9, R) their lighters and eresidents from unstantial from the residents from unstantial from the residents from unstantial from the residents from the residents from unstantial from the residents from th	en resident receives adequate esistance devices to prevent enterestation, interview, and document failed to appropriately monitor, diately notify the provider for 1 who had new onset confusion pement after known ingestion to facility also failed to ensure ents who smoked (R3, R4, R5, 10, R11, R12, and R13) had excigarettes secured to prevent eafely smoking indoors.  Iterly Minimum Data Set (MDS) admitted to the facility in or chemical dependency of term care. R3 had diagnoses of dependence, nicotine or depression, anxiety and a cephalopathy (brain disease nction or structure, causing tus from toxic substances). R3 in for day to day activities and most Activities of Daily Living behaviors noted on her  p.m., incident report identified mergency medical services lated to adverse effects from		1. R3 sent to ER on 4/15/2 returned on 4/16 for confusion Avera Marshall as in-patient 4/28/21. A smoking assessing completed on 4/21 which de unsafe to smoke. Immediate Resident Council meeting was smoking policy was reviewed R3, R4, R6, R7, R8, R9, R10 and R13. and requested smoking policy. R5 was not at resident Council meeting whospitalization and no longer to use of O2.  2. All residents who smoke potential to be affected by the The Smoking/Vaping Policy Procedure has been updated use of no lighters in resident on their person. This was reflected to the Resident Council meeting with 5/20/21. Staff were educated regarding the smoking policy follow-up education will be council on 5/6/21.  3. A follow-up Resident Council Resident Council meeting with 5/19, 5/20, and 5/21.	on. Sent to on 4/22/21 to ment was emed her ely on 5/6/21 as held and d with resident 0, R11, R12, toking a per facility in attendance due to recent remoking due to reflect the is practice. and d to reflect the solution or solution of the	
	(cannabis), R3 ele	as reported to be THC octed to go outside with her a cigarette. R3 broke the fence		with residents that smoke wi 5/20/21. Staff were educate regarding the smoking policy	d on 5/6/21	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		SURVEY PLETED
		245400	B. WING			05/0	) 04/2021
NAME OF F	PROVIDER OR SUPPLIER			(	STREET ADDRESS, CITY, STATE, ZIP CODE		7 1/2021
WARASS	O RESTORATIVE CA	DE CENTED		(	660 MAPLE STREET		
WADASS	O RESTONATIVE CA	NE CENTER		1	WABASSO, MN 56293		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  CONTROL OF THE PROPERTY OF T	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page 2			888			
	and ran to the adjace roommate reported retrieved R3 and ta hospital.	cent property's park. R3's the elopement to staff. Staff ken by EMS to the local			follow-up education will be complete 5/19, 5/20, and 5/21. The outside I was fixed on 5/4/21 and a replacem lighter was ordered on 5/19/21. In case where the outside lighter is incorrectly staff will light regidents.	ighter nent	
	Review of the 4/16/21, report to the State Agency (SA) and the 4/21/21, facility 5 day investigation identified the facility noted staff "followed the care plan at the time the incident". Through their investigation, staff identified R3 was found in her				inoperable staff will light residents cigarettes.  4. Audits will be completed on residence with the smoking/vapin	g	
	confiscated the vap she was not allowed included vaping ma	nurse (CN) vaping. The CN ing material and informed R3 d to smoke in the facility which terials. The interim director of ke with R3 who was noted to			policy 2x weekly for 4 weeks, 1x pe 1x a month and monthly for 3 mont These audits will be completed by t team. Any deficient practices will be immediately identified and correcte	hs. he IDT	
	be "somewhat conf due to the resident smoking materials i	used". Staff did a room search having been caught with n her room and upon the a box containing a vape pipe			Results will be brought to QAPI cor for further review and recommenda	nmittee	
	and a bottle of vapid IDON confiscated the where she got the v	ng liquid marked THC. The ne materials and asked R3 rape pipe and THC. R3 stated					
	minutes later, nursing becoming very conf	ne". Approximately 30-40 ng staff observed the resident used and delusional. R3 was king patio with her roommate					
	when her roommate broken the fence ar playground, adjace	e informed staff R3 had nd started running to the nt to the facility. Staff					
	asked R3 what she wanted to swing". F	up with the resident and was doing. R3 stated "I just 13 returned to the facility and					
	normal limits and no then sent to the em	ssment, which was within o injuries were noted. R3 was ergency room (ER) for					
	the ER hospital note marijuana (cannabi	n, agitation, and delusions. Per es, R3 test positive for s and/or THC) in her system. ministrator spoke with R3 and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		245400	B. WING		0	C <b>5/04/2021</b>
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIF 660 MAPLE STREET WABASSO, MN 56293	<b>.</b>	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	asked her where she reluctant to give any stated she got the stated her boyfriend had given it to her a had used the THC and used anti-anxiety monitor, document, adverse reactions to drowsiness, lack of reflexes, slurred sp disorientation, impairmpulsive behavior, R3 was a smoker. The suffer injury from and was able to sm to observe clothing burns and notify the suspected she had. There was no ment monitoring or side of had similar side effect with the building, or the cigarette lighter.  R3's progress notes to similar side effect of the main redirect R3 and her no mention staff ide elopement and conmonitored her closed level of conscious physician of new or stated to serve of the war and the door of the main redirect R3 and her no mention staff ide elopement and conmonitored her closed level of conscious physician of new or stated to serve of the work of th	ne got the THC. R3 was y information, however she THC from her boyfriend. R3 d had visited her recently and at that time. R3 identified she after that visit.  ed care plan identified she redication. Staff were to and report any potential to therapy, including energy, clumsiness, slow eech, confusion and ired thinking and judgement, and hallucinations every shift. The care plan noted she would m unsafe smoking practices toke unsupervised. Staff were and skin for signs of cigarette enurse immediately it was or was violating the policy. It is in the the thinking and judgement, and skin for signs of cigarette enurse immediately it was or was violating the policy. It is in the thinking and judgement, and skin for signs of cigarette enurse immediately it was or was violating the policy. It is in the thinking and judgement, and skin for signs of cigarette enurse immediately it was or was violating the policy. It is in the thinking and judgement, and skin for signs of cigarette enurse immediately it was or was violating the policy. It is in the thinking and judgement, and skin for signs of cigarette enurse immediately it was or was violating the policy. It is in the thinking and judgement, and skin for signs of cigarette enurse immediately it was or was violating the policy. It is in the thinking and judgement, and hallucinations every shift. The care plan noted she would musafe smoking practices of cigarette enurse immediately it was or was violating the policy. It is in the plan thinking and judgement, and hallucinations every shift. The care plan noted she would musafe smoking practices of cigarette enurse immediately it was or was violating the policy. It is in the plan thinking and judgement, and report the plan thinking and judgement and report the plan thinking and judgement and plan thinking and judgement and judgement and judgement and judgement and judgement and judgement and jud	F 6	689		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION	COM	E SURVEY IPLETED
		245400	B. WING				C <b>04/2021</b>
	PROVIDER OR SUPPLIER	RE CENTER		660 M	T ADDRESS, CITY, STATE, ZIP CODE  APLE STREET  ASSO, MN 56293	<u>,                                    </u>	0 1/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	in her room with Thobserved by staff in window sill with the cigarette. There was the lighter for safety while she awaited thassessment.  3) 8:07 p.m., staff of confusion and erration out her screen in her room. Staff noted we EMS, R3 was unmous moke with her room recovered her at the staff had a for "bizarre behaviousing illicit substance increased paranoial history of alcohol are exam revealed her thoughts were errationable were errationable to another, difficulty maintaining responses were slocannabis use disord complete labs. Late facility, staff notified vape in her room. Flot up" during the disent to the ER. Neidentified any updat staff perform a seaf for safety and recommaterials or remove was also no mention supervision and mouse the safety was also no mention supervision and mouse the safety and recommandation of the safety and recommand	ge 4 IC. Then later R3 was her room, sitting in her window open smoking a s no mention staff confiscated or placed R3 on a 1 to 1 (1:1) ransport to the ER for locumented R3 had increased ic behavior including popping er room and smoking in her while nursing had contacted onitored and went outside to m mate and eloped. Staff e adjacent property park. ual time), a Late Entry note by R3's physician (NP-A) asked for R3 to be assessed and reported she had and confusion. R3 had a nd substance abuse. R3's pupils were dilated and ic and moving from one and was found to have g a conversation. Her www. NP-A diagnosed her with der and wrote orders to er, while NP-A was still in the later they discovered a THC R3 reported she had used it "a lay. R3 tried to elope and was A made no mention she led interventions. like to have rech of R3's room immediately very of any other potential illicities her lighter for safety. There in staff had increased onitoring for the potential is from the THC to prevent her	F6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245400	B. WING		0	C <b>5/04/2021</b>
	PROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
F 689	day after the incide "no" to having any as smoking in a not R4's progress note noted to be smokin Staff took away R4 advised R4 she wo lighter on her persoindication when station her person, or have be a safe amoun lighter safety.  R4's 4/11/21, smokwas marked "no" to be a safe amoun lighter safety.  R4's 4/11/21, smokwas marked "no" to incidents such as a sarea.  R5's 4/29/21, smokwas documented a incidents, however marked "check all marked R5 had be non-smoking area.  R5's current, undarwas a smoker and even though staff hypreviously.  Interview on 5/03/2 administrator and to identified they agressmoking. The agree	king assessment, completed 1 ent identified R3 was marked smoking related incidents such en-smoking area.  It is identified on 4/1/21, R4 was ag in her room at 1:30 a.m  It's lighter at the time and enter the such enter the same of the second incident of the second incident of the second incident of the second incident of time to determine future of time to determine future incident of the second incident incide	F 6	589		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245400	B. WING			C <b>05/04/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	03/1	0-1/2021
WABASS	O RESTORATIVE CA	RE CENTER		660 MAPLE STREET WABASSO, MN 56293			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 689	appropriately super have eloped. Smok safety hazard and were aware of some smoking policy and have smoked indocallowed lighters and resident's person as would rise if they did Interviews on 5/3/2 (NA)-A and later at identified R3, R4, a discovered by staff building. Lighters were identified residents when not who smoked currer. Review of the 9/25/identified residents be permitted to do smoke independent guidelines. Addition taken as determine Safety Assessment within the building. keep their smoking otherwise. For a first a 24 Hour Restriction were not to be allow materials on them. Staff were to ensure violation occurred. Review of the Marc Elopement policy id risk for wandering, of the materials of the Marc Elopement policy id risk for wandering, of the materials of the Marc Elopement policy id risk for wandering, of the materials of the Marc Elopement policy id risk for wandering, of the materials of the Marc Elopement policy id risk for wandering, of the materials of the Marc Elopement policy id risk for wandering, of the materials of the materials of the Marc Elopement policy id risk for wandering, of the materials of the	had staff monitored and vised her, she likely would not ing or vaping indoors was a was not to be allowed. They be residents not following the had been observed by staff to be instantial. The IDON and admin have it is supplies to be kept on the sthey felt residents' behaviors	F6	89			

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (2	(X3) DATE SURVEY COMPLETED	
		245400	B. WING		C <b>05/04/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293	03/04/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 689	interventions staff winterventions were to Review of the above there was no indicator revised as needed.	here was no mention what were to place or when those to be in effect or for how long.  The mentioned policies identified tion they had been reviewed	F 689		5/24/21	
SS=D	not reveal or who demental or psychosodocumented history traumatic stress dispattern of decrease increased withdraw behaviors, unless the demonstrates that demonstrates the demonstrates that demonstrates that demonstrates that demonstrates that demonstrates the demonstrates that demonstrates the demonstrates that demonstrates that demonstrates the demonstrates that demonstrates the demonstrates that demonstrates the demonstrates that demonstrates the demonstrates that demonstrates that demonstrates the demonstrates	ident whose assessment did oes not have a diagnosis of a cial adjustment difficulty or a rof trauma and/or postorder does not display a d social interaction and/or n, angry, or depressive ne resident's clinical condition development of such a pattern				
	Based on interview facility failed to notif appropriate mental resident (R1) who ewith no mental heal onset acute parano psychiatric treatments. Findings include:  R1's 1/4/21, admissidentified he had mer R1 had diagnoses of (acute neurological deficiency induced).	r and document review, the by the physician and provide health services for 1 of 1 exhibited increased behaviors the intervention resulting in new id schizophrenia and inpatient int.  Sion Minimum Data Set (MDS) oderate cognitive impairment of Wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in and memory disturbances),		<ol> <li>R1 was sent to Redwood Hospita 4/29/21 for a 72-hour psychiatric hold R1on 4/29/21 made the self determine to not sign a bed-hold and was disch from the facility.</li> <li>A review of all residents on psychotropic medications was compon 5/19/21. All residents care plans behavior sheets have been updated reflect the use of psychotropic medications. Residents currently receiving psychotropic medications version by the psychiatric nurse practition 5/21 and 5/24/21 to review the neany further mental health services.</li> </ol>	d. nation larged leted and to  vill be oner	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		245400	B. WING	<del> </del>	C <b>05/04/2021</b>	
	PROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 743	anxiety, major depidence alcohol dependence R1's Care Area Assupervision on the discharge back to the chemical depender R1's April 2021, phadministration reconsummers administered Seros (anti-psychotic) twice Trazodone 50 mg (insomnia, venlafax (anti-depressant) for daily for anxiety, a micrograms), Niconsultivitamin for alcome at bedtime for in R1's 12/1/20, mention and physical while admission to the fashistory of alcohol anxiety, and depreseparanoid schizophres R1's 12/24/20, regis summary identified alcohol dependence delirium tremens (to stoppage of alcohol disorder. There was lengthy stay that R1's current, undata not always aware of the stoppage of alcohol to the fast or paranoid schizopthe hospital hospital h	ression and low thyroid and e with withdrawal delirium. Sessment identified he required unit. R1 had expectations to the community after completing ncy treatment.  ysicians orders and medication and (MAR) identified he was quel 25 milligrams (mg) ce daily for major depression, anti-depressant) at bedtime for ine 225 mg daily or depression, buspirone twice 24 hour nicotine patch (14 rette gum hourly as needed, a chol abuse, and Melatonin 3 insomnia.  al health consultation history R1 was hospitalized before his cility identified a past medical buse, alcohol dependence, asion. No diagnosis of renia was noted.  onal hospital discharge diagnoses of alcohol abuse, e, anxiety, and depression, remors caused by abrupt of the property of the propert	F 743	3. The process of behavior commas been reviewed and will be re-implemented on 5/24/21. This include pharmacy recommendation involving psychotropic medication are being administer. Education behavior committee process will be completed with those involved on 4. Audits will be completed on ap behavioral documentation and not of physician 2x weekly for 4 week week 1x a month and monthly formonths. These audits will be comby the IDT team. Any deficient primit will be immediately identified and corrected. Results will be brought committee for further review and recommendations.	will ons as that on the oe 5/19/21. propriate offication as, 1x per 3 apleted actices	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245400	B. WING _			C <b>04/2021</b>
	PROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293	, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 743	staff related to his R1 had been found female resident's runfound accusation items or access to history of aggressic boundaries were simanagement and a 1) Administer his min with appropriation interacting, explain behaviors were inaunacceptable, intermonitor behaviors. 2) Monitor behaviors are had depression duencephalopathy, dowere to administer monitor for and doeffectiveness. 3) Arrange for a psindicated. 4) Monitor, docume signs or symptoms hopelessness, anxeating, verbalizing anxious or health-rathere was no indicated on the linterview on 4/30/2 aide (NA)-C identifing R1's behaviors in the chart behaviors in the stage of the signs of the sign	Wernicke's encephalopathy. I lurking out side of another form. He had a history of this of staff not allowing him certain information. R1 had a contowards male staff when the regarding behavioral expectations. Staff were to: nedications as ordered, assist the methods of coping and and reinforce why his appropriate and/or evene as necessary, and are repisodes and attempt to enlying cause and document and potential causes. R1 also to this Wernicke's expression, and anxiety. Staff medications as ordered and cument side effects and support and follow up as the entype of depression, including the interest of the properties of the properties and the properties of the properties of the properties and the properties of the propert	F 74	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245400	B. WING _		05	C / <b>04/2021</b>		
NAME OF PROVIDER OR SUPPLIER  WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 660 MAPLE STREET WABASSO, MN 56293	·			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	D BE COMPLÉTION		
F 743	When staff charted behaviors at that exobserved througho reason his behavion not documented. Tocharting completed one made up the substituting completed one work was unsure what substituting made aware of R1' was in the ER and very cooperative with interaction she had or symptoms of particular completed on the facility several interactions R1 seemed to be substituting a friend, [R14] and IDON confronted heave. The admining at him. R1 talked at their taking notes. Tight. He rattled on to leave. R1 was in (court order requiring so S-A reminded heave) the tochoosing to stay the choosing to stay the constitutions.	l each shift, they only charted xact moment, and not any ut their shift. That was the rs throughout their shift were here was no paper behavioral for the month of April as "no	F 74	13				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		245400	B. WING			05/0	) 04/2021	
NAME OF PROVIDER OR SUPPLIER  WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 660 MAPLE STREET WABASSO, MN 56293	ODE	00/0	)-i/LUL1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD E	JLD BE COMPLÉTION		
F 743	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 7	743				
	would like to seek g	s well. R1 was asked if he juardianship or a conservator, was "perfectly capable of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		245400	B. WING _			C ( <b>04/2021</b>	
NAME OF PROVIDER OR SUPPLIER  WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 743	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 74	3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3	B) DATE SURVEY COMPLETED
		245400	B. WING			C <b>05/04/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 660 MAPLE STREET WABASSO, MN 56293	IP CODE	03/04/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIAT	
F 743	upset and stated he help". The administ concerns pertaining to the facility would them to staff. R1 was examples of previous assistance given. R given any help, ever bank account. Reswas helped, however access his private by verbally aggressive reinforced he was rewant to talk to you. Not want to talk to a here". The administ own responsible padecisions, and that leave, he was free to if he wished to leave facility with his desired in the measure of the control of the meeting and I came back to the control of the meeting room for were not present. Fix yelling. Staff docummonitor.  11) 4/28/21 at 1:31 that day today while arrangements to disting facility, R1 was started facility.	ge 13  In had not been "getting any rator advised R1 any of his to his stay and care related be addressed if he voiced as reminded of specific us concerns he had and the concerns he had and started "I do not anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had anybody. I am getting out of concerns he had to do not concerns he had any ha	F 7	743		

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	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP 660 MAPLE STREET WABASSO, MN 56293	<u>.</u>	704/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 743	was doing he stated resident". Staff asks she wanted him prowhat he is doing the away from the door 12) 4/29/21 at 12:30 refused to take his stated he "wanted to medication didn't docame out of his roo filed a lawsuit again administrator and the These guys are going belong! I have don how I earned my live pay me a lot of more have teamed up and this case. We have have them go to jain better quit working was going to shut the lawsuit. He asked so phone to call the post facility. R1 was give police.  13) 4/29/21 at 10: 0 regional administra R1. R1 was reported and threatening state concern of potential building. Staff then outside resources for resources encourage hour hold for further inpatient mental he 14) 4/29/21 at 1:39 was seen on round (MD)-A. Nursing states.	d he was "protecting the ed the female resident (R14) if seent. R14 stated "I don't know ere" Staff asked him to move of a.m., R1 was noted to have evening medications. R1 o stay up all night" and the or him "any good". R1 then m and started telling staff he net the facility, the ne IDON. R1 further stated " ng to jail that is where they e lawsuits all my life. That is ring. This facility is going to ney. Me and my familywe d we have hired a lawyer for to shut this place down and I". He also advised staff they for the facility since the State lown the facility following his staff to give him the resident's olice to get him out of the en the phone and called the enter the facility following his staff to give him the resident's off. Staff noted there was a I harm to others in the reached out to different or mental health. Those ged the facility to seek a 72 revaluation and possible	F 7	43		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION  NG	(X		SURVEY PLETED
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	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 660 MAPLE STREET WABASSO, MN 56293	E	30/0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOLS) CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 743	schizophrenia. He hincreased verbal ar seeing him on rounsend R1 to the local recommendation for currently in the ER. There was no mentidentified or docume escalating behaviors related to was also no indication obtain R1 any mentidescent and the facility requested discontinued related part of a gradual do Another request was ever received hindication staff had MD-A, notifying MD behaviors and the massessment. There had actually assess behaviors since beg 3/19/21, or notified increased behaviors.  R1's physician note 1) 1/12/21, nurse proposed work for 4 consistency was admitted to the after a wellness chemissed work for 4 consistency was not bed, delusional, we alcohol level was not was going through the seeing seed work for a consistency was not bed, delusional, we alcohol level was not was going through the seeing seed work for a consistency was not bed, delusional, we alcohol level was not was going through the seeing him to the seed work for a consistency was not bed.	s related to paranoid had been behaving with had physical aggression. After ds an order was written to I emergency room (ER) with a r 72 hour hold. R1 was at that time. ion in the progress notes staff ented R1's continued s, or were monitoring R1's on the facility attempted to all health services prior to  21, fax sent to MD-A identified d to have R1's Seroquel d to "no target behaviors" as se reduction attempt (GDR). Is made 4/27/21. No response by the provider. There was no ever attempted to call the read about R1's increased heed for a medical was also no indication staff and monitored R1's ginning his Seroquel on MD-A on the fax to R1's is.	F 7	43			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(	X3) DATE SURVE COMPLETED	ΞΥ
		245400	B. WING			C <b>05/04/202</b>	,
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY 660 MAPLE STREET WABASSO, MN 562		00/0-4/202	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTED CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD E NCED TO THE APPROPRI DEFICIENCY)		ETION
F 743	determined R1 had decisions. Given the presentation to the he have repeat test days of sobriety.  2) 2/3/21 and again R1's testing was rethere were no note record that identified order to determine performed, or clarificable to be obtained 3) 4/7/21, NP-A saw oriented to person a forgetful and had disconversations that does often repeat of are coherent, speed Anxious, and insight admitted for chemic treatment. He had swith memory impair neuropsychological but was unlikely the improvement. Staff and continue his occognitive re-training to known physiolog features. R1 had exincluding the loss of alcoholism. His father reported ongoing in mention NP-A was behaviors of R1 lead paranoid schizophrical paranoid schizophrical provided.	no capacity to make his own e acute nature of his hospital, it was recommended ing performed after 60 to 90 in on 2/16/21, the order to get peated by NP-A each visit. In a capacity in the medical distaff had followed up on the why it had not been it in it is it is in a capacity in	F 7	43			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		245400	B. WING		0	C <b>5/04/2021</b>
	PROVIDER OR SUPPLIER  SO RESTORATIVE CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIR 660 MAPLE STREET WABASSO, MN 56293		<u> </u>
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F 743	R1 prior to 4/29/21, R1 be sent to the E Interview on 4/30/2 RN-C identified R1 on 4/29/21 on a 72 actively seeking inpadmission.  Interview on 4/30/2 identified R1 had not IDON had asked st charted, even though increased, to which were "unsure". Her document all behave MD did a virtual visit with paranoid schiz ER with a request for services.  Interview and document and the way and the way and the way and the way and the services.  Interview and document and the way and the way and the services and the service and the way and the stated no one was also the service one way and the service of the way and the way and the service of the way and the way an	after staff called to request R for escalating behaviors.  1 at 12:42 p.m., local hospital was admitted to the hospital hr hold. The hospital was ratient psychiatric hospital hr hold. The hospital was ratient psychiatric hospital  1 at 1:33 p.m. with the IDON behaviors charted. The aff why no behaviors were gh R1's behaviors had staff reported to her they expectation was staff were to riors with any resident. The it on 4/29 and diagnosed R1 ophrenia. R1 was sent to the or 72 hour hold and psych  ment review on 5/03/21 at the Aidentified she knew R1 to "snap, flip out and get o explain to R1 one time, if he eneeded to pay for it. R1 helping him and told her to get if his room. R1 seemed to readministrator]. Staff were to define resident behaviors or needs the needed to be communication resident behaviors or needs the needed to secalated in April, the communication book with strenties were blank for definition. NA-A agreed staff	F7	743		

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F 743	record if they happ charted, during the documentation wor accurately and dochis increasing behaper shift. Most of the to nursing staff ver Interview and document behavion nurses verbally. Now write notes and the and throw it away." was known to be "obehaviors increase seemed to escalate 4/28/21. NA-B idenshift and would chabehavior at the monot include all behashift. NA-B stated to lacking any real pe "hard to know if reschanges in condition" ok".  R1's electronic behavior and paranoia had see discharge on 4/29/21. Review of the compages for the dates.	rs in the electronic medical ened at the moment they ir shift. She agreed the uld not reflect R1's behaviors sumentation lacked evidence of aviors as staff only charted 1 x ne time behaviors were passed bally and not documented.  Imment review on 5/03/21 at A-B identified staff did not rs. Behaviors were passed to A-B stated R1 would "write and then rip them into tiny pieces. He was very paranoid and obsessed" with R14. R1's red since his admission and reflect once R14 was discharged on the	F 7	43		

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F 743	4/29/21, followed by and 5/2/21. If staff of marked "ok". No de routinely document. Interview and document the IDON and admirequested to have a serificial to the facility did not proviate the facility "does facility does have a provide psychiatric used her and the ID recall her name. The bringing on another mental health service behaviors were not the electronic medimonthly versions st IDON was unaware appropriate behavior facility he had been was not diagnosed until he was seen be to the ER. Both agreed behavior started on and contanti-psychotic medistrict monitoring.  Review of the Febri Services policy ider	y pages for 4/30/21, 5/1/21 documented, it was commonly efinitive information was	F 7	743		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG	COM	E SURVEY IPLETED
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F 743	who do not display been diagnosed wit psychosocial adjust post-traumatic stress behavioral disturbat to a specific clinical pattern unavoidable recognizing change psychological distresinterventions that a diagnosis and appromonitor those intervention. The had been reviewed  Review of the Marc Condition policy ide help identify individe having acute change stay. Direct care starecognizing subtle to resident like increase communicate these MD will help identify combinations that a consequences that changes in condition about acute change collect pertinent defect of the staff were to contage staff were to contage additional guidance not receive a timely	d goals for care. Residents symptoms of, or have not h, mental, psychiatric, ment, substance abuse or as disorder will not development to that makes the condition that makes the condition that makes the condition that indicate ass, implement care plan are relevant to the resident's opriate to his or her needs and rentions and report changes in the was no indication the policy yearly for appropriateness.  The 2018, Acute Changes in antified the physician was to use with a significant risk for the sed agitation and how to be changes to the nurse. The remedications and medication are associated with adverse could cause significant in. Before contacting the MD are of condition, staff were to use the MD. The MD was to manner to notification of the sin condition and status. It the medical director for and consultation if they do or appropriate response. In a station the policy had been	F 74	13		

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Free from Unnec P CFR(s): 483.45(c)(3) §483.45(e) Psychology Systems activities processes and behabut are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a compressed on a compressed on a compressed on the facility §483.45(e)(1) Residus Syschotropic drugs unless the medicatis specific condition activities.	ehensive assessment of a must ensure that— dents who have not used are not given these drugs in secessary to treat a sidiagnosed and documented	F 7	58		5/24/21
drugs receive gradu behavioral intervent contraindicated, in a drugs; §483.45(e)(3) Resid psychotropic drugs unless that medicat diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and orders for psychotropic drugs ys. Except as provided in				
	PROVIDER OR SUPPLIER  SO RESTORATIVE CA  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa Free from Unnec P CFR(s): 483.45(c)(3) A psy affects brain activiti processes and beh but are not limited t categories: (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic  Based on a compre resident, the facility §483.45(e)(1) Resid psychotropic drugs unless the medicati specific condition a in the clinical record §483.45(e)(2) Resid drugs receive gradu behavioral intervent contraindicated, in a drugs;  §483.45(e)(3) Resid psychotropic drugs unless that medicati diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da	PROVIDER OR SUPPLIER  SO RESTORATIVE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21 Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21 Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. 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Except as provided in	PROVIDER OR SUPPLIER  30 RESTORATIVE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21 Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3) (e)(1)-(5) \$483.45(c)(3) A psychotropic Drugs. \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. 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Except as provided in	PROVIDER OR SUPPLIER  245400  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  660 MAPLE STREET  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21  Free from Unnec Psychotropic Meds/PRN Use  CFR(s): 483.45(c)(3)(e)(1)-(5)  \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  (ii) Anti-anxiety; and  (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that—  \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  \$483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  \$483.45(e)(2) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  \$483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in

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F 758	appropriate for the beyond 14 days, he rationale in the resi indicate the duratio §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitic the appropriateness. This REQUIREMED by:  Based on interview facility failed to prove monitoring for 1 of antipsychotic medic increased behavior new onset paranoic psychiatric treatme.  Findings include:  R1's 1/4/21, admissi identified he had m R1 had diagnoses (acute neurological deficiency induced delirium, confusion anxiety, major depralcohol dependence. R1's Care Area Assisupervision on the discharge back to the chemical depender.  R1's April 2021, phyadministration recommonities and the pender.	oner believes that it is PRN order to be extended or she should document their dent's medical record and on for the PRN order.  orders for anti-psychotic 14 days and cannot be extending physician or oner evaluates the resident for sof that medication.  NT is not met as evidenced or and document review, the order appropriate behavior or resident (R1) receiving cation (Seroquel) with or, resulting in an episode of of a schizophrenia and inpatient or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), ession and low thyroid and or with withdrawal delirium. Or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), ession and low thyroid and or with withdrawal delirium. Or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or and memory disturbances), or wernicke's encephalopathy disorder caused by a thiamine by alcoholism resulting in or wernicke's encephalopathy	F 75	1. R1 was sent to Redwood Hos 4/29/21 for a 72-hour psychiatric h R1on 4/29/21 made the self deter to not sign a bed-hold and was dis from the facility.  2. A review of all residents on psychotropic medications was cor on 5/19/21. All residents care plat behavior sheets have been update reflect the use of psychotropic medications. Residents currently receiving psychotropic medication seen by the psychiatric nurse praction on 5/21 and 5/24/21 to review the any further mental health services  3. Audits will be completed on appropriate behavioral documental notification of physician 2x weekly weeks, 1x per week 1x a month a monthly for 3 months. These audicompleted by the IDT team. Any operactices will be immediately idention and corrected. Results will be brown QAPI committee for further review.	mination scharged mpleted ns and ed to swill be etitioner need for ation and for 4 nd ts will be leficient edited ught to	

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F 758	beginning 3/19/21, (anti-depressant) a venlafaxine 225 mg depression, buspire hour nicotine patch gum hourly as need abuse, and Melator insomnia.  R1's current, undat not always aware oboundaries when it staff related to his NR1 had been found female resident's rounfound accusation items or access to certain informatic aggression towards were set regarding expectations. Staff 1) Administer his mhim with appropriat interacting, explain behaviors were inaunacceptable, intermonitor behaviors. and attempt to detain document thos causes. R1 also ha Wernicke's enceph anxiety. Staff were ordered and monitor effects and effectiv 3) Arrange for a psindicated.  4) Monitor, docume	Trazodone 50 mg t bedtime for insomnia, g daily (anti-depressant) for one twice daily for anxiety, a 24 (14 micrograms), Nicorette ded, a multivitamin for alcohol nin 3 mg at bedtime for  ed care plan identified he was f physical and verbally comes to other residents and Wernicke's encephalopathy. I lurking out side of another om. He had a history of ns of staff not allowing him  on. R1 had a history of s male staff when boundaries behavioral management and were to: nedications as ordered, assist e methods of coping and and reinforce why his ppropriate and/or vene as necessary, and 2) Monitor behavior episodes ermine the underlying cause the behaviors and potential and depression due to his alopathy, depression, and to administer medications as or for and document side	F 7	758	recommendations.  4. Audits will be completed on beh committee documentation and appropriate use of antipsychotic medications 2x weekly for 4 weeks week 1x a month and monthly for 3 months. These audits will be comp by the IDT team. Any deficient pracwill be immediately identified and corrected. Results will be brought to committee for further review and recommendations.	, 1x per } leted ctices	

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hopelessness, anx eating, verbalizing anxious or health-r. There was no indic care plan and mon effects or behaviors. Interview on 4/30/2 aide (NA)-C identification and the paper of the chart behaviors in the chart behaviors in the chart behaviors at that mothers they may has shift. There was not completed for the rup the sheets."  Interview on 4/30/2 nurse (RN)-B identification and had been work was unsure what simade aware of R1' was in the ER and very cooperative winteraction she had or symptoms of path of the paper	iety, sadness, insomnia, not negative statements, repetitive elated complaints, tearfulness. action staff had followed the itored for medication side s.  If at 11:00 a.m., with nurse ied she was familiar with R1. If escalated since admission, a last few weeks. Staff were to both the electronic medical fer monthly charting system. If each shift, they only charted froment, and not documented from the electronic medical from the second throughout their to paper behavioral charting month of April as "no one made if at 11:30 a.m., with registered if it is escalating behaviors. R1 was on a 72 hr hold. He was it is escalating behaviors. R1 was on a 72 hr hold. He was ith her and the limited is with him, he showed no signs aranoia she was aware of.  Is identified:  and 4/24/21, there were no noted in progress notes.  O2 p.m., R1 was noted to be ted staff "were not nice to	F 75	58		
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC) REGULATORY OR L  Continued From pa hopelessness, anx eating, verbalizing anxious or health-r There was no indic care plan and mon effects or behaviors Interview on 4/30/2 aide (NA)-C identifi R1's behaviors had but especially in the chart behaviors in I record and the pap When staff charted behaviors at that m others they may ha shift. There was no completed for the r up the sheets".  Interview on 4/30/2 nurse (RN)-B ident and had been work was unsure what s made aware of R1' was in the ER and very cooperative w interaction she had or symptoms of pa R1's progress note 1) Between 4/8/21 behaviors docume 2) On 4/25/21 at 4: paranoid. R1 repor him". R1 had writte and was keeping a were encouraged t	PROVIDER OR SUPPLIER  SO RESTORATIVE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24 hopelessness, anxiety, sadness, insomnia, not eating, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness. There was no indication staff had followed the care plan and monitored for medication side effects or behaviors.  Interview on 4/30/21 at 11:00 a.m., with nurse aide (NA)-C identified she was familiar with R1. R1's behaviors had escalated since admission, but especially in the last few weeks. Staff were to chart behaviors in both the electronic medical record and the paper monthly charting system. When staff charted each shift, they only charted behaviors at that moment, and not documented others they may have observed throughout their shift. There was no paper behavioral charting completed for the month of April as "no one made"	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24 hopelessness, anxiety, sadness, insomnia, not eating, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness. There was no indication staff had followed the care plan and monitored for medication side effects or behaviors.  Interview on 4/30/21 at 11:00 a.m., with nurse aide (NA)-C identified she was familiar with R1. R1's behaviors had escalated since admission, but especially in the last few weeks. Staff were to chart behaviors in both the electronic medical record and the paper monthly charting system. When staff charted each shift, they only charted behaviors at that moment, and not documented others they may have observed throughout their shift. There was no paper behavioral charting completed for the month of April as "no one made up the sheets".  Interview on 4/30/21 at 11:30 a.m., with registered nurse (RN)-B identified she was new to the facility and had been working there about a week. RN-B was unsure what staff charted on R1. She was made aware of R1's escalating behaviors. R1 was in the ER and was on a 72 hr hold. He was very cooperative with her and the limited interaction she had with him, he showed no signs or symptoms of paranoia she was aware of.  R1's progress notes identified:  1) Between 4/8/21 and 4/24/21, there were no behaviors documented in progress notes.  2) On 4/25/21 at 4:02 p.m., R1 was noted to be paranoid. R1 reported staff "were not nice to him". R1 had written down the names of all staff and was keeping a log of staff activities. Staff were encouraged to talk to him and reassure him	PROVIDER OR SUPPLIER  TO RESTORATIVE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24 hopelessness, anxiety, sadness, insomnia, not eating, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness. There was no indication staff had followed the care plan and monitored for medication side effects or behaviors.  Interview on 4/30/21 at 11:00 a.m., with nurse aide (NA)-C identified she was familiar with R1. R1's behaviors in both the electronic medical record and the paper monthly charting system. When staff charted each shift, they only charted behaviors at that moment, and not documented others they may have observed throughout their shift. There was no paper behavioral charting completed for the month of April as "no one made up the sheets".  Interview on 4/30/21 at 11:30 a.m., with registered nurse (RN)-B identified she was new to the facility and had been working there about a week. RN-B was unsure what staff charted on R1. She was made aware of R1's secalating behaviors. R1 was in the ER and was on a 72 hr hold. He was very cooperative with her and the limited interaction she had with him, he showed no signs or symptoms of paranoia she was aware of.  R1's progress notes identified:  1) Between 4/8/21 and 4/24/21, there were no behaviors documented in progress notes.  2) On 4/25/21 at 4:02 p.m., R1 was noted to be paranoid. R1 reported staff "were not nice to him". R1 had written down the names of all staff and was keeping a log of staff activities. Staff were encouraged to talk to him and reassure him	PROVIDER OR SUPPLIER  SO RESTORATIVE CARE CENTER  SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAS ASSO, MN 56293)  SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAS ASSO, MN 56293)  SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAS ASSO, MN 56293)  CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY OR LSC IDEN

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NAME OF PROVIDER OR SUPPLIER  WABASSO RESTORATIVE CARE CENTER				66	TREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE STREET VABASSO, MN 56293		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	been pacing several with a batch of papelooked distressed." most of the time. Statistic concerns. He to stressed because of issues. He declined and legal challenge asked if he had any denied. A report wo worker to address he continue to monitor his concerns so the care team.  4) On 4/27/21 at 4:3 sleep at around 10 at 0430.  5) On 4/27/21 at 12 administrator and rowas requested to stompany's Facebor page. The administrator and it would upset and stated he help". The administration concerns pertaining to the facility would them to staff. R1 we examples of previous assistance given. Figiven any help, ever bank account. "Reswas helped, howev access his private by verbally aggressive reinforced he was resulted."	age 25 19 p.m., R1 was noted to have al times to and from his room ers, file, and his iPad. R1" He was talking to himself taff approached R1 to find out old staff that he was so of financial and other legal it to state the specific financial is he was facing. R1 was a plans of self-harm which he old be given to the social his concerns. Staff were to and encourage R1 to voice by could be addressed by the encourage R1 to voice by could be addressed by the encourage R1 went to a.m. on 4/26/21, and woke up encourage R1 may be addressed. R1 became that he had specific all speak to himself or nursing did be addressed. R1 became that he had not been "getting any that radvised R1 any of his grater advised R1 an	F 7	'58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 660 MAPLE STREET WABASSO, MN 56293	·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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F 758	here. "The administration own responsible particular decisions, and that leave, he was free if he wished to leave facility with his desilocation where he wastarted yelling and came back to the construction of the interim direction of the interim direction of the meeting room of the meeting room. Would arrangements to dithe facility, R1 was resident's room. Would was doing he state resident". Staff ask she wanted him prowhat he is doing the away from the door of the medication didn't do came out of his roof filed a lawsuit again administrator and to "These guys are go	anybody. I am getting out of strator informed R1 he was his arty and could make his own if he felt that he wanted to to do so. The admin requested re, that R1 would provide the ired date of discharge and was going to discharged to. R1 left. A few minutes later, R1 commons area and started in told to leave today. R1, RN-A ector of nursing (IDON) attement was not true. RN-A by had told R1 earlier. R1 was ner for privacy with the RN-A. administrator and RN to for privacy so other residents refer to go to his room while mented they would continue to standing outside of that hen staff asked him what he do he was "protecting the ed the female resident (R14) if esent. R14 stated "I don't know ere" Staff asked him to move r. 2:30 a.m., R1 was noted to see his evening medications. R1 to stay up all night" and the ohim "any good". R1 then om and started telling staff he	F 75	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245400	B. WING			C <b>5/04/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 660 MAPLE STREET WABASSO, MN 56293		3/0 <del>4</del> /2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	how I earned my live me a lot of money. teamed up and we case. We have to see them go to jail". He quit working for the going to shut down lawsuit. He asked see phone to call the post facility. R1 was give police.  8) On 4/29/21 at 10 regional administration R1. R1 was reported and threatening state concern of potential building. Staff then outside resources for esources encourage thour hold for further inpatient mental her seen on rounds (MD)-A. Nursing state in the room during resourcesed behaviors schizophrenia. Her increased verbal are seeing him on rounds seed R1 to the local recommendation for currently in the ER. There was no ment identified or docume escalating behaviors related to was also no indication.	ing. This facility is going to pay Me and my familywe have have hired a lawyer for this hut this place down and have also advised staff they better facility since the State was the facility following his taff to give him the resident's dice to get him out of the enthe phone and called the cor of the situation regarding doto be refusing medications ff. Staff noted there was a harm to others in the reached out to different for mental health. Those ged the facility to seek a 72 revaluation and possible alth services. So p.m., staff documented R1 is today by the medical director aff was not allowed to remain rounds. R1 had been having is related to paranoid and been behaving with a physical aggression. After ds an order was written to I emergency room (ER) with a r 72 hour hold. R1 was	F 7	758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 758	the facility requested discontinued related part of a gradual do Another request was was ever received kindication staff had provider, notifying No behaviors and the rassessment. There had actually assess behaviors since bega/19/21, or notified increased behaviors.  R1's physician note 1) 1/12/21, nurse proposed work for 4 control bedy delusional, we alcohol level was now as going through the sting was perform determined R1 had decisions. Given the presentation to the he have repeat test days of sobriety.  2) 2/3/21 and again R1's testing was reperformed, or clarificable to be obtained 3) 4/7/21, NP-A saw 4/7/2	21, fax sent to MD-A identified d to have R1's Seroquel d to "no target behaviors" as see reduction attempt (GDR). Is made 4/27/21. No response by the provider. There was no ever attempted to call the MD-A about R1's increased need for a medical was also no indication staff and monitored R1's ginning his Seroquel on MD-A on the fax to R1's seed. In the seed and monitored R1's ginning his Seroquel on MD-A on the fax to R1's seed. In the seed and monitored R1's ginning his Seroquel on MD-A on the fax to R1's seed. In the seed and monitored R1's seed and given the seed of the seed on the seed of the seed on the seed of the order was needed or seed or se	F 7	758		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SO RESTORATIVE CA			STREET ADDRESS, CITY, STATE, ZIP C 660 MAPLE STREET WABASSO, MN 56293	ODE		
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F 758	forgetful and had of conversations that does often repeat were coherent, spemood was anxious was presently adm (CD) treatment. He continues with meneuropsychological but was unlikely the improvement. Staff and continue his of cognitive re-training to known physiological features. R1 had eincluding the loss of alcoholism. His fat reported ongoing in mention NP-A was behaviors of R1 lesparanoid schizoph 4) 4/8/21, MD-A disneurodiagnostic terprovided. There was no indicate provided. There was no indicate provided as to the first paranoid schizoph with a request for the services.	difficulty remembering occurred immediately prior. He questions. Thought processes eech was fluent and clear, and his insight was fair. R1 litted for chemical dependency had started classes. He mory impairment. Follow-up all testing had been requested, ere would be much f were to continue medications occupational therapy for g. R1 had a mood disorder due gical conditions with depressive experienced significant losses of his job recently due to her was fighting cancer. R1 msomnia. There was no made aware of escalating ading to his diagnosis of	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245400	B. WING		0	C <b>5/04/2021</b>
	PROVIDER OR SUPPLIER  SO RESTORATIVE CA			STREET ADDRESS, CITY, STATE, ZIP 660 MAPLE STREET WABASSO, MN 56293	<u>.</u>	J/04/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 758	well. He was quick angry". NA-A tried to wanted a haircut, he stated no one was he [expletive] out on have "had it out" for have communicated each shift by docum book. R1 was progrobehaviors since his communication book entries were blank to NA-A agreed staff resulting the communication something changed staff hadn't worked only chart behaviors record if they happed charted, during their documentation wou accurately and documentation wou accurately and documents increasing behaper shift. Most of the to nursing staff verbundle with the nursing staff verbundle was known to be "obehaviors increased seemed to escalate 4/28/21. NA-B identification and throw it away".	to "snap, flip out and get o explain to R1 one time, if he eneeded to pay for it. R1 nelping him and told her to get if his room. R1 seemed to [administrator]. Staff were to desident behaviors or needs nenting in the communication ressively getting worse for admission. Review of the ok with NA-A identified most for residents or marked "ok". outinely made no mentions on shift. "It was hard to know if if for a resident, especially if in a few days". NA-A would in the electronic medical ened at the moment they if shift. She agreed the old not reflect R1's behaviors umentation lacked evidence of viors as staff only charted 1 x is et ime behaviors were passed to ally and not documented.  The identified staff did not is. Behaviors were passed to A-B stated R1 would "write and the rip them into tiny pieces he was very paranoid and bessed" with R14. R1's is disince his admission and a once R14 was discharged on tified staff documented 1 x per rt only if a resident had a ment she charted, not for any y may have observed	F 7	758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245400	B. WING _		05	C / <b>04/2021</b>
	PROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 660 MAPLE STREET WABASSO, MN 56293	<u>-</u>	70 1/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 758	pertinent information residents had apport condition by a blan R1's electronic behavious and paranoia had so discharge on 4/29/21 idemarked no behavious and paranoia had so discharge on 4/29/21. Review of the compages for the dates 4/27/21. No pages 4/29/21, followed bodocumented, it was information was round interview and documented it was information was round in the facility did not proving the facility does have a provide psychiatric used her. The IDO The facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not documented in the facility was loot telehealth provider were not document	ok was lacking any real on. It was hard to know if bintments or changes in k section or an "ok".  Pavior charting from 4/8/21 entified staff had continuously ors, although R1's behaviors steadily increased up to his	F 75	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245400	B. WING		05	C 5/ <b>04/2021</b>
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 758	until he was seen b to the ER. Both agr book staff used for missing days, and h notes to pass off in IDON agreed staff I increased behavior started on and cont anti-psychotic medi strict monitoring.  Review of the curre Prescribing Informat being treated with a indication should be observed closely for suicidality, and unus especially during th course of drug ther changes, either ince following symptoms attacks, insomnia, i aggressiveness, im (psychomotor restle mania, have been r with antidepressant disorder as well as psychiatric and non caregivers of patier antidepressants for other indications, be non-psychiatric, sho to monitor patients agitation, irritability, and the other symp as the emergence of	y the MD the day he was sent eed the daily communication report was incomplete, and no behaviors or other report to oncoming staff. The nad not monitored R1's when swere noted, or when he was inued to receive and cation Seroquel, requiring ont, undated Seroquel ation identified all patients antidepressants for any emonitored appropriately and relinical worsening, sual changes in behavior, e initial few months of a apy, or at times of dose reases or decreases. The sanxiety, agitation, panic appropriately, hostility, pulsivity, akathisia essness), hypomania, and eported in adults being treated s for major depressive for other indications, both psychiatric. Families and the being treated with major depressive disorder or onth psychiatric and build be alerted about the need for the emergence of unusual changes in behavior, toms described above, as well of suicidality, and to report		758		
	non-psychiatric, she to monitor patients agitation, irritability, and the other symp as the emergence such symptoms improviders. Such mo	buld be alerted about the need for the emergence of unusual changes in behavior, toms described above, as well				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  SO RESTORATIVE CA			STREET ADDRESS, CITY, STATE, ZIF 660 MAPLE STREET WABASSO, MN 56293	<u>.</u>	3/04/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 758	Services policy ider signs of emotional a receive services an individual needs an who do not display been diagnosed wit psychosocial adjust post-traumatic stress behavioral disturbat to a specific clinical pattern unavoidable recognizing change psychological distresinterventions that a diagnosis and appromonitor those intervention. The had been reviewed  Review of the Marc Condition policy ide help identify individe having acute change stay. Direct care starecognizing subtle be resident like increase communicate these MD will help identify combinations that a consequences that changes in condition about acute change collect pertinent def Staff were to contact respond in a timely problems or change.	ge 33  Lary 2019, Behavioral Health of the residents who exhibit and/or psychosocial distress of support that address their of goals for care. Residents symptoms of, or have not the mental, psychiatric, ament, substance abuse or as disorder will not develop ances that cannot be attributed condition that makes the condition that makes the condition that indicate ass, implement care plan are relevant to the resident's appriate to his or her needs and dentions and report changes in the rewas no indication the policy yearly for appropriateness.  The 2018, Acute Changes in antified the physician was to could were to be trained in the policy yearly for appropriate to his or her needs and dentions and report changes in the sed agitation and how to could swith a significant risk for the sed agitation and how to be changes to the nurse. The dention and medication are associated with adverse could cause significant in the sed agitation, and medication are associated with adverse could cause significant in the sed agitation and status are to notification of the sin condition and status. The medical director for the medical director for the medical director for the sin condition and status.	F 7	'58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	additional guidance not receive a timely	and consultation if they do or appropriate response. ation the policy had been	F 7	58		