



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

July 31, 2026

Administrator

WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

RE: CCN: 854542100

Cycle Start Date: July 8, 2026

Dear Administrator:

On July 8, 2026, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 8, 2026, the situation of immediate jeopardy to potential health and safety cited at F740 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 15, 2026.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 15, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 15, 2026, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by August 15, 2026 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility.

Therefore, WABASSO RESTORATIVE CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 15, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 8, 2027 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

tamika.brown@cms.hhs.gov

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

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

Washington, D.C. 20201

202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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Electronically delivered

July 31, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 25C841-H1

Dear Administrator:

The above facility survey was completed on July 8, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State

Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,



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

Health Regulation Division

Telephone: (651) 201-4112

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/1/26, 7/2/26, 7/6/26, 7/7/26, and 7/8/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F740 when R1 who exhibited declining mood after two psychotropic medications were discontinued. As a result, R1 attempted suicide with a shard of a broken mirror. Additionally, the facility failed to ensure objects that could cause self-harm were not available to R1 upon return to the facility. The IJ began on 6/23/26, and the immediacy was removed on 7/8/26. The following complaints were reviewed: H54003119C (3063608), H54003119C (3063307), and H54002900C (3041217) with deficiencies issued at: F740, F755, F580, and F605. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			08/13/2026
F0740 SS = J	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a			F0740	Resident #1 was immediately assessed following the identified deficient practice. Psychiatric services were consulted, psychotropic medications were reviewed and reinstated as clinically indicated per psychiatry orders, constant observation was implemented providing 1:1 supervision until patient was deemed safe by psychiatry, and resident-specific suicide prevention interventions were added to the care plan. Environmental safety measures were implemented including removal of potential self-harm items, completion of room safety checks, increased supervision, and revision of the		08/13/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0740 SS = J	Continued from page 1 resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to implement appropriate interventions and supervision, monitor and assess changes in mood and mental status, coordinate care with psychiatric providers, and notify the providers of changes in mood/behavior for 1 of 3 residents (R1) who had a significant history of suicidal ideation and suicide attempts. These failures resulted in Immediate Jeopardy (IJ) when R1 attempted suicide after a progressive decline in mood and behavior following the discontinuation of two psychotropic medications without increased monitoring, provider notification, or revision of interventions. Additionally, following R1's return from the hospital, the facility failed to ensure objects that could be used for self-harm were removed or secured despite ordered suicide precautions. The Immediate Jeopardy (IJ) began on 6/23/26, when it was identified R1 had a change in mood and behaviors, interventions and monitoring were not reviewed, and psychiatry was not notified of changes; then on 6/27/26 R1 attempted suicide by stabbing himself in the neck with a shard of mirror glass and required hospitalization. On 7/6/26 at 1:30 p.m., the Administrator and director of nursing (DON) were notified of the IJ. The IJ was removed on 7/8/26, after it was verified the facility implemented an acceptable removal plan. However, non-compliance remained at a lower scope and severity of D, no actual harm, with potential for more than minimal harm. Findings include: R1's face sheet identified diagnoses of suicidal ideations, generalized anxiety disorder, insomnia due to other mental disorders, and major depressive disorder, recurrent, severe without psychotic features. R1's after visit summary of hospitalization dated 3/7/26-3/19/26, identified R1 had been admitted to the hospital for suicidal ideation. Behavioral health consult requested to be done within two weeks of discharge. R1's physician orders directed to start taking Duloxetine (antidepressant medication) on 3/20/26 (did not include dose).			F0740	Continued from page 1 resident's behavioral health care plan to include warning signs, coping strategies, and provider notification parameters. CSSRI's were initiated to be completed every day and night shift for staff monitoring risk factors. An audit of all current residents with diagnoses of depression, anxiety, suicidal ideation, suicide attempts, behavioral health diagnoses, and/or psychotropic medication use was completed by the Director of Nursing or designee. Residents identified as at risk were assessed for changes in mood, behavior, suicidal ideation, monitoring needs, appropriateness of care plans, psychiatric follow-up, environmental safety measures, and provider notification requirements. Care plans, monitoring interventions, and psychiatric referrals were updated as indicated. The facility reviewed policies with all staff regarding Behavioral Health Services, Suicide Risk Assessment, Psychotropic Medication Management, and Notification of Changes. Licensed nurses, social services, and direct care staff received education regarding recognition of changes in mood, behavior, and psychosocial status; suicide risk identification, assessment, and intervention; required provider notification; coordination of care with psychiatric providers; documentation requirements; environmental safety practices; and care plan development and revision. A standardized behavioral health monitoring process and environmental safety checklist were implemented for residents identified as at risk. The Director of Nursing or designee will audit 3-4 resident records weekly x 4 weeks, then 3-4 resident records monthly for 2 months until compliance has been met, for evidence that significant changes in condition were appropriately assessed, reported to the physician, and documented according to facility policy. Audit findings will be reviewed and trended by the Quality Assurance and Performance Improvement (QAPI) Committee. QAPI will be held on Aug 17th to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained. Facility alleges substantial compliance on August 13th, 2026.		08/13/2026

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F0740 SS = J	Continued from page 2 R1’s admission Minimum Data Set (MDS) dated 4/2/26, identified R1 had no cognitive impairment and did not have inattention, disorganized thinking, or altered level of consciousness. R1 had no hallucinations, delusions, or behaviors with staff or other residents. R1’s PHQ-9 (assessment used to identify depression symptoms) was zero, which indicated R1 did not have any symptoms of depression and was administered an antidepressant. R1 had no impairments on upper body, but impairments on both sides of lower extremities. However, was dependent on staff for activities of daily living that involved mobility. R1 was continent of bowel and bladder and used a wheelchair. R1’s physician order dated 3/19/26, included the order for Duloxetine 30 milligrams (mg) by mouth daily as per the hospital discharge summary. On 3/20/26 the dose was changed to 60 mg. R1’s Social Service Trauma Informed Care History dated 3/24/26, indicated the most difficult time in his life was when his older brother committed suicide and he had a traumatic marriage. R1 got through those difficult times by learning about it. R1 relied on “my own strategies to go through hard times. I work on a positive attitude.” R1’s triggers were “if I become moody and get down, it’s a trigger to more depressed feelings.” R1’s social service progress note dated 3/25/26 at 9:52 a.m., indicated a Columbia assessment was completed which identified R1 was at “low risk” for suicide (the Columbia-Suicide Severity Rating Scale supports suicide risk assessment through a series of simple, plain-language questions and identifies whether someone is at-risk for suicide, severity and immediacy of that risk, and gauges the level of support the person needs). R1 signed psychiatric consents and will see psychiatry today. R1 was on 15-minute checks for safety. R1 stated if he were to end his life, he would stop eating, drinking, and taking medications. The progress note did not identify R1’s responses, the scoring, or the clinical rationale supporting the low-risk determination. The completed assessment was requested but not received. R1’s nursing order dated 3/25/26, identified in the Medication Administration Record (MAR) to ensure R1 takes all medications, check mouth to confirm all medications are swallowed, and report any refusals. R1’s psychiatric visit note dated 3/25/26, identified after meeting with R1 it was “HIGHLY” recommended “HOSPITALIZATION” at a geripsych			F0740			08/13/2026

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F0740 SS = J	Continued from page 3 unit if possible or specialist psych unit as R1 “CANNOT BE ADEQUATELY CARED FOR IN A SAFE AND SOUND FASHION” at current facility due to inability to complete 1:1 observation due to staff limitations. If R1 returned from ED, must be placed on 1:1 observation or at minimum 10-minute checks with room clearing. R1’s progress note dated 3/25/26 at 2:01 p.m., identified R1 was evaluated by the rural psychiatric physician and was ordered to be sent to the emergency department (ED) for further evaluation. If R1 returned he would be placed on 1:1 observation and would be seen by rural psychiatrist 3/26/26. R1’s Emergency Department After Visit Summary (AVS) dated 3/25/26, identified R1 was seen at the Emergency Department (ED) for suicidal ideation and depression. R1’s NP Psychiatric-Mental Health ED consult evaluation dated 3/26/26, included R1 came from facility due to suicidal ideation in which he was going to stop eating and drinking to commit suicide. R1 continued to endorse suicidal ideation. R1 stated he had been having suicidal thoughts and failed to kill himself in January when he attempted to slit wrists with a butter knife as well as a sharp plate edge. The facility should include a part to the care plan on how to appropriately respond to R1’s report of suicidal thoughts and when they require additional assessment at the ED. R1 may benefit from a 1:1 assist in reassuring safety at the facility and certain sharp objects should be monitored while medication adjustments and therapy take place. The therapist can develop a plan with R1 moving forward and work with facility. The AVS summary included discharge instructions to follow-up with outpatient recommendations from psychiatric consultant, and return for worsening depression, increased thoughts of self-harm, isolation, or new concern. Patient education included: a suicidal crisis can move quickly. A person may feel ok in one moment, be affected by something that happens that is upsetting to them and jump to making decisions without thinking. Plan for safety by limiting access to things that can harm you including medications, poisons, sharps, items to strangle or suffocate, alcohol and firearms. Increase communication. Additional patient education had a section that listed The Danger Signs of Suicide which included (but not limited to): Suddenly become happier or calmer and making funeral plans/setting affairs in order/or giving away belongings. Education also included Symptoms of Depression which included (but not limited to) Irritability, increased crying, anxiety, and panic attacks.			F0740			08/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
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F0740 SS = J	Continued from page 4 R1’s progress note dated 3/26/26, identified R1 returned from hospital with no new orders. R1’s care plan dated 3/26/26, identified ineffective coping related to history of traumatic events, suicidal thoughts, mental health, brother's death, and “triggers moody when depressed.” Interventions included: allow to express feelings, assist to acknowledge the traumatic event and begin to work through the event by talking about the experience and expressing feelings in a calm, safe environment. Encourage resident to resume normal activities and begin new ones. The focus interventions dated 3/28/26 informed staff of R1’s past traumas and he “got through difficult times by “finding coping strategies and working on positive attitude” however the care plan did not identify if R1’s coping strategies were different than 3/26/26 interventions, and no strategies or interventions to maintain or develop a positive attitude were defined or individualized. R1’s care plan dated 3/26/26, identified R1 used psychotropic medications related to depression, anxiety, and insomnia. Target behaviors dated 3/26/26 included: negative thought process, self-isolation, low self-worth, “teariness” (sic). Behavioral interventions dated 3/26/26 included grounding techniques (techniques were not specified), show empathy, encourage to join activities, and mealtime outside of room. Behavior Triggers dated 3/28/26: 1-being away from daughters/grandchildren; 2-remembering difficult times. Additional interventions included referral to psych services and administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Care plan directed staff to monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy which included (not limited to): change in mood/behavior/cognition, hallucinations/delusions, social isolation, suicidal thoughts, fatigue, insomnia, appetite loss, and weight loss. Further directed to monitor/document/report as needed (PRN) any adverse reactions to anti-anxiety therapy which included (not limited to): drowsiness, lack of energy, depression, dizziness, and impaired thinking/judgement. Target behaviors included Additional intervention directed referral to psych services. Review of R1’s record between 3/25/26 through 3/26/26 indicated, following R1's psychiatric evaluation and emergency department assessment for suicidal ideation on 3/25/26 and 3/26/26 it was not evident the facility revised R1's care plan to			F0740			08/13/2026

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F0740 SS = J	Continued from page 5 address the psychiatric providers' resident-specific recommendations. Specifically, the care plan did not address staff response when R1 verbalized suicidal thoughts, circumstances requiring additional emergency psychiatric evaluation, the recommended level of observation of 1:1 or 10-minute checks to maintain R1's safety, or environmental safety interventions, including room clearing and monitoring access to sharp objects while medication adjustments and therapy were taking place. Additionally, the care plan did not identify therapeutic interventions or therapist involvement to develop an ongoing plan addressing R1's suicidal ideation and behavioral health needs. R1's progress note dated 3/27/26 at 5:49 a.m., identified R1 remained on 15-minute safety checks due to suicidal ideation. R1 observed to be pleasant with no signs/symptoms of distress. R1 denied plans for self-harm. R1 stayed in bed throughout entire shift. At 8:25 a.m., R1 had suicidal ideation but no plan at the time. R1 stated he felt like not eating or drinking anything in order to die. R1 ate fairly for all meals offered. R1 complained of extreme pain on his legs and lack of sleep. R1 was on medication for sleep and pain control but felt they were not effective. Provider notified. R1's psychiatric visit note dated 3/27/26, identified R1 began Risperidone (antipsychotic) 1-2 mg at bedtime to address severe depression and perseveration. Recommendation also included being referred for psychotherapy and pain management. Agreed with maintaining R1 on 15-minute checks with ongoing close monitoring along with daily telehealth visits for seven days. R1's progress note dated 3/27/26 at 1:48 p.m., identified R1 was seen by psych provider via telehealth. R1 "expressed numerous times he no longer wanted to live and prayed every day that he would." R1 stated he had no quality of life, was a bad person, and just wanted "a needle that will end his life just like a sick dog". R1 told his daughters not to visit him. R1 felt if he had better sleep, he may not feel like this. Psych provider prescribed Trazadone 50 mg at bedtime. Staff are to complete Columbia scores daily, 15-minute checks, and observe that R1 was taking medications. R1 would also have televisits daily with psych provider over the weekend and into the next week. Psych provider also ordered Risperidone 1 mg at bedtime starting 3/28/26. Record review identified the directives were transcribed into the electronic health record as nursing orders.			F0740			08/13/2026

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F0740 SS = J	Continued from page 6 R1’s progress note dated 3/29/26 at 5:36 p.m., identified R1 wished to die but denied an intent or plan. Risperidone had not arrived to facility but will start as soon as available. R1 was cheerful but complained of feeling “sad still” regarding stroke and recovery. Continue suicide precautions with 15-minute checks and daily psych visits. R1’s Columbia-Suicide Severity Rating Scale dated 3/31/26, identified in the past month R1 did not wish he was dead or wished he could go to sleep and not wake up, did not have a response marked for if he had any thoughts of killing himself, and answered ‘NO’ to thinking about how he might do it, having these thoughts and some intention of acting on them. Another unanswered question was if he had started to work out or worked out the details of how to kill himself and if he intended to carry out the plan. The final question involved asking if he had ever done anything, started to do anything, or prepared to do anything to end his life which was answered ‘NO’. Based on the results R1 was a low risk for suicide however, the record did not indicate how the low-risk categorization was determined despite the incomplete assessment. R1’s care plan dated 3/31/26, identified R1 had a mood problem related to depression and was at risk for decreased socialization, worsening depression, and anxiety. Interventions included: administer medications as ordered. Monitor/document for side effects and effectiveness; behavioral health consults as needed (psycho-geriatric team, psychiatrist etc); monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing medications or therapy, sense of hopelessness or helplessness, impaired judgement or safety awareness; monitor/record mood to determine if problems seem to be related to external causes: medications, treatments, concern over diagnosis. R1’s Medication Administration Record (MAR) for 3/1/26-3/31/26, identified R1 took his Risperidone on 3/29/26, 3/30/26, and 3/31/26. R1’s progress note dated 4/1/26, at 10:36 a.m., identified R1 had a telehealth psych appointment. R1 was in a good mood and stated he no longer had thoughts of dying. R1’s progress note dated 4/3/26, but recorded as a late entry, identified R1 graduated from daily			F0740			08/13/2026

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F0740 SS = J	Continued from page 7 telehealth psych visits and would be seen for a regular follow-up appointment 4/9/26. R1 was discontinued from 15-minute checks and Columbia-Suicide assessments. R1’s telehealth psych visit note dated 4/9/26, identified R1 stated he was returning to his old self and no longer wearing a mask. Attributed dramatic improvement to initiation of Risperidone. Endorsed good appetite and good sleep. Denied hopelessness or low self-worth. Significant improvement in anxiety. Described suicidal ideation as a “temporary blimp” and “uncharacteristic”. Expressed strong motivation for self-advocacy and helping others. R1 expressed multiple future-orientated goals including moving closer to family. R1’s telehealth psych visit note dated 4/16/26, identified past suicide attempts included refusal of medications, food, and fluids, cutting of wrists and throat with serrated butter knife and broken plate, and purchasing of a tarp and knife to cut wrists and throat in freezing weather. Staff report R1 continued to have a good mood and was pleasant. Sleeping and eating well. Does not appear overly anxious, had been getting up in wheelchair and wheeling around facility. No significant behaviors and no recent suicidal or homicidal statements. R1 stated his mood was fine with no current feelings of depression beyond frustration with residing at facility. Continue current scheduled medication regimen without changes given significant improvement and follow-up in one month. R1 and facility staff aware of reaching out sooner should concerns, questions, or side effects arise. Safety plan included to utilize holistic approach of healthy eating, journaling, and general self-care. Proactively ensure medications/sharps/weapons/firearms/etc. are always secured. R1 was in a monitored environment without access to firearms and medications administered by nursing. In the event of a crisis, R1 would reduce time alone, inform staff, contact professional supports, or return to clinic. In the event of an emergency, call 911 and present to the ED. R1’s MAR dated 4/1/26-4/30/26, documented R1 took Duloxetine 60 mg daily, and Risperidone 1 mg daily without refusals of either medication documented. R1’s nursing order dated 4/24/26, identified to monitor R1 for suicidal ideation with regular mood and safety checks. Track all food and fluid intake each meal, encourage eating, offer alternatives if meals are refused. Notify provider of poor intake or			F0740			08/13/2026

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F0740 SS = J	Continued from page 8 worsening condition. R1’s telehealth psych visit note dated 4/30/26, identified R1 should continue Duloxetine 60 mg and Risperidone 1 mg for treatment-resistant major depressive disorder daily. R1 reported stable mood without significant depression but would experience occasional lows due to current living environment. No acute safety concerns expressed and denied self-injurious thoughts and behaviors, suicidal ideation, homicidal ideation, and psychosis. R1’s progress notes on 5/9/26, 5/10/26, 5/13/26, identified R1 was monitored for suicidal ideation with no suicidal ideation noted. R1’s progress note dated 5/14/26, identified R1 had a telehealth psych visit. R1 stated everything was going well. No medication changes and follow-up in one month. R1’s progress note dated 5/15/26, identified R1 had no suicidal ideation or comments. R1’s progress notes dated 5/20/26, identified R1 requested to have multiple medications discontinued as he does not want them. R1’s progress note dated 5/21/26, identified per pharmacy reviews, R1’s Risperidone had been discontinued. R1 was ok with this. R1’s handwritten patient orders dated 5/21/26, identified to discontinue Risperidone 1 mg. This order was signed by APRN-A and acknowledged by LPN-A. Although the facility identified Risperidone was discontinued based on a pharmacy recommendation; however, despite request, no pharmacy recommendation supporting the discontinuation was provided During a telephone interview on 7/6/26 at 9:12 a.m., pharmacist (PH)-B reviewed R1’s record from pharmacy. PH-B could not locate a gradual dose reduction recommendation for Risperidone or a pharmacy recommendation to discontinue. PH-B stated her record showed on 5/21/26, APRN-A had signed a handwritten order to discontinue Risperidone. PH-B stated the order to discontinue Risperidone “raised a red flag” for her and she did not think Risperidone should have stopped abruptly. During a return call telephone interview on 7/8/26 at 9:05 a.m., pharmacist (PH)-A reviewed her pharmacy recommendations for R1 from April and May 2026. PH-A stated in April, she gave a recommendation for			F0740			08/13/2026

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F0740 SS = J	Continued from page 9 clarification on the diagnosis used for Risperidone. PH-A stated she did not make any recommendations in May to discontinue or change the Risperidone. R1’s progress note dated 5/23/26, identified R1 was monitored for suicidal ideation, none noted. R1 was happy and described the day started good. R1’s progress note dated 5/25/26, identified R1 was monitored for suicidal ideation and none noted. R1’s progress note dated 5/28/26, at 7:44 a.m., indicated R1 did not want to take Duloxetine. Progress note at 10:45 a.m., R1 had spoken to LPN-A, who also identified as nurse manager, that he would like his Duloxetine discontinued as he “doesn’t need it anymore”. Note further indicated a physician order was obtained to taper off Duloxetine every other day for two weeks then discontinue. R1’s physician order dated 5/29/26, identified Duloxetine 60 mg give one day off and one day on until 6/12/26. R1’s MAR dated 5/1/26-5/31/26, documented R1 was administered Risperidone daily without refusal until the last dose was given on 5/20/26. The MAR also documented Duloxetine was administered daily when scheduled without refusal. R1’s progress note dated 6/1/26, identified R1 had no suicidal ideation during the shift. R1’s social service progress note dated 6/2/26, identified R1 came to the office about a past complaint. Social service offered a grievance form but R1 declined and stated he would let it go. R1 requested to return to Assisted Living he had previously resided at or another facility. R1’s progress note dated 6/10/26 at 1:26 p.m., identified R1 had been seen for wound rounds. Provider and LPN-A noted R1 to be sarcastic and short-tempered during visit. R1 was tapered off his Duloxetine, last dose 5/28/26. R1’s telehealth psych visit note dated 6/11/26, identified nursing staff reported R1 requested to discontinue Duloxetine, and was currently being tapered off with plan to be discontinued on 6/12/26. Risperidone was discontinued 5/21/26 (sic), following pharmacy recommendation. Since these adjustments were made, R1 had seemed more negative and “gruff”, made comments that come across as more critical and harsh. Had not made suicidal or homicidal statements. Does not appear			F0740			08/13/2026

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F0740 SS = J	Continued from page 10 overly anxious, no concerns with eating or sleeping habits. Requested to discharge from facility to live closer to family. R1 stated he “couldn’t be better”. Denied depression, irritability, hopelessness, or low self-worth, excessive risk-taking activities. R1 stated he could think clearly since Risperidone discontinued and Duloxetine changed. Medications discontinued and tapered by primary care physician. No acute safety concerns as R1 denied suicidal ideation, homicidal ideation, and hallucinations. No medication adjustments recommended due to the significant medication changes completed one week apart. Recommend ongoing close monitoring by facility staff for any return of suicidal ideation which occurred upon admission to facility which required initiation of Risperidone approximately three months ago to address. Safety plan remained unchanged. Will plan for a 1-month follow-up meeting sooner should concerns or questions arise. Review of R1's record from 5/20/26 through 6/27/26 indicated the facility did not increase the frequency of mood monitoring or suicide risk assessments following the discontinuation of Risperidone and Duloxetine despite psychiatry's recommendation for ongoing close monitoring. R1’s progress note dated 6/11/26, identified R1 had a telehealth psych visit. Provider made no medication changes. Staff to monitor for mood changes due to decrease in antidepressants. Follow-up in one month. R1’s progress note dated 6/12/26, identified R1 was monitored for suicidal ideation with no suicidal ideation noted. R1’s progress note dated 6/16/26 at 10:52 p.m., identified R1 had used profanity and disrespected staff. R1 was lying in bed, awake, staring at the ceiling, perturbed, irritated, and ruminating. R1 was not getting the answers he wanted to hear and did not want to have a positive/problem solving conversation. Interventions attempted included reapproach and firm boundaries which were not effective. Although R1 was showing signs of mood changes, the facility did not report concerns to psychiatry or primary care provider, and the care plan was not revised with new interventions to address the decline. R1’s progress note dated 6/23/26 at 11:58 a.m., identified R1 was seen due to concerns of self-isolation, depressive symptoms, and negative			F0740			08/13/2026

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F0740 SS = J	Continued from page 11 interactions with staff. R1 recently discontinued Duloxetine and Risperidone and stated he was doing well without them. Discussed psychiatric follow-up for medication management or talk therapy. R1 declined and stated he did not need psychiatric services. Education provided regarding the benefits of ongoing psychiatric support. R1 verbalized understanding and declined services. Although R1's 6/23/26 progress note identified concerns with self-isolation, depressive symptoms, and negative interactions with staff, the medical record did not reflect documentation supporting the frequency or progression of these behaviors beyond the progress notes dated 6/10/26, 6/11/26, and 6/16/26. There was no evidence the facility increased mood monitoring or completed additional assessments in response to R1's decline. Further, the record did not indicate the physician or psychiatry were notified of the change in R1's mood despite the subsequent offer of psychiatric services. Additionally, there was no evidence the care plan was evaluated for effectiveness or revised to include resident-specific interventions addressing the documented decline. R1's social service note on 6/23/26 at 1:24 p.m., identified R1 requested assistance for a ride to his bank. R1 stated his account was hacked and he needed to go in-person to fix it. Social service and health unit coordinator (HUC)-A attempted to help R1 with ride costs. R1 was unkind with words toward HUC-A, and used the "F" word. HUC-A redirected R1 and he responded calmer. R1's Columbia-Suicide Severity Rating Scale dated 6/23/26, identified R1 answered 'NO' to all questions and was a low risk for suicide. R1's progress note dated 6/25/26, identified R1 stated he did not like anything about the facility. Inquired of discharge plan and R1 stated "that is none of anyone's business. No one needs to know". R1 did not follow all of therapist's instructions during therapy session. Refused to do therapy band exercises and stated the band did not do him any good. When reflected back to R1 that he used to have a pleasant relationship with therapist, R1 replied "I know. Now everything has changed". R1 would not elaborate or respond to telling therapist what could be done to improve situation. During an interview on 7/1/26 at 12:02 p.m., DON stated she thought R1's primary care provider was notified of R1's change of mood and behaviors, could not recall if psychiatry had been notified of			F0740			08/13/2026

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F0740 SS = J	Continued from page 12 the changes but was unable to locate notification of changes to either provider for 6/16/26, 6/23/26, or 6/25/26. R1 declined taking medications and that is why facility started monitoring him. DON had reviewed the progress note from 6/16/26, and that is why she went to talk with him on 6/23/26 (seven days later). R1 did not respond very nice to the conversation. R1 had behavior of isolating; he would come out for some activities sometimes and would watch games and movies. DON stated of R1's behaviors leading up to the incident "not something you could see that was bad, but you can notice somebody, when you know them, when something is wrong". DON stated it was not a lot of behaviors but seeing "something going on, isolated, being quiet, not saying hi, just general mood going down" but had not increased the mood and behavior monitoring. R1's progress note dated 6/26/26 at 12:55 p.m., identified R1 was monitored for suicidal ideation and signs/symptoms of depression. R1 appeared depressed. No suicidal ideation noted. R1's Columbia-Suicide Severity Rating Scale dated 6/26/26, identified R1 answered 'NO' to all questions and was a low risk for suicide. During an interview on 7/6/26 at 1:32 p.m., LPN-E stated he worked 6/26/26, that was the first time he noticed R1 was not talking as much as usual. The facility had an order to monitor for moods, so LPN-E documented that R1 "was not having usual moods". LPN-E completed the Columbia-Suicide assessment because of R1's mood and felt R1 was honest during the assessment. LPN-E had not been informed by NA's or other nurses that R1 had been acting differently in May or June. LPN-E did not notify physician or psychiatry of R1's mood change. During an interview on 7/6/26 at 8:02 a.m., NA-C stated she started working at the facility mid-May. When NA-C first came R1 was happy to see "us", was in a good mood, wanted to go to lunch, therapy, and outside during the shift. NA-C thought a couple of weeks ago R1 started to refuse medications, getting depressed, not talking as much. NA-C gave examples that R1 used to talk about his family a lot and then suddenly would only say "thank you" and not engage in conversation. NA-C recalled one day R1 was really sad and depressed because his granddaughter was home and he could not see her. Sometimes when he would have therapy he would get in a bad mood. R1 socially isolated a lot more but some days were better than others. During an interview on 7/6/26 at 10:18 a.m.,			F0740			08/13/2026

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F0740 SS = J	Continued from page 13 licensed practical nurse (LPN)-C stated he had noticed R1 had shown more signs of withdrawing since medication discontinuation but not much of a noticeable difference. LPN-C could not recall when R1’s mood started to decline. During an interview on 7/6/26 at 6:46 a.m., NA-A stated prior to 6/27/26, beginning the end of May or beginning of June, R1 was more depressed, socially isolated, had some moments when he was talking like he was sad and hopeless and other days he would act and talk normal. NA-A stated at first she had noticed R1 had a lot of anger, then would be quiet. NA-A recalled on 6/27/26, R1 got up around 9:45 a.m. instead of 11:00 a.m. R1 was thanking everyone at lunch “which now that I think about it, might have been something”. He had been more social than normal but not too social. During an interview on 7/1/26 at 10:10 a.m., maintenance (MN)-A stated R1 had been a “very open spirit to me” but had appeared a bit more down lately. During an interview on 7/1/26 at 10:15 a.m., housekeeper (HK)-A stated on 6/27/26, she went to his room to clean. R1 was lying in bed. HK-A stated they said “good morning” to each other and that was it. R1 was being really quiet that morning and that was “kind of off for him”. R1’s progress note dated 6/27/26 at 1:54 p.m., identified LPN-B was “notified of an urgent need to respond immediately to the yard”. R1 was observed with fresh blood on his shirt but not actively bleeding at the time. LPN-B instructed staff to call 9-11 while he remained with R1. R1 initially refused attempt by staff to apply pressure to neck area, where a puncture wound was suspected. R1 stated “I am in prison. I just want to go meet my mother and friends who recently died”. LPN-B was able to persuade R1 to surrender a piece of glass, which may have been used to puncture his neck. R1 continued to be closely monitored under supervision until he was taken to the ED. Earlier in the day, R1 had been observed in a good mood, taken medications, ate lunch in the dining room, and had a conversation with LPN-B. R1’s ED notes dated 6/27/26-6/30/36, identified R1 had been in the ED since 6/27/26, due to a suicide attempt. R1 took a piece of broken glass, cut small puncture wounds to neck, chest and right upper thigh. R1 required six total stitches. R1 was medically cleared for inpatient psychiatric care but was declined due to needing assistance and medical			F0740			08/13/2026

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F0740 SS = J	Continued from page 14 floor declined due to not having acute medical need. R1 stated he decided to face reality and reset priorities and goals. R1 reported stabbing himself with the mirror was him acting out so he could leave the facility. R1 did not want to try another antidepressant and stated he did not like how they made him feel. R1 did not want to go to a therapist "I am smarter than the therapist". R1 planned to cope at discharge with journaling and reading. R1 had staff he trusted at the facility he would reach out to if suicidal thoughts returned. R1 completed a Stanley-Brown Safety Plan on 6/30/26, prior to return to facility. Step 1: warning signs: silent/being quiet, shut down/stop interacting. Step 2: internal coping strategies included: writing/journaling, humor, watch news, read, draw, praying/religion. Step 3: list of family/friends to contact, go outside/sit in sun. Step 4: list of people to ask for help. Step 5: list of professionals to contact including suicide prevention number. Step 6: R1 did not identify environmentally lethal methods at facility. R1 stated treating people with respect, not being alone, and life were important and worth living for to him. Review of R1's post-hospital care plan did/did not identify incorporation of the Stanley-Brown Safety Plan, warning signs, coping strategies, or resident-specific interventions recommended by the emergency department. During a telephone interview on 7/1/26 at 10:48 a.m., nursing assistant (NA)-A stated that a couple of weeks before 6/27/26, R1 complained about his roommate and reported he could not sleep but did not explain why. NA-A had never heard R1 make comments of self-harm, and the suicide attempt shocked her. On 6/27/26, R1 got out of bed around 9:45 a.m. and nothing about his behavior caused concern. Around 1:30 p.m., after a resident reported glass and blood on the floor, NA-A and NA-B went to investigate. NA-A stated, "I ran back to get the nurse and [NA-B] went outside to look for [R1]." NA-A called 9-1-1 after locating R1 outside. During a telephone interview on 7/1/26 at 11:02 a.m., LPN-B stated he interacted with R1 several times on 6/27/26, including in the morning and after lunch, and R1 appeared normal, took his medications, and did not appear to be in distress. Later, nursing assistants alerted him after a resident reported blood on the floor and R1 was found in the courtyard. LPN-B observed fresh blood on R1 and attempted therapeutic communication. R1 had a sharp piece of glass in his hand, which he surrendered to LPN-B. R1 refused LPN-B's attempt			F0740			08/13/2026

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F0740 SS = J	Continued from page 15 to apply pressure to his neck and stated, “let me go, nobody loves me, I need to see my mother and friends.” During the conversation, R1 stated he was not getting any better, had lost his aura, was going to lose his apartment, no one loved him, he wanted to be with his mother and friend that recently passed away, loved his family, but had to go because he did not see the point of being here. R1’s progress note dated 6/30/26, at 9:05 a.m., identified ED nurse called and stated R1 indicated he only stabbed himself “because of his roommate”. Facility stated R1 would be placed in a different room if he returned to facility. Psych would re-evaluate to determine with a new room in mind if that would change R1’s mindset. At 2:46 p.m., psych provider was notified of R1’s return to facility and need to be seen. Appointment scheduled 7/7/26 at 2:00 p.m. At 3:00 p.m., identified R1 returned to facility at 1:40 p.m. safety precautions in place: 1:1 at all times, room checks every two hours, all cords and mirrors removed from room. Styrofoam dishes/plastic utensils provided for meals, R1 educated staff would be near at all times and to ask if he needed anything. Review of R1’s MAR/TAR following hospitalization identified on 6/30/26 beginning at 11:00 p.m., in the MAR, an order that directed “Resident is on 1:1 supervision: suicidal warning signs: silent/being quiet; shut down; stop interacting.” These were documented by staff with a checkmark three times each day, with times recorded as “Day 6, Eve 2, Night”. However, on 7/2/26, the TAR identified an order initiated on 7/2/26 at 6:00 p.m. directing staff to continue 15-minute safety checks pending psychiatric re-evaluation and to document R1's mood, behavior, suicidal thoughts/behaviors, and any side effects from Risperdal and duloxetine, including sedation, dizziness, restlessness, or worsening depression, with prompt reporting of significant changes. The order instructed documentation on the day and night shifts. Review of the corresponding TAR identified documentation fields labeled "thoug" (thoughts) and "Day" and "Night." From 7/2/26 through 7/7/26, staff documented the "thoug" field primarily with "No" or "N," and documented the day and night monitoring by placing initials and checkmarks in the corresponding boxes. The TAR contained no narrative documentation describing R1's mood, behavior, suicidal thoughts or behaviors, observed warning signs, or assessment for medication side effects as directed by the order. The 15-minute check order was discontinued on 7/8/26, which led to six days of these two orders conflicting with each			F0740			08/13/2026

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F0740 SS = J	Continued from page 16 other and each order documented as completed. Review of the monitoring record identified staff documented monitoring primarily by checkmarks without narrative documentation of mood, behavior, suicidal thoughts, or observed warning signs. R1’s telehealth psych visit dated 7/2/26, at 9:00 a.m., R1 was seen for severe recurrent major depression without psychotic features, generalized anxiety disorder, and insomnia disorder related to another mental disorder. R1 described his overall state as one of “zero quality of life”, profound loneliness, and a sense of abandonment from family. R1 stated “I’m alone. Why am I here?” R1 remained on 1:1, which the nurse noted tends to antagonize more than help him. Plan: placed in private room proximate to nursing station with environmental hazard mitigation in place. Given the antagonistic impact of recent 1:1, Ok to transition to every 15-minute checks. Resume Duloxetine 60 mg daily; while R1 was skeptical of its past benefit, R1 struggled greatly with negative bias currently and may be falling to appreciate its past protective effects. Resume previously helpful Risperidone 1 mg at bedtime. Psychiatry will manage all psychiatric medications going forward. Review of R1’s record identified orders for Duloxetine 60 mg daily and Risperidone 1.0 mg daily was re-initiated after hospitalization and following R1’s psychiatric visit on 7/2/26. During an interview on 7/1/26 at 9:38 a.m., HUC-A stated R1 had been provided 1:1 care since he returned from the hospital on 6/30/26, and she was currently providing them. Along with 1:1, anything R1 could use to self-harm was removed from the room. HUC-A was able to visualize R1 in bed, looking out the window. HUC-A stated she did not interact often with R1 in her role at the facility. During an observation and interview on 7/1/26 at 10:30 a.m., R1 was in a private room, sitting in a wheelchair. R1 stated “I apologize. I only do one thing poorly at a time”. R1 stated he had not been sleeping well prior to his suicide attempt because his roommate was up at night watching tv a lot. R1 questioned why the facility would room people together that had sleep issues and that he complained to the staff all the time to turn his roommates tv off. R1 stated on 6/27/26, he became full of rage and anger and broke a mirror in his room.” I broke the mirror, started cleaning it up and had a wild ass idea I could get out of here so cut my wrist and carotid on both sides”. “When I saw those pieces, I saw that I could end it all”, but			F0740			08/13/2026

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F0740 SS = J	Continued from page 17 “didn’t fulfill my intended purpose”. R1 had two visible stitches on both sides of his neck and two stitches on his right upper thigh. R1 did not intend to cut his thigh and that was an accident. “I have no purpose and I am weak”. R1 hoped to find a facility closer to his family but felt he sealed his fate with this incident. “I am responsible for me and my health. I could go on and on”. R1 stated his prior assisted living facility requested everything be moved out in 14 days. R1 stated he told his daughter to give his belongings to his grandchildren. They are busy and R1 did not want to “drag them down with me”. “My spirit is killed and I’m not afraid of death. Talk is cheap.” During an interview on 7/1/26 at 11:30 a.m., DON stated when R1 returned to facility on 6/30/26, he was moved to a private room from a semi-private room to meet his needs. The facility removed all mirrors, and R1 was 1:1 supervision until psych could see R1 on 7/7/26, when it would be re-evaluated. During an observation and interview on 7/6/26 at 10:10 a.m., R1’s room door was three-quarters shut with no 1:1 supervision according to the physician order. R1 was lying in bed in the dark with the TV on that was black and white static and had a urinal full of yellow fluid sitting on his overbed table. R1 stated his troubles began when he had a stroke. R1 had been able to stand and pivot transfer but developed a bone infection and became non-weight bearing. R1 stated he had gotten steadily weaker since he had stopped walking because therapy ended due to non-progression “Now I am just a rug laying on the floor. I got really depressed over it”. R1 stated he felt like he was “chained to the bed”. “I am not much good to anybody”. R1 explained he used a “machine to sleep, a machine to move” and “I don’t feel much like a human being anymore”. R1 stated he was “fine” looked over at the tv and “the truth, I am not happy”. R1 stated he did not want to be a burden to his family “all alone here, isolate and destroy what they have done for me”. R1 stated his daughter cannot help him “I don’t want to bring them down”. R1 stated the facility put him in a private room to help him. R1 explained he was not allowed to have a call light, bed control to position his bed, or his CPAP tubing because he could “take that and wrap it around myself”. They took away my pencil case because “I could stab myself in the ear with it” and he could not even charge his phone because they took the charger away. Although R1 reported the call light and tubing was removed, R1’s call light was lying on the bed by his waist, and his CPAP machine tubing was hanging over the head of			F0740			08/13/2026

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F0740 SS = J	Continued from page 18 the bed within his reach. In addition, a can of V8 juice was observed on R1’s bedside table and a garbage can with a bag was also within R1’s reach. During the conversation R1 had a monotone voice and demonstrated a flat affect. During an observation and interview on 7/6/26 at 10:17 a.m., registered nurse (RN)-A entered R1’s room. RN-A emptied R1’s urinal, asked if he needed anything and left the room however did not remove any of the items that could pose a safety risk. At 10:19 a.m., RN-A stated she observed the tubing, can of V8 juice, call light, and garbage can all within R1’s reach. RN-A stated R1 could access any of those items and use them to attempt suicide. RN-A returned to R1’s room and removed the garbage bag from the can, removed the tubing and placed it in the bottom drawer of side table, double tied the call light to the side of R1’s bed. RN-A stated, "I would sure like to know how they [staff] are monitoring every 15-minutes, I haven't seen a sheet" [not consistent with ordered 1:1]. RN-A approached NAs inquiring how they monitored R1 every 15 minutes. NA’s showed RN-A a piece of paper they signed off in 15-minute increments. RN-A educated NAs of her findings in R1’s room and why they could not be there but did not direct 1:1 supervision. During an observation on 7/7/26 at 7:45 a.m., HUC was in front of R1’s room with a table, chair, and laptop providing 1:1, while R1 was in bed in his room. At 8:40 a.m., R1 was in his room with no staff present providing 1:1. At 9:09 a.m., an unidentified NA delivered R1’s breakfast tray but left the room, leaving R1 alone without supervision. During an interview on 7/7/26 at 9:10 a.m., LPN-E reviewed R1’s medical chart. R1 had a nursing order beginning 6/30/26. LPN-E explained there was an order that directed 1:1 supervision: (monitor) suicidal warning signs: silent/being quiet; shut down; stop interacting. A second nursing order beginning 7/2/26, included continue 15-minute safety checks until “6/7,” pending psychiatric re-evaluation. Document mood, behavior, suicidal thoughts/behaviors, and any side effects from Risperdal and Duloxetine including sedation, dizziness, restlessness, or worsening depression. Report significant changes promptly for suicidal assessment. LPN-E verified the orders were conflicting as the record showed R1 was on both 1:1 supervision and 15-minute checks. During an observation and interview on 7/7/26 at 9:48 a.m., HUC was in room with overbed table and laptop facing R1. R1 was in bed. Curtains were			F0740			08/13/2026

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F0740 SS = J	Continued from page 19 almost completely drawn, tv was on filled with static, and room was dark. R1 stated he did not eat breakfast. R1 did not want to continue conversation “I have price of gas concerns”. During an interview on 7/2/26 at 2:22 p.m., RN-A and LPN-D reviewed R1's medical record. RN-A stated psychiatry should have been consulted before Risperidone and Duloxetine were discontinued. Both RN-A and LPN-D stated R1's physician and psychiatrist should have been notified when R1 began demonstrating changes in mood and behavior, particularly given his history of suicidal ideation. LPN-D stated R1 should have received increased monitoring following the discontinuation of the psychotropic medications. RN-A stated she would have expected daily suicide risk, depression, and social withdrawal assessments. LPN-D further stated she reviewed the TAR monitoring documentation on 7/1/26 and questioned the meaning of the check marks, plus signs, and minus signs because they did not indicate whether R1 exhibited any symptoms. She stated the documentation was insufficient and should have been supported by descriptive progress notes. Both RN-A and LPN-D stated the physician, and psychiatrist should have been notified based on the changes documented on 6/16/26, 6/23/26, and 6/25/26. During an interview on 7/2/26 at 12:42 p.m., the Administrator, Director of Nursing (DON), and LPN-A reviewed R1's record. DON stated residents expressing suicidal ideation were managed by talking with them and having them see psychiatry. When asked whether psychiatry had been notified before Risperidone and Duloxetine were discontinued, DON initially stated, "I think we told psych he was refusing and [APRN-A] tapered it [Duloxetine] but psych was aware of the refusals." After reviewing the record, DON confirmed psychiatry had not been informed of the medication discontinuations and APRN-A had not consulted psychiatry before discontinuing the medications. DON further stated R1 was monitored every shift for behavior changes. LPN-A stated a checkmark on the monitoring record indicated the observation had been completed and, if no mood changes were observed, only a checkmark was documented. If a mood change was noted, staff would document it in a progress note. The Administrator stated documenting monitoring with only a checkmark was "pretty broad." LPN-A further stated assessments were not completed daily or every shift because nurses frequently documented that R1 had no suicidal ideation. DON stated, "It was not that the			F0740			08/13/2026

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F0740 SS = J	Continued from page 20 facility did not do anything. R1 was dependent for cares, and we knew he could only go so many hours without staff checking on him... in hindsight I don't know." The Administrator stated the facility could not predict the future. During a telephone interview on 7/1/26 at 3:18 p.m., psychiatry physician assistant (PPA)-A stated the last contact she had with the facility or R1 was on 6/11/26, when she was told the Risperidone had been discontinued and the Duloxetine was being tapered off and ending. PPA-A did not recommend either of the medications be discontinued without a discussion with her. PPA-A was notified on 7/1/26, that R1 had returned from the hospital and scheduled a visit for 7/7/26, but was unaware that he had been in the hospital for a suicide attempt. PPA-A began working with R1 in March. During her initial evaluation on 3/25/26 she had R1 sent to the ED with significant concerns. When R1 returned from ED, PPA-A placed R1 on acute daily follow-up visits for seven days, and Risperidone. Once Risperidone was initiated, PPA-A saw a significance difference in R1's mental health in a one-week period. PPA-A stated psychiatry had difficulties with the facility processes because the facility would "mess with psych meds, usually from pharmacy recommendations" without consulting psychiatry or informing them of the changes. During a telephone interview on 7/6/26 at 9:52 a.m., medical director (MD)-A stated someone with suicidal ideation should be treated for at least one year before any kind of tapering be done with the medication. MD-A expected a suicidal evaluation from facility staff on a consistent basis and since R1 was suicidal, MD-A would expect the facility would continue monitoring for suicidal ideations. MD-A stated the facility should absolutely notify the providers of changes in mood and behaviors. Attempts to interview APRN-A on 7/1/26 at 3:15 p.m. and 7/6/26 at 9:35 a.m. were unsuccessful. Voicemails were left with no return call. A phone call and text message were sent on 7/1/26 at 10:48 a.m., to NA-B with no response. Phone number for trained medication aide (TMA)-A was requested on 7/1/26 and not received. Requested policies for suicidal ideation/past suicide attempts/self-harm, and psychiatry but did not receive prior to IJ. The IJ was removed on 7/8/26 at 11:59 a.m., after verifying the facility completed the following:			F0740			08/13/2026

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F0740 SS = J	Continued from page 21 -policies and procedures related to mental and behavioral health services, including notification of changes process were reviewed. -revised notification of changes policy to incorporate protocols for assessing mood and behavior, identifying signs and symptoms of depression, and outlining when to notify the provider of worsening or escalating symptoms. -completed a comprehensive behavioral and mood assessment for R1, implemented enhanced monitoring, removed potential self-harm hazards for room, updated care plan to reflect monitoring and intervention strategies. -implemented a room safety checklist for R1's room to be inspected each shift for potential hazards or objects that could be used to self-harm. -identified like residents with a history of suicidal ideation or suicide attempts and implemented appropriate monitoring, updated care plans and interventions. -all staff and providers complete education on behavioral health, resident assessment and supervision, communication of changes in psychotropic medications, changes in mood or mental status, coordination of care, documentation standards, environmental safety. The facility Suicide Assessment policy reviewed 7/7/26, identified notify the physician if resident presents with suicidal ideation, even if the resident is not specific about a plan or intent. The facility Use of Psychotropic Medications policy reviewed 7/7/26, identified the attending physician will assume leadership in medication management in collaboration with resident, family, other professionals, and interdisciplinary team. The Notification of Changes policy reviewed 7/7/26, identified the facility must inform the resident, consult with residents physician, family or legal representative when there is a change requiring such notification such as significant change in residents mental or psychosocial condition. The facility Behavioral Health Services policy reviewed 7/7/26, identified the facility wished to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and			F0740			08/13/2026

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F0740 SS = J	Continued from page 22 psychosocial functioning and well-being. Facility will use comprehensive assessment process for identifying and assessing a residents mental and psychosocial status and provide person centered care. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting behavioral health needs of residents			F0740			08/13/2026
F0580 SS = D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update			F0580	Resident R1's record was reviewed following the identified deficient practice to ensure physician and psychiatric provider notification occurred regarding the resident's change in condition. The resident's clinical record was reviewed, assessments were completed, monitoring interventions were implemented, and the care plan was updated to address changes in mental and psychosocial status. Any recommendations received from the providers were implemented and documented. An audit was completed of residents who experienced a significant change in physical, mental, or psychosocial condition within the previous 30 days to determine whether required provider notification was completed and documented. Any identified concerns were immediately reviewed with the attending physician and appropriate interventions, assessments, and care plan revisions were completed as indicated. The facility's Notification of Changes policy was reviewed with licensed nurses and interdisciplinary team members. Education was provided regarding identification of significant changes in physical, mental, and psychosocial status, timely physician notification requirements, documentation of provider notifications and physician recommendations, and escalation of concerns involving mood changes, behavioral changes, suicidal ideation, social withdrawal, and worsening psychosocial status. The Director of Nursing or designee will review all documented significant changes during the daily clinical meeting to verify provider notification was completed when indicated. The Director of Nursing or designee will audit 3-4 resident records weekly for 4 weeks, then 3-4 resident records monthly for 2 months for evidence that significant changes in condition were appropriately assessed, reported to the physician, and documented according to facility policy. Audit		08/13/2026

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NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0580 SS = D	Continued from page 23 the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to notify the physician for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1’s face sheet dated 7/1/26, identified diagnoses of suicidal ideations, generalized anxiety disorder, major depressive disorder, insomnia due to other mental disorders, and major depressive disorder recurrent severe without psychotic features. R1’s admission Minimum Data Set (MDS) dated 4/2/26, identified R1 had no cognitive impairment. R1 had no hearing impairment and wore glasses. R1 did not have inattention, disorganized thinking, or altered level of consciousness. R1 had no hallucinations, delusions, or behaviors with staff or other residents. R1’s PHQ-9 (assessment used to identify depression symptoms) was zero, which indicated R1 did not have any symptoms of depression. R1 was on an antidepressant. R1 had no impairments on upper body but impairments on both sides of lower extremities, was dependent on staff for toileting, bathing, dressing, rolling, sitting, and transfers. R1 was continent of bowel and bladder. R1 used a wheelchair for mobility. R1’s care plan dated 3/26/26, identified R1 used psychotropic medications related to depression, anxiety, and insomnia. Interventions included: administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy: change in mood/behavior/cognition, hallucinations/delusions, social isolation, suicidal			F0580	Continued from page 23 findings will be reviewed and trended by the QAPI Committee. QAPI will be held on Aug 17th to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meetings monthly for 3 months or until substantial compliance is maintained. Facility alleges substantial compliance on August 13th, 2026.		08/13/2026

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F0580 SS = D	Continued from page 24 thoughts, withdrawal, decline in activities of daily living ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait (walking) changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes; monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion/disorientation, depression, dizziness, lightheadedness, impaired thinking/judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: mania, hostility, rage, aggressive or impulsive behavior, hallucination; referral to psych services; target behaviors: negative thought process, self-isolation, low self-worth, teariness. R1’s order dated 5/21/26, identified to discontinue Risperidone (antipsychotic) 1 milligram (mg). R1 had been on this medication for off-labeled use of major depressive disorder. R1’s progress note dated 5/28/26, at 7:44 a.m., identified R1 did not want to take Duloxetine (antidepressant) 60 mg anymore, nurse notified. At 10:45 a.m., R1 had spoken to licensed practical nurse (LPN)-A, who also identified as nurse manager, that he would like his Duloxetine discontinued as he “doesn’t need it anymore”. Order from physician to taper off Duloxetine every other day for two weeks then discontinue. R1’s progress note dated 6/16/26 at 10:52 p.m., identified R1 had used profanity and disrespected staff. R1 was laying in bed, awake, staring at the ceiling, perturbed, irritated, and ruminating. R1 was not getting the answers he wanted to hear and did not want to have a positive/problem solving conversation. Interventions attempted included reapproach and firm boundaries which were not effective. R1’s record did not identify notification to physician or psychiatry regarding this incident. R1’s progress note dated 6/23/26 at 11:58 a.m., identified R1 was seen due to concerns of self-isolation, depressive symptoms, and negative interactions with staff. R1 recently discontinued Duloxetine and Risperidone and stated he was doing well without them. Discussed psychiatric follow-up for medication management or talk therapy. R1 declined and stated he did not need psychiatric services. Education provided regarding the benefits of ongoing psychiatric support. R1 verbalized understanding and declined services. R1’s record			F0580			08/13/2026

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F0580 SS = D	Continued from page 25 did not identify notification to physician or psychiatry regarding this incident. R1’s progress note dated 6/25/26, identified R1 stated he did not like anything about the facility. Inquired of discharge plan and R1 stated “that is none of anyone’s business. No one needs to know”. R1 did not follow all of therapists instructions during therapy session. Refused to do therapy band exercises and stated the band did not do him any good. When reflected back to R1 that he used to have a pleasant relationship with therapist, R1 replied “I know. Now everything has changed”. R1 would not elaborate or respond to telling therapist what could be done to improve situation. R1’s record did not identify notification to physician or psychiatry regarding this incident. R1’s progress note dated 6/26/26 at 12:55 p.m., identified R1 was monitored for suicidal ideation and signs/symptoms of depression. R1 appeared depressed. No suicidal ideation noted. R1’s record did not identify notification to physician or psychiatry regarding this incident. During an interview on 7/6/26 at 6:46 a.m., nursing assistant (NA)-A stated beginning the end of May or beginning of June, R1 was more depressed, socially isolated, had some moments when he was talking like he was sad and hopeless and other days he would act and talk normal. NA-A stated at first she had noticed R1 had a lot of anger, then would be quiet. Now, he is just doing a little bit of speaking. During an interview on 7/6/26 at 8:02 a.m., NA-C stated she started working at the facility mid-May. When NA-C first came R1 was happy to see “us”, was in a good mood, wanted to go to lunch, therapy, and outside during the shift. NA-C thought a couple of weeks ago R1 started to refuse medications, getting depressed, not talking as much. NA-C gave examples that R1 used to talk about his family a lot and then suddenly would only say “thank you” and not engage in conversation. NA-C recalled one day R1 was really sad and depressed because his granddaughter was home and he could not see her. Sometimes when he would have therapy he would get in a bad mood. R1 socially isolated a lot more but some days were better than others. R1’s record did not identify these mood changes noted by NA’s were reported to nurses, physician, or psychiatrist. During an interview on 7/6/26 at 1:32 p.m., licensed practical nurse (LPN)-E stated he worked 6/26/26,			F0580			08/13/2026

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F0580 SS = D	Continued from page 26 that was the first time he noticed R1 was not talking as much as usual. The facility had an order to monitor for moods so LPN-E documented that R1 “was not having usual moods”. LPN-E stated he did not notify physician or psychiatry of R1’s mood change. During an interview on 7/1/26 at 12:02 p.m., DON stated she thought R1’s primary care provider was notified of R1’s change of mood and behaviors, could not recall if psychiatry had been notified of the changes but was unable to locate notification of changes to either provider for 6/16/26, 6/23/26, or 6/25/26. R1 had behavior of isolating. He would come out for some activities sometimes and would watch games and movies. DON stated of R1’s behaviors leading up to the incident “not something you could see that was bad, but you can notice somebody, when you know them, when something is wrong”. DON stated it was not a lot of behaviors but seeing “something going on, isolated, being quiet, not saying hi, just general mood going down”. During a telephone interview on 7/6/26 at 9:52 a.m., medical director (MD)-A stated the facility should absolutely notify the providers of changes in mood and behaviors after every occurrence. The Notification of Changes policy reviewed 7/7/26, identified the facility must inform the resident, consult with residents physician, family or legal representative when there is a change requiring such notification such as significant change in residents mental or psychosocial condition.			F0580			08/13/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12			F0605	Resident R2's psychotropic medication regimen was reviewed by the attending provider and consultant pharmacist. The PRN psychotropic medication order was reviewed for appropriateness, indication, utilization, and compliance with regulatory requirements. Appropriate physician documentation was completed, and the medication order was revised as indicated. An audit of all residents receiving PRN psychotropic medications was completed to verify compliance with regulatory requirements regarding physician review, documentation, indication for use, and duration of therapy. Any resident identified with a PRN psychotropic medication requiring physician review was referred to the attending provider for evaluation and appropriate action. Any identified documentation concerns were corrected.		08/13/2026

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F0605 SS = D	Continued from page 27 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §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-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or			F0605	Continued from page 27 The Director of Nursing, licensed nurses, and medication management personnel were educated on facility policy and regulatory requirements related to psychotropic medications, including PRN psychotropic medication review requirements, physician documentation, monitoring, and follow-up. A tracking process has been implemented to identify PRN psychotropic medication orders approaching required review dates. The Director of Nursing or designee will review newly initiated PRN psychotropic medication orders weekly to ensure physician review requirements are met and documented. The consultant pharmacist will continue monthly medication regimen reviews and communicate recommendations to the facility for timely follow-up. The Director of Nursing or designee will audit all residents receiving PRN psychotropic medications weekly for 12 weeks, then monthly until compliance is met. Audits will verify appropriate indication for use, required physician review and documentation, compliance with monitoring requirements, and appropriate follow-up actions and care plan interventions as indicated. Audit findings will be reviewed and trended through the Quality Assurance and Performance Improvement (QAPI) process. QAPI will be held on Aug 17th, 2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meetings monthly for 3 months or until substantial compliance is maintained. Facility alleges substantial compliance on August 13th, 2026.		08/13/2026

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F0605 SS = D	Continued from page 28 discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. 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)(3) 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 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to assess continued need of as needed (prn) psychotropic medications for 1 of 3 residents (R2) with provider every 14 days. Findings include:			F0605			08/13/2026

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F0605 SS = D	Continued from page 29 R2’s face sheet dated 7/7/26, identified diagnoses of suicidal ideations, generalized anxiety disorder, and major depressive disorder. R2’s admission Minimum Data Set (MDS) dated 4/24/26, identified R2 had no memory issues, no issues with hearing or speech. R2 did not have behaviors towards staff or other residents. R2 was independent with activities of daily living. R2 was on an antipsychotic and received on a routine basis. R2’s care plan dated 4/15/26, identified R2 used psychotropic medications due to depression, anxiety, insomnia, post-traumatic stress disorder, and history of suicidal ideations. Interventions included: administer psychotropic medications as ordered. Monitor for side effects and effectiveness every shift. Behavioral interventions: redirection, offer walk outside, distraction. Monitor/document/report as needed adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Referral to psych services, target behaviors of social isolation, pacing. R2’s physician orders dated 4/14/26, identified Hydroxyzine Pamoate 50 milligrams (mg) capsule by mouth every 12 hours as needed for anxiety. R2’s medication administration record (MAR) dated 4/1/26-4/30/26, identified R2 received Hydroxyzine 50 mg on 4/16/26, 4/18/26, 4/20/26, 4/21/26, 4/26/26, and 4/27/26. R2’s physician encounter note dated 4/28/26, identified R2 was seen at facility on day 14 but did not address Hydroxyzine PRN usage for renewal or discontinuation. R2’s physician encounter note dated 4/29/26, identified R2 was seen at facility on day 15 but did not address Hydroxyzine PRN usage for renewal or discontinuation. R2’s Pharmacist’s Recommendation to Prescriber dated 5/14/26, identified Hydroxyzine 50 milligrams (mg) was ordered on 4/14/26, and is overdue for 14-day review. It had not been used at all in May. Please consider discontinuation of PRN Hydroxyzine. Rationale included if PRN is to exceed 14 days, prescriber must document rationale in the medical			F0605			08/13/2026

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F0605 SS = D	Continued from page 30 record—AND—indicate the duration for the PRN order. R2’s MAR dated 5/1/26-5/31/26, identified R2 received Hydroxyzine 50 mg on 5/16/26, 5/18/26, and 5/20/26. R2’s handwritten physician order dated 5/21/26, identified discontinue Hydroxyzine 50 mg signed but not dated by physician. During an interview on 7/7/26 at 12:55 p.m., licensed practical nurse (LPN)-C and LPN-E were seated at the nurse's station. LPN-E stated for PRN psychotropic medications the floor nurse would monitor them. The medication should have a stop date on it so it would not just be continuous. LPN-C wondered if maybe that was why there were orders to monitor those medications in the MAR. When the floor nurse would notice the medication was at the 14-day mark, the provider should be emailed to renew the medication. LPN-C stated the medication should not be given after the 14-day mark unless the provider was aware. LPN-C and LPN-E verified R2 had not had a stop date on Hydroxyzine and it had been given to R2 after 14 days. During an interview on 7/2/26 at 12:42 p.m., director of nursing (DON) stated the doctor had to assess prn psychotropic medications every 14 days. Nurses and management review psychotropic PRN medications and sometimes would miss them. That is why the facility had the pharmacy recommendations monthly, they are there to help the facility when they miss it. DON could not articulate why R2 did not have the Hydroxyzine addressed by a physician during rounds. During a telephone interview on 7/6/26 at 9:52 a.m., medical director (MD)-A stated PRN psychotropics should be reviewed every 14 days for necessity. When reviewed they should determine if the medication could be discontinued, kept PRN, or prescribed. The facility Use of Psychotropic Medications policy reviewed 7/7/26, identified residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the residents medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Psychotropic medication used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the residents medical record and is subject to			F0605			08/13/2026

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F0605 SS = D	Continued from page 31 limitations. PRN orders for antipsychotic medications only shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. The policy did not address PRN psychotropic medication orders.			F0605			08/13/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to follow physician orders for 1 of 3 residents (R1) reviewed for weight gain. Findings include:			F0755	Resident R2's physician orders, weights, medication administration records, and clinical status were reviewed. The attending provider was notified of the identified concern. The resident was assessed for signs and symptoms of fluid overload and congestive heart failure exacerbation. Orders were reviewed and implemented as prescribed. The clinical record was updated as appropriate. An audit was completed of residents with diagnoses including congestive heart failure, edema, fluid overload, daily weight monitoring, and/or PRN diuretic orders. The audit included review of physician orders, daily weight documentation, medication administration records, documentation of nursing interventions, and provider notification when parameters were met. Any identified concerns were reviewed with the attending provider and corrective action was taken as indicated. Licensed nursing staff were educated on following physician orders as written, monitoring residents with congestive heart failure and fluid retention, recognizing signs and symptoms of fluid overload, reviewing weight parameters and required interventions, timely provider notification when resident-specific parameters are met, and accurate medication administration and documentation requirements. The Director of Nursing or designee will review new orders related to weight monitoring, diuretics, and CHF management to ensure appropriate implementation. A process has been implemented to review daily weight reports and identify residents who meet ordered parameters requiring nursing intervention or provider notification. The Director of Nursing or designee will audit 3-4 residents with CHF, edema, weight-monitoring orders, and/or diuretic therapy weekly for four weeks, then monthly for two additional months. Audits will verify compliance with orders, medication administration, assessments, provider notifications, and required interventions. Audit findings will be		08/13/2026

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NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0755 SS = D	Continued from page 32 R2's face sheet identified diagnoses of heart failure, rheumatoid arthritis, and localized edema. R2's admission Minimum Data Set (MDS) dated 4/24/26, identified R2 had no memory issues, no issues with hearing or speech. R2 was independent with activities of daily living. R2's care plan dated 4/15/26, identified R1 received diuretic for congestive heart failure. Interventions included: administer diuretic medication as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor dose. May require modification in order to achieve desired effects while minimizing adverse consequences, especially when multiple antihypertensives are prescribed simultaneously. When discontinuing, gradual tapering may be required to avoid adverse consequences caused by abrupt cessation. Monitor/document/report PRN adverse reactions to diuretic therapy: dizziness, postural hypotension, fatigue, and in increased risk of falls. R2's physician order dated 4/14/26, identified Furosemide (diuretic) 20 mg for edema PRN daily for 1.5 pounds above baseline. R2's weights with corresponding medication administration record (MAR) for Furosemide administration from 4/15/26-5/12/26, identified: 4/15/26-baseline weight was 168.0 pounds. 4/16/26-no weight was obtained. 4/17/26-weight was 169.8 pounds. This was 1.8 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/18/26- weight was 169.7 pounds. This was 1.7 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/19/26-weight was 169.6 pounds. This was 1.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/20/26- weight was 171.6 pounds. This was 3.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/21/26- weight was 172.1 pounds. This was 4.1 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given.			F0755	Continued from page 32 reviewed and trended through the Quality Assurance and Performance Improvement (QAPI) process. QAPI will be held on Aug 17th to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meetings monthly for 3 months or until substantial compliance is maintained. Facility alleges substantial compliance on August 13th, 2026.		08/13/2026

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F0755 SS = D	Continued from page 33 4/22/26- weight was 173.2 pounds. This was 5.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/23/26- no weight was obtained. 4/24/26- weight was 173.9 pounds. This was 5.9 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/25/26- weight was 176.0 pounds. This was 8.0 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/26/26-weight was 178.0 pounds. This was 10 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/27/26- weight was 177.0 pounds. This was 9.0 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/28/26- weight was 182.0 pounds. This was 14 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/29/26- weight was 182.0 pounds. This was 14 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/30/36- weight was 183.2 pounds. This was 15.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/1/26- weight was 185.2 pounds. This was 17.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/2/26- weight was 184.2 pounds. This was 16.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/3/26- weight was 183.1 pounds. This was 15.1 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/4/26- weight was 186.8 pounds. This was 18.8 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/5/26- weight was 186.6 pounds. This was 18.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/6/26- weight was 181.0 pounds. This was 13.0 pounds above the baseline weight of 168.0 pounds.			F0755			08/13/2026

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F0755 SS = D	Continued from page 34 No PRN Furosemide given. 5/7/26- weight was 182.4 pounds. This was 14.4 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/8/26- weight was 187.2 pounds. This was 19.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/9/26- weight was 188.4 pounds. This was 20.4 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/10/26- weight was 188.6 pounds. This was 20.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/11/26- weight was 190.4 pounds. This was 22.4 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/12/26- weight was 190.6 pounds. This was 22.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. Although R2 had a continuous weight gain greater than 1.5 pounds per day, PRN Furosemide was not administered from 4/14/26-5/12/26. During an observation and interview on 7/6/26 at 10:10 a.m., R2 was in his room, sitting in a wheelchair. R2 stated the hospital had changed his Furosemide from daily to PRN “why take Furosemide off when I had congestive heart failure. Unacceptable. Could have built fluid around my heart”. R2 stated he did not feel fluid buildup on himself. During an interview on 7/6/26 at 6/46 a.m., registered nurse (RN)-A stated R2 had diagnoses of localized edema and heart failure. RN-A stated R2 was ordered to get daily weights but could not articulate why the facility did not capture the weight gain. Furosemide should have been given in April and May each time the weight was above baseline as the order said. During an interview on 7/2/26 at 12:42 p.m., DON stated she would have expected nursing staff to give Furosemide every time R2's weight had increased 1.5 pounds as the order directed. The point of daily weights was for the facility to track if they are gaining weight. At the beginning of R2's stay the facility was not monitoring properly but when it was discovered, the facility did what it could to rectify			F0755			08/13/2026

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F0755 SS = D	Continued from page 35 the situation.			F0755			08/13/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/1/26, 7/2/26, 7/6/26, 7/7/26, and 7/8/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54003119C (3063608), H54003119C (3063307), and			20000			08/13/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 H54002900C (3041217)with licensing orders issued at: 20265, 20830, 21545, and 21540. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.			20000			08/13/2026
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending			20265	Corrected		08/13/2026

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20265	Continued from page 2 physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to notify the physician for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1’s face sheet dated 7/1/26, identified diagnoses of suicidal ideations, generalized anxiety disorder, major depressive disorder, insomnia due to other mental disorders, and major depressive disorder recurrent severe without psychotic features. R1’s admission Minimum Data Set (MDS) dated 4/2/26, identified R1 had no cognitive impairment. R1 had no hearing impairment and wore glasses. R1 did not have inattention, disorganized thinking, or altered level of consciousness. R1 had no hallucinations, delusions, or behaviors with staff or other residents. R1’s PHQ-9 (assessment used to identify depression symptoms) was zero, which indicated R1 did not have any symptoms of			20265			08/13/2026

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20265	Continued from page 3 depression. R1 was on an antidepressant. R1 had no impairments on upper body but impairments on both sides of lower extremities, was dependent on staff for toileting, bathing, dressing, rolling, sitting, and transfers. R1 was continent of bowel and bladder. R1 used a wheelchair for mobility. R1's care plan dated 3/26/26, identified R1 used psychotropic medications related to depression, anxiety, and insomnia. Interventions included: administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy: change in mood/behavior/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in activities of daily living ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait (walking) changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes; monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion/disorientation, depression, dizziness, lightheadedness, impaired thinking/judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: mania, hostility, rage, aggressive or impulsive behavior, hallucination; referral to psych services; target behaviors: negative thought process, self-isolation, low self-worth, teariness. R1's order dated 5/21/26, identified to discontinue Risperidone (antipsychotic) 1 milligram (mg). R1 had been on this medication for off-labeled use of major depressive disorder. R1's progress note dated 5/28/26, at 7:44 a.m., identified R1 did not want to take Duloxetine (antidepressant) 60 mg anymore, nurse notified. At 10:45 a.m., R1 had spoken to licensed practical nurse (LPN)-A, who also identified as nurse manager, that he would like his Duloxetine discontinued as he "doesn't need it anymore". Order from physician to taper off Duloxetine every other day for two weeks then discontinue. R1's progress note dated 6/16/26 at 10:52 p.m., identified R1 had used profanity and disrespected			20265			08/13/2026

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20265	Continued from page 4 staff. R1 was laying in bed, awake, staring at the ceiling, perturbed, irritated, and ruminating. R1 was not getting the answers he wanted to hear and did not want to have a positive/problem solving conversation. Interventions attempted included reapproach and firm boundaries which were not effective. R1’s record did not identify notification to physician or psychiatry regarding this incident. R1’s progress note dated 6/23/26 at 11:58 a.m., identified R1 was seen due to concerns of self-isolation, depressive symptoms, and negative interactions with staff. R1 recently discontinued Duloxetine and Risperidone and stated he was doing well without them. Discussed psychiatric follow-up for medication management or talk therapy. R1 declined and stated he did not need psychiatric services. Education provided regarding the benefits of ongoing psychiatric support. R1 verbalized understanding and declined services. R1’s record did not identify notification to physician or psychiatry regarding this incident. R1’s progress note dated 6/25/26, identified R1 stated he did not like anything about the facility. Inquired of discharge plan and R1 stated “that is none of anyone's business. No one needs to know”. R1 did not follow all of therapists instructions during therapy session. Refused to do therapy band exercises and stated the band did not do him any good. When reflected back to R1 that he used to have a pleasant relationship with therapist, R1 replied “I know. Now everything has changed”. R1 would not elaborate or respond to telling therapist what could be done to improve situation. R1’s record did not identify notification to physician or psychiatry regarding this incident. R1’s progress note dated 6/26/26 at 12:55 p.m., identified R1 was monitored for suicidal ideation and signs/symptoms of depression. R1 appeared depressed. No suicidal ideation noted. R1’s record did not identify notification to physician or psychiatry regarding this incident. During an interview on 7/6/26 at 6:46 a.m., nursing assistant (NA)-A stated beginning the end of May or beginning of June, R1 was more depressed, socially isolated, had some moments when he was talking like he was sad and hopeless and other days he would act and talk normal. NA-A stated at first she had noticed R1 had a lot of anger, then would be			20265			08/13/2026

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20265	Continued from page 5 quiet. Now, he is just doing a little bit of speaking. During an interview on 7/6/26 at 8:02 a.m., NA-C stated she started working at the facility mid-May. When NA-C first came R1 was happy to see “us”, was in a good mood, wanted to go to lunch, therapy, and outside during the shift. NA-C thought a couple of weeks ago R1 started to refuse medications, getting depressed, not talking as much. NA-C gave examples that R1 used to talk about his family a lot and then suddenly would only say “thank you” and not engage in conversation. NA-C recalled one day R1 was really sad and depressed because his granddaughter was home and he could not see her. Sometimes when he would have therapy he would get in a bad mood. R1 socially isolated a lot more but some days were better than others. R1’s record did not identify these mood changes noted by NA’s were reported to nurses, physician, or psychiatrist. During an interview on 7/6/26 at 1:32 p.m., licensed practical nurse (LPN)-E stated he worked 6/26/26, that was the first time he noticed R1 was not talking as much as usual. The facility had an order to monitor for moods so LPN-E documented that R1 “was not having usual moods”. LPN-E stated he did not notify physician or psychiatry of R1’s mood change. During an interview on 7/1/26 at 12:02 p.m., DON stated she thought R1’s primary care provider was notified of R1’s change of mood and behaviors, could not recall if psychiatry had been notified of the changes but was unable to locate notification of changes to either provider for 6/16/26, 6/23/26, or 6/25/26. R1 had behavior of isolating. He would come out for some activities sometimes and would watch games and movies. DON stated of R1’s behaviors leading up to the incident “not something you could see that was bad, but you can notice somebody, when you know them, when something is wrong”. DON stated it was not a lot of behaviors but seeing “something going on, isolated, being quiet, not saying hi, just general mood going down”. During a telephone interview on 7/6/26 at 9:52 a.m., medical director (MD)-A stated the facility should absolutely notify the providers of changes in mood and behaviors after every occurrence.			20265			08/13/2026

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NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20265	Continued from page 6 The Notification of Changes policy reviewed 7/7/26, identified the facility must inform the resident, consult with residents physician, family or legal representative when there is a change requiring such notification such as significant change in residents mental or psychosocial condition. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee should develop and implement measures to ensure timely notification to the physician. The facility should update policies and procedures, educate staff on those changes, and perform measurable audits to ensure the needs of resident(s) are maintained. The facility should report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20265			08/13/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to implement appropriate interventions and supervision, monitor and assess changes in mood and mental status, coordinate care with psychiatric providers, and notify the providers of changes in mood/behavior for 1 of 3 residents (R1) who had a significant history of suicidal ideation and suicide attempts. These failures resulted in Immediate Jeopardy (IJ) when R1 attempted suicide after a progressive decline in mood and behavior following the discontinuation of two psychotropic medications without increased monitoring, provider			20830	Corrected		08/13/2026

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20830	Continued from page 7 notification, or revision of interventions. Additionally, following R1's return from the hospital, the facility failed to ensure objects that could be used for self-harm were removed or secured despite ordered suicide precautions. The Immediate Jeopardy (IJ) began on 6/23/26, when it was identified R1 had a change in mood and behaviors, interventions and monitoring were not reviewed, and psychiatry was not notified of changes; then on 6/27/26 R1 attempted suicide by stabbing himself in the neck with a shard of mirror glass and required hospitalization. On 7/6/26 at 1:30 p.m., the Administrator and director of nursing (DON) were notified of the IJ. The IJ was removed on 7/8/26, after it was verified the facility implemented an acceptable removal plan. However, non-compliance remained at a lower scope and severity of D, no actual harm, with potential for more than minimal harm. Findings include: R1's face sheet identified diagnoses of suicidal ideations, generalized anxiety disorder, insomnia due to other mental disorders, and major depressive disorder, recurrent, severe without psychotic features. R1's after visit summary of hospitalization dated 3/7/26-3/19/26, identified R1 had been admitted to the hospital for suicidal ideation. Behavioral health consult requested to be done within two weeks of discharge. R1's physician orders directed to start taking Duloxetine (antidepressant medication) on 3/20/26 (did not include dose). R1's admission Minimum Data Set (MDS) dated 4/2/26, identified R1 had no cognitive impairment and did not have inattention, disorganized thinking, or altered level of consciousness. R1 had no hallucinations, delusions, or behaviors with staff or other residents. R1's PHQ-9 (assessment used to identify depression symptoms) was zero, which indicated R1 did not have any symptoms of depression and was administered an antidepressant. R1 had no impairments on upper body, but impairments on both sides of lower extremities. However, was dependent on staff for activities of daily living that involved mobility. R1 was continent of bowel and bladder and used a wheelchair. R1's physician order dated 3/19/26, included the order for Duloxetine 30 milligrams (mg) by mouth daily as per the hospital discharge summary. On 3/20/26 the dose was changed to 60 mg.		20830			08/13/2026	

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20830	Continued from page 8 R1’s Social Service Trauma Informed Care History dated 3/24/26, indicated the most difficult time in his life was when his older brother committed suicide and he had a traumatic marriage. R1 got through those difficult times by learning about it. R1 relied on “my own strategies to go through hard times. I work on a positive attitude.” R1’s triggers were “if I become moody and get down, it’s a trigger to more depressed feelings.” R1’s social service progress note dated 3/25/26 at 9:52 a.m., indicated a Columbia assessment was completed which identified R1 was at “low risk” for suicide (the Columbia-Suicide Severity Rating Scale supports suicide risk assessment through a series of simple, plain-language questions and identifies whether someone is at-risk for suicide, severity and immediacy of that risk, and gauges the level of support the person needs). R1 signed psychiatric consents and will see psychiatry today. R1 was on 15-minute checks for safety. R1 stated if he were to end his life, he would stop eating, drinking, and taking medications. The progress note did not identify R1’s responses, the scoring, or the clinical rationale supporting the low-risk determination. The completed assessment was requested but not received. R1’s nursing order dated 3/25/26, identified in the Medication Administration Record (MAR) to ensure R1 takes all medications, check mouth to confirm all medications are swallowed, and report any refusals. R1’s psychiatric visit note dated 3/25/26, identified after meeting with R1 it was “HIGHLY” recommended “HOSPITALIZATION” at a geripsych unit if possible or specialist psych unit as R1 “CANNOT BE ADEQUATELY CARED FOR IN A SAFE AND SOUND FASHION” at current facility due to inability to complete 1:1 observation due to staff limitations. If R1 returned from ED, must be placed on 1:1 observation or at minimum 10-minute checks with room clearing. R1’s progress note dated 3/25/26 at 2:01 p.m., identified R1 was evaluated by the rural psychiatric physician and was ordered to be sent to the emergency department (ED) for further evaluation. If R1 returned he would be placed on 1:1 observation and would be seen by rural psychiatrist 3/26/26. R1’s Emergency Department After Visit Summary (AVS) dated 3/25/26, identified R1 was seen at the Emergency Department (ED) for suicidal ideation and			20830			08/13/2026

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20830	Continued from page 9 depression. R1’s NP Psychiatric-Mental Health ED consult evaluation dated 3/26/26, included R1 came from facility due to suicidal ideation in which he was going to stop eating and drinking to commit suicide. R1 continued to endorse suicidal ideation. R1 stated he had been having suicidal thoughts and failed to kill himself in January when he attempted to slit wrists with a butter knife as well as a sharp plate edge. The facility should include a part to the care plan on how to appropriately respond to R1’s report of suicidal thoughts and when they require additional assessment at the ED. R1 may benefit from a 1:1 assist in reassuring safety at the facility and certain sharp objects should be monitored while medication adjustments and therapy take place. The therapist can develop a plan with R1 moving forward and work with facility. The AVS summary included discharge instructions to follow-up with outpatient recommendations from psychiatric consultant, and return for worsening depression, increased thoughts of self-harm, isolation, or new concern. Patient education included: a suicidal crisis can move quickly. A person may feel ok in one moment, be affected by something that happens that is upsetting to them and jump to making decisions without thinking. Plan for safety by limiting access to things that can harm you including medications, poisons, sharps, items to strangle or suffocate, alcohol and firearms. Increase communication. Additional patient education had a section that listed The Danger Signs of Suicide which included (but not limited to): Suddenly become happier or calmer and making funeral plans/setting affairs in order/or giving away belongings. Education also included Symptoms of Depression which included (but not limited to) Irritability, increased crying, anxiety, and panic attacks. R1’s progress note dated 3/26/26, identified R1 returned from hospital with no new orders. R1’s care plan dated 3/26/26, identified ineffective coping related to history of traumatic events, suicidal thoughts, mental health, brother's death, and “triggers moody when depressed.” Interventions included: allow to express feelings, assist to acknowledge the traumatic event and begin to work through the event by talking about the experience and expressing feelings in a calm, safe environment. Encourage resident to resume normal activities and begin new ones. The focus interventions dated 3/28/26 informed staff of R1’s past traumas and he “got through difficult times by “finding coping strategies and working on positive attitude” however the care plan did not identify if R1’s coping strategies were different than 3/26/26 interventions,			20830			08/13/2026

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20830	Continued from page 10 and no strategies or interventions to maintain or develop a positive attitude were defined or individualized. R1's care plan dated 3/26/26, identified R1 used psychotropic medications related to depression, anxiety, and insomnia. Target behaviors dated 3/26/26 included: negative thought process, self-isolation, low self-worth, "teariness" (sic). Behavioral interventions dated 3/26/26 included grounding techniques (techniques were not specified), show empathy, encourage to join activities, and mealtime outside of room. Behavior Triggers dated 3/28/26: 1-being away from daughters/grandchildren; 2-remembering difficult times. Additional interventions included referral to psych services and administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Care plan directed staff to monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy which included (not limited to): change in mood/behavior/cognition, hallucinations/delusions, social isolation, suicidal thoughts, fatigue, insomnia, appetite loss, and weight loss. Further directed to monitor/document/report as needed (PRN) any adverse reactions to anti-anxiety therapy which included (not limited to): drowsiness, lack of energy, depression, dizziness, and impaired thinking/judgement. Target behaviors included Additional intervention directed referral to psych services. Review of R1's record between 3/25/26 through 3/26/26 indicated, following R1's psychiatric evaluation and emergency department assessment for suicidal ideation on 3/25/26 and 3/26/26 it was not evident the facility revised R1's care plan to address the psychiatric providers' resident-specific recommendations. Specifically, the care plan did not address staff response when R1 verbalized suicidal thoughts, circumstances requiring additional emergency psychiatric evaluation, the recommended level of observation of 1:1 or 10-minute checks to maintain R1's safety, or environmental safety interventions, including room clearing and monitoring access to sharp objects while medication adjustments and therapy were taking place. Additionally, the care plan did not identify therapeutic interventions or therapist involvement to develop an ongoing plan addressing R1's suicidal ideation and behavioral health needs. R1's progress note dated 3/27/26 at 5:49 a.m., identified R1 remained on 15-minute safety checks due to suicidal ideation. R1 observed to be pleasant		20830			08/13/2026	

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20830	Continued from page 11 with no signs/symptoms of distress. R1 denied plans for self-harm. R1 stayed in bed throughout entire shift. At 8:25 a.m., R1 had suicidal ideation but no plan at the time. R1 stated he felt like not eating or drinking anything in order to die. R1 ate fairly for all meals offered. R1 complained of extreme pain on his legs and lack of sleep. R1 was on medication for sleep and pain control but felt they were not effective. Provider notified. R1’s psychiatric visit note dated 3/27/26, identified R1 began Risperidone (antipsychotic) 1-2 mg at bedtime to address severe depression and perseveration. Recommendation also included being referred for psychotherapy and pain management. Agreed with maintaining R1 on 15-minute checks with ongoing close monitoring along with daily telehealth visits for seven days. R1’s progress note dated 3/27/26 at 1:48 p.m., identified R1 was seen by psych provider via telehealth. R1 “expressed numerous times he no longer wanted to live and prayed every day that he would.” R1 stated he had no quality of life, was a bad person, and just wanted “a needle that will end his life just like a sick dog”. R1 told his daughters not to visit him. R1 felt if he had better sleep, he may not feel like this. Psych provider prescribed Trazadone 50 mg at bedtime. Staff are to complete Columbia scores daily, 15-minute checks, and observe that R1 was taking medications. R1 would also have televisits daily with psych provider over the weekend and into the next week. Psych provider also ordered Risperidone 1 mg at bedtime starting 3/28/26. Record review identified the directives were transcribed into the electronic health record as nursing orders. R1’s progress note dated 3/29/26 at 5:36 p.m., identified R1 wished to die but denied an intent or plan. Risperidone had not arrived to facility but will start as soon as available. R1 was cheerful but complained of feeling “sad still” regarding stroke and recovery. Continue suicide precautions with 15-minute checks and daily psych visits. R1’s Columbia-Suicide Severity Rating Scale dated 3/31/26, identified in the past month R1 did not wish he was dead or wished he could go to sleep and not wake up, did not have a response marked for if he had any thoughts of killing himself, and answered ‘NO’ to thinking about how he might do it, having these thoughts and some intention of acting on them. Another unanswered question was if he had started to work out or worked out the details of how to kill himself and if he intended to carry out the			20830			08/13/2026

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20830	Continued from page 12 plan. The final question involved asking if he had ever done anything, started to do anything, or prepared to do anything to end his life which was answered 'NO'. Based on the results R1 was a low risk for suicide however, the record did not indicate how the low-risk categorization was determined despite the incomplete assessment. R1's care plan dated 3/31/26, identified R1 had a mood problem related to depression and was at risk for decreased socialization, worsening depression, and anxiety. Interventions included: administer medications as ordered. Monitor/document for side effects and effectiveness; behavioral health consults as needed (psycho-geriatric team, psychiatrist etc); monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing medications or therapy, sense of hopelessness or helplessness, impaired judgement or safety awareness; monitor/record mood to determine if problems seem to be related to external causes: medications, treatments, concern over diagnosis. R1's Medication Administration Record (MAR) for 3/1/26-3/31/26, identified R1 took his Risperidone on 3/29/26, 3/30/26, and 3/31/26. R1's progress note dated 4/1/26, at 10:36 a.m., identified R1 had a telehealth psych appointment. R1 was in a good mood and stated he no longer had thoughts of dying. R1's progress note dated 4/3/26, but recorded as a late entry, identified R1 graduated from daily telehealth psych visits and would be seen for a regular follow-up appointment 4/9/26. R1 was discontinued from 15-minute checks and Columbia-Suicide assessments. R1's telehealth psych visit note dated 4/9/26, identified R1 stated he was returning to his old self and no longer wearing a mask. Attributed dramatic improvement to initiation of Risperidone. Endorsed good appetite and good sleep. Denied hopelessness or low self-worth. Significant improvement in anxiety. Described suicidal ideation as a "temporary blimp" and "uncharacteristic". Expressed strong motivation for self-advocacy and helping others. R1 expressed multiple future-orientated goals including moving closer to family. R1's telehealth psych visit note dated 4/16/26,		20830			08/13/2026	

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20830	Continued from page 13 identified past suicide attempts included refusal of medications, food, and fluids, cutting of wrists and throat with serrated butter knife and broken plate, and purchasing of a tarp and knife to cut wrists and throat in freezing weather. Staff report R1 continued to have a good mood and was pleasant. Sleeping and eating well. Does not appear overly anxious, had been getting up in wheelchair and wheeling around facility. No significant behaviors and no recent suicidal or homicidal statements. R1 stated his mood was fine with no current feelings of depression beyond frustration with residing at facility. Continue current scheduled medication regimen without changes given significant improvement and follow-up in one month. R1 and facility staff aware of reaching out sooner should concerns, questions, or side effects arise. Safety plan included to utilize holistic approach of healthy eating, journaling, and general self-care. Proactively ensure medications/sharps/weapons/firearms/etc. are always secured. R1 was in a monitored environment without access to firearms and medications administered by nursing. In the event of a crisis, R1 would reduce time alone, inform staff, contact professional supports, or return to clinic. In the event of an emergency, call 911 and present to the ED. R1's MAR dated 4/1/26-4/30/26, documented R1 took Duloxetine 60 mg daily, and Risperidone 1 mg daily without refusals of either medication documented. R1's nursing order dated 4/24/26, identified to monitor R1 for suicidal ideation with regular mood and safety checks. Track all food and fluid intake each meal, encourage eating, offer alternatives if meals are refused. Notify provider of poor intake or worsening condition. R1's telehealth psych visit note dated 4/30/26, identified R1 should continue Duloxetine 60 mg and Risperidone 1 mg for treatment-resistant major depressive disorder daily. R1 reported stable mood without significant depression but would experience occasional lows due to current living environment. No acute safety concerns expressed and denied self-injurious thoughts and behaviors, suicidal ideation, homicidal ideation, and psychosis. R1's progress notes on 5/9/26, 5/10/26, 5/13/26, identified R1 was monitored for suicidal ideation with no suicidal ideation noted. R1's progress note dated 5/14/26, identified R1 had a telehealth psych visit. R1 stated everything was			20830			08/13/2026

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20830	Continued from page 14 going well. No medication changes and follow-up in one month. R1's progress note dated 5/15/26, identified R1 had no suicidal ideation or comments. R1's progress notes dated 5/20/26, identified R1 requested to have multiple medications discontinued as he does not want them. R1's progress note dated 5/21/26, identified per pharmacy reviews, R1's Risperidone had been discontinued. R1 was ok with this. R1's handwritten patient orders dated 5/21/26, identified to discontinue Risperidone 1 mg. This order was signed by APRN-A and acknowledged by LPN-A. Although the facility identified Risperidone was discontinued based on a pharmacy recommendation; however, despite request, no pharmacy recommendation supporting the discontinuation was provided During a telephone interview on 7/6/26 at 9:12 a.m., pharmacist (PH)-B reviewed R1's record from pharmacy. PH-B could not locate a gradual dose reduction recommendation for Risperidone or a pharmacy recommendation to discontinue. PH-B stated her record showed on 5/21/26, APRN-A had signed a handwritten order to discontinue Risperidone. PH-B stated the order to discontinue Risperidone "raised a red flag" for her and she did not think Risperidone should have stopped abruptly. During a return call telephone interview on 7/8/26 at 9:05 a.m., pharmacist (PH)-A reviewed her pharmacy recommendations for R1 from April and May 2026. PH-A stated in April, she gave a recommendation for clarification on the diagnosis used for Risperidone. PH-A stated she did not make any recommendations in May to discontinue or change the Risperidone. R1's progress note dated 5/23/26, identified R1 was monitored for suicidal ideation, none noted. R1 was happy and described the day started good. R1's progress note dated 5/25/26, identified R1 was monitored for suicidal ideation and none noted. R1's progress note dated 5/28/26, at 7:44 a.m., indicated R1 did not want to take Duloxetine. Progress note at 10:45 a.m., R1 had spoken to LPN-A, who also identified as nurse manager, that he would like his Duloxetine discontinued as he "doesn't need it anymore". Note further indicated a physician order was obtained to taper off Duloxetine			20830			08/13/2026

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20830	Continued from page 15 every other day for two weeks then discontinue. R1's physician order dated 5/29/26, identified Duloxetine 60 mg give one day off and one day on until 6/12/26. R1's MAR dated 5/1/26-5/31/26, documented R1 was administered Risperidone daily without refusal until the last dose was given on 5/20/26. The MAR also documented Duloxetine was administered daily when scheduled without refusal. R1's progress note dated 6/1/26, identified R1 had no suicidal ideation during the shift. R1's social service progress note dated 6/2/26, identified R1 came to the office about a past complaint. Social service offered a grievance form but R1 declined and stated he would let it go. R1 requested to return to Assisted Living he had previously resided at or another facility. R1's progress note dated 6/10/26 at 1:26 p.m., identified R1 had been seen for wound rounds. Provider and LPN-A noted R1 to be sarcastic and short-tempered during visit. R1 was tapered off his Duloxetine, last dose 5/28/26. R1's telehealth psych visit note dated 6/11/26, identified nursing staff reported R1 requested to discontinue Duloxetine, and was currently being tapered off with plan to be discontinued on 6/12/26. Risperidone was discontinued 5/21/26 (sic), following pharmacy recommendation. Since these adjustments were made, R1 had seemed more negative and "gruff", made comments that come across as more critical and harsh. Had not made suicidal or homicidal statements. Does not appear overly anxious, no concerns with eating or sleeping habits. Requested to discharge from facility to live closer to family. R1 stated he "couldn't be better". Denied depression, irritability, hopelessness, or low self-worth, excessive risk-taking activities. R1 stated he could think clearly since Risperidone discontinued and Duloxetine changed. Medications discontinued and tapered by primary care physician. No acute safety concerns as R1 denied suicidal ideation, homicidal ideation, and hallucinations. No medication adjustments recommended due to the significant medication changes completed one week apart. Recommend ongoing close monitoring by facility staff for any return of suicidal ideation which occurred upon admission to facility which required initiation of Risperidone approximately three months ago to address. Safety plan remained unchanged. Will plan for a 1-month follow-up meeting sooner			20830			08/13/2026

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20830	Continued from page 16 should concerns or questions arise. Review of R1's record from 5/20/26 through 6/27/26 indicated the facility did not increase the frequency of mood monitoring or suicide risk assessments following the discontinuation of Risperidone and Duloxetine despite psychiatry's recommendation for ongoing close monitoring. R1’s progress note dated 6/11/26, identified R1 had a telehealth psych visit. Provider made no medication changes. Staff to monitor for mood changes due to decrease in antidepressants. Follow-up in one month. R1’s progress note dated 6/12/26, identified R1 was monitored for suicidal ideation with no suicidal ideation noted. R1’s progress note dated 6/16/26 at 10:52 p.m., identified R1 had used profanity and disrespected staff. R1 was lying in bed, awake, staring at the ceiling, perturbed, irritated, and ruminating. R1 was not getting the answers he wanted to hear and did not want to have a positive/problem solving conversation. Interventions attempted included reapproach and firm boundaries which were not effective. Although R1 was showing signs of mood changes, the facility did not report concerns to psychiatry or primary care provider, and the care plan was not revised with new interventions to address the decline. R1’s progress note dated 6/23/26 at 11:58 a.m., identified R1 was seen due to concerns of self-isolation, depressive symptoms, and negative interactions with staff. R1 recently discontinued Duloxetine and Risperidone and stated he was doing well without them. Discussed psychiatric follow-up for medication management or talk therapy. R1 declined and stated he did not need psychiatric services. Education provided regarding the benefits of ongoing psychiatric support. R1 verbalized understanding and declined services. Although R1's 6/23/26 progress note identified concerns with self-isolation, depressive symptoms, and negative interactions with staff, the medical record did not reflect documentation supporting the frequency or progression of these behaviors beyond the progress notes dated 6/10/26, 6/11/26, and 6/16/26. There was no evidence the facility increased mood monitoring or completed additional assessments in response to R1's decline. Further,			20830			08/13/2026

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20830	Continued from page 17 the record did not indicate the physician or psychiatry were notified of the change in R1's mood despite the subsequent offer of psychiatric services. Additionally, there was no evidence the care plan was evaluated for effectiveness or revised to include resident-specific interventions addressing the documented decline. R1's social service note on 6/23/26 at 1:24 p.m., identified R1 requested assistance for a ride to his bank. R1 stated his account was hacked and he needed to go in-person to fix it. Social service and health unit coordinator (HUC)-A attempted to help R1 with ride costs. R1 was unkind with words toward HUC-A, and used the "F" word. HUC-A redirected R1 and he responded calmer. R1's Columbia-Suicide Severity Rating Scale dated 6/23/26, identified R1 answered 'NO' to all questions and was a low risk for suicide. R1's progress note dated 6/25/26, identified R1 stated he did not like anything about the facility. Inquired of discharge plan and R1 stated "that is none of anyone's business. No one needs to know". R1 did not follow all of therapist's instructions during therapy session. Refused to do therapy band exercises and stated the band did not do him any good. When reflected back to R1 that he used to have a pleasant relationship with therapist, R1 replied "I know. Now everything has changed". R1 would not elaborate or respond to telling therapist what could be done to improve situation. During an interview on 7/1/26 at 12:02 p.m., DON stated she thought R1's primary care provider was notified of R1's change of mood and behaviors, could not recall if psychiatry had been notified of the changes but was unable to locate notification of changes to either provider for 6/16/26, 6/23/26, or 6/25/26. R1 declined taking medications and that is why facility started monitoring him. DON had reviewed the progress note from 6/16/26, and that is why she went to talk with him on 6/23/26 (seven days later). R1 did not respond very nice to the conversation. R1 had behavior of isolating; he would come out for some activities sometimes and would watch games and movies. DON stated of R1's behaviors leading up to the incident "not something you could see that was bad, but you can notice somebody, when you know them, when something is wrong". DON stated it was not a lot of behaviors but seeing "something going on, isolated, being quiet, not saying hi, just general mood going down" but had not increased the mood and behavior monitoring.			20830			08/13/2026

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20830	Continued from page 18 R1’s progress note dated 6/26/26 at 12:55 p.m., identified R1 was monitored for suicidal ideation and signs/symptoms of depression. R1 appeared depressed. No suicidal ideation noted. R1’s Columbia-Suicide Severity Rating Scale dated 6/26/26, identified R1 answered ‘NO’ to all questions and was a low risk for suicide. During an interview on 7/6/26 at 1:32 p.m., LPN-E stated he worked 6/26/26, that was the first time he noticed R1 was not talking as much as usual. The facility had an order to monitor for moods, so LPN-E documented that R1 “was not having usual moods”. LPN-E completed the Columbia-Suicide assessment because of R1’s mood and felt R1 was honest during the assessment. LPN-E had not been informed by NA’s or other nurses that R1 had been acting differently in May or June. LPN-E did not notify physician or psychiatry of R1’s mood change. During an interview on 7/6/26 at 8:02 a.m., NA-C stated she started working at the facility mid-May. When NA-C first came R1 was happy to see “us”, was in a good mood, wanted to go to lunch, therapy, and outside during the shift. NA-C thought a couple of weeks ago R1 started to refuse medications, getting depressed, not talking as much. NA-C gave examples that R1 used to talk about his family a lot and then suddenly would only say “thank you” and not engage in conversation. NA-C recalled one day R1 was really sad and depressed because his granddaughter was home and he could not see her. Sometimes when he would have therapy he would get in a bad mood. R1 socially isolated a lot more but some days were better than others. During an interview on 7/6/26 at 10:18 a.m., licensed practical nurse (LPN)-C stated he had noticed R1 had shown more signs of withdrawing since medication discontinuation but not much of a noticeable difference. LPN-C could not recall when R1’s mood started to decline. During an interview on 7/6/26 at 6:46 a.m., NA-A stated prior to 6/27/26, beginning the end of May or beginning of June, R1 was more depressed, socially isolated, had some moments when he was talking like he was sad and hopeless and other days he would act and talk normal. NA-A stated at first she had noticed R1 had a lot of anger, then would be quiet. NA-A recalled on 6/27/26, R1 got up around 9:45 a.m. instead of 11:00 a.m. R1 was thanking everyone at lunch “which now that I think about it, might have been something”. He had been more social than normal but not too social.			20830			08/13/2026

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20830	Continued from page 19 During an interview on 7/1/26 at 10:10 a.m., maintenance (MN)-A stated R1 had been a “very open spirit to me” but had appeared a bit more down lately. During an interview on 7/1/26 at 10:15 a.m., housekeeper (HK)-A stated on 6/27/26, she went to his room to clean. R1 was lying in bed. HK-A stated they said “good morning” to each other and that was it. R1 was being really quiet that morning and that was “kind of off for him”. R1’s progress note dated 6/27/26 at 1:54 p.m., identified LPN-B was “notified of an urgent need to respond immediately to the yard”. R1 was observed with fresh blood on his shirt but not actively bleeding at the time. LPN-B instructed staff to call 9-11 while he remained with R1. R1 initially refused attempt by staff to apply pressure to neck area, where a puncture wound was suspected. R1 stated “I am in prison. I just want to go meet my mother and friends who recently died”. LPN-B was able to persuade R1 to surrender a piece of glass, which may have been used to puncture his neck. R1 continued to be closely monitored under supervision until he was taken to the ED. Earlier in the day, R1 had been observed in a good mood, taken medications, ate lunch in the dining room, and had a conversation with LPN-B. R1’s ED notes dated 6/27/26-6/30/36, identified R1 had been in the ED since 6/27/26, due to a suicide attempt. R1 took a piece of broken glass, cut small puncture wounds to neck, chest and right upper thigh. R1 required six total stitches. R1 was medically cleared for inpatient psychiatric care but was declined due to needing assistance and medical floor declined due to not having acute medical need. R1 stated he decided to face reality and reset priorities and goals. R1 reported stabbing himself with the mirror was him acting out so he could leave the facility. R1 did not want to try another antidepressant and stated he did not like how they made him feel. R1 did not want to go to a therapist “I am smarter than the therapist”. R1 planned to cope at discharge with journaling and reading. R1 had staff he trusted at the facility he would reach out to if suicidal thoughts returned. R1 completed a Stanley-Brown Safety Plan on 6/30/26, prior to return to facility. Step 1: warning signs: silent/being quiet, shut down/stop interacting. Step 2: internal coping strategies included: writing/journaling, humor, watch news, read, draw, praying/religion. Step 3: list of family/friends to contact, go outside/sit in sun. Step 4: list of people to ask for			20830			08/13/2026

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20830	Continued from page 20 help. Step 5: list of professionals to contact including suicide prevention number. Step 6: R1 did not identify environmentally lethal methods at facility. R1 stated treating people with respect, not being alone, and life were important and worth living for to him. Review of R1's post-hospital care plan did/did not identify incorporation of the Stanley-Brown Safety Plan, warning signs, coping strategies, or resident-specific interventions recommended by the emergency department. During a telephone interview on 7/1/26 at 10:48 a.m., nursing assistant (NA)-A stated that a couple of weeks before 6/27/26, R1 complained about his roommate and reported he could not sleep but did not explain why. NA-A had never heard R1 make comments of self-harm, and the suicide attempt shocked her. On 6/27/26, R1 got out of bed around 9:45 a.m. and nothing about his behavior caused concern. Around 1:30 p.m., after a resident reported glass and blood on the floor, NA-A and NA-B went to investigate. NA-A stated, "I ran back to get the nurse and [NA-B] went outside to look for [R1]." NA-A called 9-1-1 after locating R1 outside. During a telephone interview on 7/1/26 at 11:02 a.m., LPN-B stated he interacted with R1 several times on 6/27/26, including in the morning and after lunch, and R1 appeared normal, took his medications, and did not appear to be in distress. Later, nursing assistants alerted him after a resident reported blood on the floor and R1 was found in the courtyard. LPN-B observed fresh blood on R1 and attempted therapeutic communication. R1 had a sharp piece of glass in his hand, which he surrendered to LPN-B. R1 refused LPN-B's attempt to apply pressure to his neck and stated, "let me go, nobody loves me, I need to see my mother and friends." During the conversation, R1 stated he was not getting any better, had lost his aura, was going to lose his apartment, no one loved him, he wanted to be with his mother and friend that recently passed away, loved his family, but had to go because he did not see the point of being here. R1's progress note dated 6/30/26, at 9:05 a.m., identified ED nurse called and stated R1 indicated he only stabbed himself "because of his roommate". Facility stated R1 would be placed in a different room if he returned to facility. Psych would re-evaluate to determine with a new room in mind if that would change R1's mindset. At 2:46 p.m., psych provider was notified of R1's return to facility and need to be seen. Appointment scheduled 7/7/26			20830			08/13/2026

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20830	Continued from page 21 at 2:00 p.m. At 3:00 p.m., identified R1 returned to facility at 1:40 p.m. safety precautions in place: 1:1 at all times, room checks every two hours, all cords and mirrors removed from room. Styrofoam dishes/plastic utensils provided for meals, R1 educated staff would be near at all times and to ask if he needed anything. Review of R1's MAR/TAR following hospitalization identified on 6/30/26 beginning at 11:00 p.m., in the MAR, an order that directed "Resident is on 1:1 supervision: suicidal warning signs: silent/being quiet; shut down; stop interacting." These were documented by staff with a checkmark three times each day, with times recorded as "Day 6, Eve 2, Night". However, on 7/2/26, the TAR identified an order initiated on 7/2/26 at 6:00 p.m. directing staff to continue 15-minute safety checks pending psychiatric re-evaluation and to document R1's mood, behavior, suicidal thoughts/behaviors, and any side effects from Risperdal and duloxetine, including sedation, dizziness, restlessness, or worsening depression, with prompt reporting of significant changes. The order instructed documentation on the day and night shifts. Review of the corresponding TAR identified documentation fields labeled "thoug" (thoughts) and "Day" and "Night." From 7/2/26 through 7/7/26, staff documented the "thoug" field primarily with "No" or "N," and documented the day and night monitoring by placing initials and checkmarks in the corresponding boxes. The TAR contained no narrative documentation describing R1's mood, behavior, suicidal thoughts or behaviors, observed warning signs, or assessment for medication side effects as directed by the order. The 15-minute check order was discontinued on 7/8/26, which led to six days of these two orders conflicting with each other and each order documented as completed. Review of the monitoring record identified staff documented monitoring primarily by checkmarks without narrative documentation of mood, behavior, suicidal thoughts, or observed warning signs. R1's telehealth psych visit dated 7/2/26, at 9:00 a.m., R1 was seen for severe recurrent major depression without psychotic features, generalized anxiety disorder, and insomnia disorder related to another mental disorder. R1 described his overall state as one of "zero quality of life", profound loneliness, and a sense of abandonment from family. R1 stated "I'm alone. Why am I here?" R1 remained on 1:1, which the nurse noted tends to antagonize more than help him. Plan: placed in private room proximate to nursing station with environmental hazard mitigation in place. Given the antagonistic		20830			08/13/2026	

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20830	Continued from page 22 impact of recent 1:1, Ok to transition to every 15-minute checks. Resume Duloxetine 60 mg daily; while R1 was skeptical of its past benefit, R1 struggled greatly with negative bias currently and may be falling to appreciate its past protective effects. Resume previously helpful Risperidone 1 mg at bedtime. Psychiatry will manage all psychiatric medications going forward. Review of R1's record identified orders for Duloxetine 60 mg daily and Risperidone 1.0 mg daily was re-initiated after hospitalization and following R1's psychiatric visit on 7/2/26. During an interview on 7/1/26 at 9:38 a.m., HUC-A stated R1 had been provided 1:1 care since he returned from the hospital on 6/30/26, and she was currently providing them. Along with 1:1, anything R1 could use to self-harm was removed from the room. HUC-A was able to visualize R1 in bed, looking out the window. HUC-A stated she did not interact often with R1 in her role at the facility. During an observation and interview on 7/1/26 at 10:30 a.m., R1 was in a private room, sitting in a wheelchair. R1 stated "I apologize. I only do one thing poorly at a time". R1 stated he had not been sleeping well prior to his suicide attempt because his roommate was up at night watching tv a lot. R1 questioned why the facility would room people together that had sleep issues and that he complained to the staff all the time to turn his roommates tv off. R1 stated on 6/27/26, he became full of rage and anger and broke a mirror in his room." I broke the mirror, started cleaning it up and had a wild ass idea I could get out of here so cut my wrist and carotid on both sides". "When I saw those pieces, I saw that I could end it all", but "didn't fulfill my intended purpose". R1 had two visible stitches on both sides of his neck and two stitches on his right upper thigh. R1 did not intend to cut his thigh and that was an accident. "I have no purpose and I am weak". R1 hoped to find a facility closer to his family but felt he sealed his fate with this incident. "I am responsible for me and my health. I could go on and on". R1 stated his prior assisted living facility requested everything be moved out in 14 days. R1 stated he told his daughter to give his belongings to his grandchildren. They are busy and R1 did not want to "drag them down with me". "My spirit is killed and I'm not afraid of death. Talk is cheap." During an interview on 7/1/26 at 11:30 a.m., DON stated when R1 returned to facility on 6/30/26, he was moved to a private room from a semi-private			20830			08/13/2026

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20830	Continued from page 23 room to meet his needs. The facility removed all mirrors, and R1 was 1:1 supervision until psych could see R1 on 7/7/26, when it would be re-evaluated. During an observation and interview on 7/6/26 at 10:10 a.m., R1’s room door was three-quarters shut with no 1:1 supervision according to the physician order. R1 was lying in bed in the dark with the TV on that was black and white static and had a urinal full of yellow fluid sitting on his overbed table. R1 stated his troubles began when he had a stroke. R1 had been able to stand and pivot transfer but developed a bone infection and became non-weight bearing. R1 stated he had gotten steadily weaker since he had stopped walking because therapy ended due to non-progression “Now I am just a rug laying on the floor. I got really depressed over it”. R1 stated he felt like he was “chained to the bed”. “I am not much good to anybody”. R1 explained he used a “machine to sleep, a machine to move” and “I don’t feel much like a human being anymore”. R1 stated he was “fine” looked over at the tv and “the truth, I am not happy”. R1 stated he did not want to be a burden to his family “all alone here, isolate and destroy what they have done for me”. R1 stated his daughter cannot help him “I don’t want to bring them down”. R1 stated the facility put him in a private room to help him. R1 explained he was not allowed to have a call light, bed control to position his bed, or his CPAP tubing because he could “take that and wrap it around myself”. They took away my pencil case because “I could stab myself in the ear with it” and he could not even charge his phone because they took the charger away. Although R1 reported the call light and tubing was removed, R1’s call light was lying on the bed by his waist, and his CPAP machine tubing was hanging over the head of the bed within his reach. In addition, a can of V8 juice was observed on R1’s bedside table and a garbage can with a bag was also within R1’s reach. During the conversation R1 had a monotone voice and demonstrated a flat affect. During an observation and interview on 7/6/26 at 10:17 a.m., registered nurse (RN)-A entered R1’s room. RN-A emptied R1’s urinal, asked if he needed anything and left the room however did not remove any of the items that could pose a safety risk. At 10:19 a.m., RN-A stated she observed the tubing, can of V8 juice, call light, and garbage can all within R1’s reach. RN-A stated R1 could access any of those items and use them to attempt suicide. RN-A returned to R1’s room and removed the garbage bag from the can, removed the tubing and placed it in the bottom drawer of side table, double tied the call			20830			08/13/2026

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20830	Continued from page 24 light to the side of R1’s bed. RN-A stated, "I would sure like to know how they [staff] are monitoring every 15-minutes, I haven't seen a sheet" [not consistent with ordered 1:1]. RN-A approached NAs inquiring how they monitored R1 every 15 minutes. NA's showed RN-A a piece of paper they signed off in 15-minute increments. RN-A educated NAs of her findings in R1’s room and why they could not be there but did not direct 1:1 supervision. During an observation on 7/7/26 at 7:45 a.m., HUC was in front of R1’s room with a table, chair, and laptop providing 1:1, while R1 was in bed in his room. At 8:40 a.m., R1 was in his room with no staff present providing 1:1. At 9:09 a.m., an unidentified NA delivered R1’s breakfast tray but left the room, leaving R1 alone without supervision. During an interview on 7/7/26 at 9:10 a.m., LPN-E reviewed R1’s medical chart. R1 had a nursing order beginning 6/30/26. LPN-E explained there was an order that directed 1:1 supervision: (monitor) suicidal warning signs: silent/being quiet; shut down; stop interacting. A second nursing order beginning 7/2/26, included continue 15-minute safety checks until “6/7,” pending psychiatric re-evaluation. Document mood, behavior, suicidal thoughts/behaviors, and any side effects from Risperdal and Duloxetine including sedation, dizziness, restlessness, or worsening depression. Report significant changes promptly for suicidal assessment. LPN-E verified the orders were conflicting as the record showed R1 was on both 1:1 supervision and 15-minute checks. During an observation and interview on 7/7/26 at 9:48 a.m., HUC was in room with overbed table and laptop facing R1. R1 was in bed. Curtains were almost completely drawn, tv was on filled with static, and room was dark. R1 stated he did not eat breakfast. R1 did not want to continue conversation “I have price of gas concerns”. During an interview on 7/2/26 at 2:22 p.m., RN-A and LPN-D reviewed R1's medical record. RN-A stated psychiatry should have been consulted before Risperidone and Duloxetine were discontinued. Both RN-A and LPN-D stated R1's physician and psychiatrist should have been notified when R1 began demonstrating changes in mood and behavior, particularly given his history of suicidal ideation. LPN-D stated R1 should have received increased monitoring following the discontinuation of the psychotropic medications. RN-A stated she would have expected daily suicide risk, depression, and social withdrawal assessments. LPN-D further			20830			08/13/2026

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20830	Continued from page 25 stated she reviewed the TAR monitoring documentation on 7/1/26 and questioned the meaning of the check marks, plus signs, and minus signs because they did not indicate whether R1 exhibited any symptoms. She stated the documentation was insufficient and should have been supported by descriptive progress notes. Both RN-A and LPN-D stated the physician, and psychiatrist should have been notified based on the changes documented on 6/16/26, 6/23/26, and 6/25/26. During an interview on 7/2/26 at 12:42 p.m., the Administrator, Director of Nursing (DON), and LPN-A reviewed R1's record. DON stated residents expressing suicidal ideation were managed by talking with them and having them see psychiatry. When asked whether psychiatry had been notified before Risperidone and Duloxetine were discontinued, DON initially stated, "I think we told psych he was refusing and [APRN-A] tapered it [Duloxetine] but psych was aware of the refusals." After reviewing the record, DON confirmed psychiatry had not been informed of the medication discontinuations and APRN-A had not consulted psychiatry before discontinuing the medications. DON further stated R1 was monitored every shift for behavior changes. LPN-A stated a checkmark on the monitoring record indicated the observation had been completed and, if no mood changes were observed, only a checkmark was documented. If a mood change was noted, staff would document it in a progress note. The Administrator stated documenting monitoring with only a checkmark was "pretty broad." LPN-A further stated assessments were not completed daily or every shift because nurses frequently documented that R1 had no suicidal ideation. DON stated, "It was not that the facility did not do anything. R1 was dependent for cares, and we knew he could only go so many hours without staff checking on him... in hindsight I don't know." The Administrator stated the facility could not predict the future. During a telephone interview on 7/1/26 at 3:18 p.m., psychiatry physician assistant (PPA)-A stated the last contact she had with the facility or R1 was on 6/11/26, when she was told the Risperidone had been discontinued and the Duloxetine was being tapered off and ending. PPA-A did not recommend either of the medications be discontinued without a discussion with her. PPA-A was notified on 7/1/26, that R1 had returned from the hospital and scheduled a visit for 7/7/26, but was unaware that he had been in the hospital for a suicide attempt. PPA-A began working with R1 in March. During her			20830			08/13/2026

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20830	Continued from page 26 initial evaluation on 3/25/26 she had R1 sent to the ED with significant concerns. When R1 returned from ED, PPA-A placed R1 on acute daily follow-up visits for seven days, and Risperidone. Once Risperidone was initiated, PPA-A saw a significance difference in R1's mental health in a one-week period. PPA-A stated psychiatry had difficulties with the facility processes because the facility would "mess with psych meds, usually from pharmacy recommendations" without consulting psychiatry or informing them of the changes. During a telephone interview on 7/6/26 at 9:52 a.m., medical director (MD)-A stated someone with suicidal ideation should be treated for at least one year before any kind of tapering be done with the medication. MD-A expected a suicidal evaluation from facility staff on a consistent basis and since R1 was suicidal, MD-A would expect the facility would continue monitoring for suicidal ideations. MD-A stated the facility should absolutely notify the providers of changes in mood and behaviors. Attempts to interview APRN-A on 7/1/26 at 3:15 p.m. and 7/6/26 at 9:35 a.m. were unsuccessful. Voicemails were left with no return call. A phone call and text message were sent on 7/1/26 at 10:48 a.m., to NA-B with no response. Phone number for trained medication aide (TMA)-A was requested on 7/1/26 and not received. Requested policies for suicidal ideation/past suicide attempts/self-harm, and psychiatry but did not receive prior to IJ. The IJ was removed on 7/8/26 at 11:59 a.m., after verifying the facility completed the following: -policies and procedures related to mental and behavioral health services, including notification of changes process were reviewed. -revised notification of changes policy to incorporate protocols for assessing mood and behavior, identifying signs and symptoms of depression, and outlining when to notify the provider of worsening or escalating symptoms. -completed a comprehensive behavioral and mood assessment for R1, implemented enhanced monitoring, removed potential self-harm hazards for room, updated care plan to reflect monitoring and intervention strategies. -implemented a room safety checklist for R1's room			20830			08/13/2026

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20830	Continued from page 27 to be inspected each shift for potential hazards or objects that could be used to self-harm. -identified like residents with a history of suicidal ideation or suicide attempts and implemented appropriate monitoring, updated care plans and interventions. -all staff and providers complete education on behavioral health, resident assessment and supervision, communication of changes in psychotropic medications, changes in mood or mental status, coordination of care, documentation standards, environmental safety. The facility Suicide Assessment policy reviewed 7/7/26, identified notify the physician if resident presents with suicidal ideation, even if the resident is not specific about a plan or intent. The facility Use of Psychotropic Medications policy reviewed 7/7/26, identified the attending physician will assume leadership in medication management in collaboration with resident, family, other professionals, and interdisciplinary team. The Notification of Changes policy reviewed 7/7/26, identified the facility must inform the resident, consult with residents physician, family or legal representative when there is a change requiring such notification such as significant change in residents mental or psychosocial condition. The facility Behavioral Health Services policy reviewed 7/7/26, identified the facility wished to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being. Facility will use comprehensive assessment process for identifying and assessing a residents mental and psychosocial status and provide person centered care. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting behavioral health needs of residents SUGGESTED METHOD OF CORRECTION: The Administrator, DON, or designee could review and revise policies and procedures for staff to notify psychiatry services with behavioral and/or mood changes in residents. The facility could educate staff on behaviors of residents with suicidal ideation, strategies for assisting residents with suicidal ideation, monitoring of residents with behaviors			20830			08/13/2026

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20830	Continued from page 28 related to suicidal ideation. The DON or designee could complete audits and bring audits to Quality Assurance Performance Improvement (QAPI) meetings. TIME PERIOD FOR CORRECTION: 21 days.		20830			08/13/2026	
21540	Unnecessary Drug Usage; Monitoring CFR(s): MN Rule 4658.1315 Subp. 2 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to assess continued need of as needed (prn) psychotropic medications for 1 of 3 residents (R2) with provider every 14 days. Findings include: R2's face sheet dated 7/7/26, identified diagnoses of suicidal ideations, generalized anxiety disorder, and major depressive disorder. R2's admission Minimum Data Set (MDS) dated 4/24/26, identified R2 had no memory issues, no issues with hearing or speech. R2 did not have behaviors towards staff or other residents. R2 was independent with activities of daily living. R2 was on an antipsychotic and received on a routine basis.		21540	Corrected		08/13/2026	

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21540	Continued from page 29 R2’s care plan dated 4/15/26, identified R2 used psychotropic medications due to depression, anxiety, insomnia, post-traumatic stress disorder, and history of suicidal ideations. Interventions included: administer psychotropic medications as ordered. Monitor for side effects and effectiveness every shift. Behavioral interventions: redirection, offer walk outside, distraction. Monitor/document/report as needed adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Referral to psych services, target behaviors of social isolation, pacing. R2’s physician orders dated 4/14/26, identified Hydroxyzine Pamoate 50 milligrams (mg) capsule by mouth every 12 hours as needed for anxiety. R2’s medication administration record (MAR) dated 4/1/26-4/30/26, identified R2 received Hydroxyzine 50 mg on 4/16/26, 4/18/26, 4/20/26, 4/21/26, 4/26/26, and 4/27/26. R2’s physician encounter note dated 4/28/26, identified R2 was seen at facility on day 14 but did not address Hydroxyzine PRN usage for renewal or discontinuation. R2’s physician encounter note dated 4/29/26, identified R2 was seen at facility on day 15 but did not address Hydroxyzine PRN usage for renewal or discontinuation. R2’s Pharmacist’s Recommendation to Prescriber dated 5/14/26, identified Hydroxyzine 50 milligrams (mg) was ordered on 4/14/26, and is overdue for 14-day review. It had not been used at all in May. Please consider discontinuation of PRN Hydroxyzine. Rationale included if PRN is to exceed 14 days, prescriber must document rationale in the medical record—AND—indicate the duration for the PRN order. R2’s MAR dated 5/1/26-5/31/26, identified R2 received Hydroxyzine 50 mg on 5/16/26, 5/18/26,			21540			08/13/2026

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21540	Continued from page 30 and 5/20/26. R2’s handwritten physician order dated 5/21/26, identified discontinue Hydroxyzine 50 mg signed but not dated by physician. During an interview on 7/7/26 at 12:55 p.m., licensed practical nurse (LPN)-C and LPN-E were seated at the nurse’s station. LPN-E stated for PRN psychotropic medications the floor nurse would monitor them. The medication should have a stop date on it so it would not just be continuous. LPN-C wondered if maybe that was why there were orders to monitor those medications in the MAR. When the floor nurse would notice the medication was at the 14-day mark, the provider should be emailed to renew the medication. LPN-C stated the medication should not be given after the 14-day mark unless the provider was aware. LPN-C and LPN-E verified R2 had not had a stop date on Hydroxyzine and it had been given to R2 after 14 days. During an interview on 7/2/26 at 12:42 p.m., director of nursing (DON) stated the doctor had to assess prn psychotropic medications every 14 days. Nurses and management review psychotropic PRN medications and sometimes would miss them. That is why the facility had the pharmacy recommendations monthly, they are there to help the facility when they miss it. DON could not articulate why R2 did not have the Hydroxyzine addressed by a physician during rounds. During a telephone interview on 7/6/26 at 9:52 a.m., medical director (MD)-A stated PRN psychotropics should be reviewed every 14 days for necessity. When reviewed they should determine if the medication could be discontinued, kept PRN, or prescribed. The facility Use of Psychotropic Medications policy reviewed 7/7/26, identified residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the residents medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Psychotropic medication used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the			21540			08/13/2026

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21540	Continued from page 31 residents medical record and is subject to limitations. PRN orders for antipsychotic medications only shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. The policy did not address PRN psychotropic medication orders. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of PRN medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.		21540			08/13/2026	
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be		21545	Corrected		08/13/2026	

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21545	Continued from page 32 filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to follow physician orders for 1 of 3 residents (R1) reviewed for weight gain. Findings include: R2's face sheet identified diagnoses of heart failure, rheumatoid arthritis, and localized edema. R2's admission Minimum Data Set (MDS) dated 4/24/26, identified R2 had no memory issues, no issues with hearing or speech. R2 was independent with activities of daily living. R2's care plan dated 4/15/26, identified R1 received diuretic for congestive heart failure. Interventions included: administer diuretic medication as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor dose. May require modification in order to achieve desired effects while minimizing adverse consequences, especially when multiple antihypertensives are prescribed simultaneously. When discontinuing, gradual tapering may be required to avoid adverse consequences caused by abrupt cessation. Monitor/document/report PRN adverse reactions to diuretic therapy: dizziness, postural hypotension, fatigue, and in increased risk of falls. R2's physician order dated 4/14/26, identified Furosemide (diuretic) 20 mg for edema PRN daily for			21545			08/13/2026

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21545	Continued from page 33 1.5 pounds above baseline. R2's weights with corresponding medication administration record (MAR) for Furosemide administration from 4/15/26-5/12/26, identified: 4/15/26-baseline weight was 168.0 pounds. 4/16/26-no weight was obtained. 4/17/26-weight was 169.8 pounds. This was 1.8 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/18/26- weight was 169.7 pounds. This was 1.7 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/19/26-weight was 169.6 pounds. This was 1.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/20/26- weight was 171.6 pounds. This was 3.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/21/26- weight was 172.1 pounds. This was 4.1 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/22/26- weight was 173.2 pounds. This was 5.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/23/26- no weight was obtained. 4/24/26- weight was 173.9 pounds. This was 5.9 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/25/26- weight was 176.0 pounds. This was 8.0 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given.			21545			08/13/2026

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21545	Continued from page 34 4/26/26-weight was 178.0 pounds. This was 10 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/27/26- weight was 177.0 pounds. This was 9.0 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/28/26- weight was 182.0 pounds. This was 14 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/29/26- weight was 182.0 pounds. This was 14 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 4/30/36- weight was 183.2 pounds. This was 15.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/1/26- weight was 185.2 pounds. This was 17.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/2/26- weight was 184.2 pounds. This was 16.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/3/26- weight was 183.1 pounds. This was 15.1 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/4/26- weight was 186.8 pounds. This was 18.8 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/5/26- weight was 186.6 pounds. This was 18.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/6/26- weight was 181.0 pounds. This was 13.0 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given.			21545			08/13/2026

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21545	Continued from page 35 5/7/26- weight was 182.4 pounds. This was 14.4 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/8/26- weight was 187.2 pounds. This was 19.2 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/9/26- weight was 188.4 pounds. This was 20.4 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/10/26- weight was 188.6 pounds. This was 20.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/11/26- weight was 190.4 pounds. This was 22.4 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. 5/12/26- weight was 190.6 pounds. This was 22.6 pounds above the baseline weight of 168.0 pounds. No PRN Furosemide given. Although R2 had a continuous weight gain greater than 1.5 pounds per day, PRN Furosemide was not administered from 4/14/26-5/12/26. During an observation and interview on 7/6/26 at 10:10 a.m., R2 was in his room, sitting in a wheelchair. R2 stated the hospital had changed his Furosemide from daily to PRN “why take Furosemide off when I had congestive heart failure. Unacceptable. Could have built fluid around my heart”. R2 stated he did not feel fluid buildup on himself. During an interview on 7/6/26 at 6/46 a.m., registered nurse (RN)-A stated R2 had diagnoses of localized edema and heart failure. RN-A stated R2 was ordered to get daily weights but could not articulate why the facility did not capture the weight gain. Furosemide should have been given in April and May each time the weight was above baseline as the order said. During an interview on 7/2/26 at 12:42 p.m., DON			21545			08/13/2026

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NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET , WABASSO, Minnesota, 56293			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21545	Continued from page 36 stated she would have expected nursing staff to give Furosemide every time R2's weight had increased 1.5 pounds as the order directed. The point of daily weights was for the facility to track if they are gaining weight. At the beginning of R2's stay the facility was not monitoring properly but when it was discovered, the facility did what it could to rectify the situation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days			21545			08/13/2026