



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 2, 2023

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

RE: CCN: 245400
Cycle Start Date: December 28, 2022

Dear Administrator:

On February 28, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



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March 2, 2023

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

Re: Reinspection Results
Event ID: KXQD12

Dear Administrator:

On February 28, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 28, 2022. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



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January 13, 2023

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

RE: CCN: 245400
Cycle Start Date: December 28, 2022

Dear Administrator:

On December 28, 2022, a 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.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by March 28, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 28, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

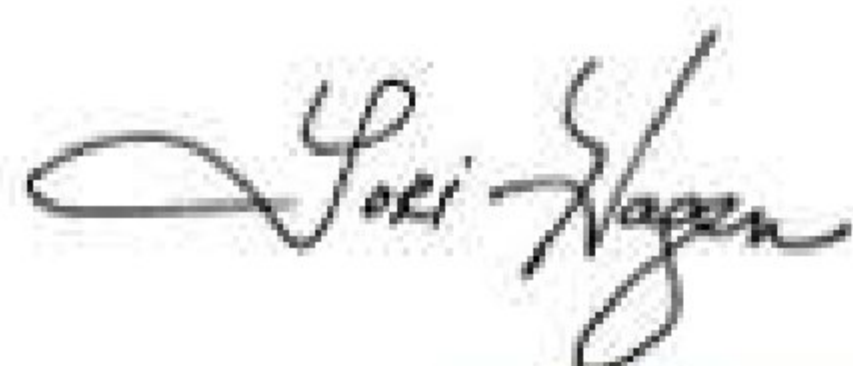
Wabasso Restorative Care Center

January 13, 2023

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst

Federal Enforcement | Licensing and Certification

Health Regulation Division

Minnesota Department of Health

Telephone: 651-201-4306

E-mail: Lori.Hagen@state.mn.us



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January 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: KXQD11

Dear Administrator:

The above facility was surveyed on December 27, 2022, through December 28, 2022, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

Wabasso Restorative Care Center

January 13, 2023

Page 2

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.

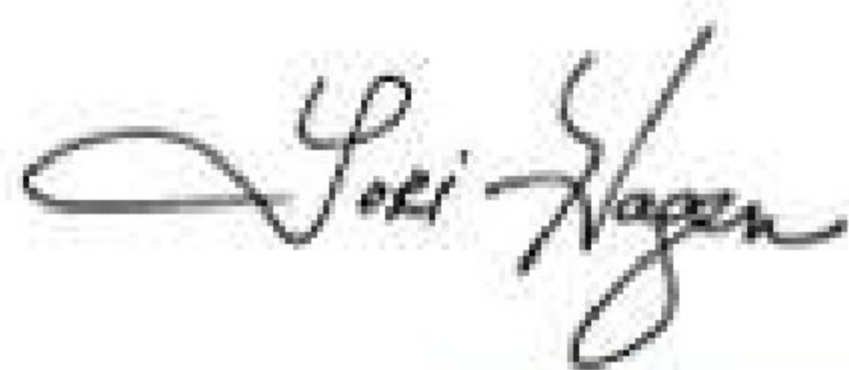
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 contact me with any questions.



Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2022
NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	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
F 000	INITIAL COMMENTS On 12/27/2022-12/28/2022, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54006569C (MN00089273 and MN00089274), with a deficiencies cited at F622, F623, F626, and F689. 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.	F 000			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622			1/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2023

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

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F 622	Continued From page 1 sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is	F 622			

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F 622	Continued From page 2 communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to inform the resident/resident representative of transfer discharge rights prior to	F 622	It is the policy of Wabasso Rehabilitation and Wellness Center to inform all residents and /or POA of their rights prior		

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F 622	Continued From page 3 discharge for 1 of 1 resident (R1) reviewed for transfer/discharge. Findings include: R1's facility Admission Record indicated R1 was admitted to the facility on 12/6/2022, with diagnoses that included sepsis, repeated falls, and alcohol abuse disorder. R1 was admitted for short term rehabilitation and chemical dependency treatment. R1's Brief Interview for Mental Status date 12/8/2022, indicated R1 had severe cognitive impairment. R1's discharge progress note dated 12/9/22, at 1:00 p.m. indicated R1 had been awake all night with multiple falls and requiring 1:1 staffing to ensure safety, agitated, attempting to leave facility, and not able to understand need to remain in isolation or wear a mask. Spoke with ER nurse who stated the change in cognition warranted medical evaluation. Further indicates an emergency discharge form was emailed to ombudsman and attempts were made to call family. Resident was transported to the ER at 11:00 a.m. and director of nursing (DON) and social worker (SW) informed the hospital staff R1 was discharged from their facility. R1's record did not indicate R1 and R1's representative were informed of their discharge rights which included the right to appeal the discharge. R1's ER physician progress note dated 12/9/2022, at 11:42 a.m. indicated R1 presented for evaluation after multiple falls at the nursing	F 622	to transfer or discharge. R1 has been discharged and placed in another facility. All residents reviewed for risk of transfer/discharge. All residents have the potential of being affected by a transfer or discharge from the facility. All residents being transferred to the hospital or having a facility-initiated discharge will be given a copy of the transfer or discharge form prior or at the time of event. This will include information as stated in the regulations. The Ombudsman will be notified of facility-initiated discharges on the day of occurrence per regulation. Discharges for the last 30 days will be reviewed for proper discharge procedure and any discharged found to not have proper notice will be sent a discharge notice via mail. Social Services and Nursing staff will be educated on the policy and procedure process. Audits of discharges will be done 2x/ week for 3 weeks and then weekly x 3 weeks then monthly x 3 months. All results will be brought to the QAPI committee for review.		

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F 622	Continued From page 4 home and testing positive for COVID-19. The note also indicated nursing home staff brought patient to ER in a private car and told the hospital staff, R1 "was too much work for us to be able to care for him", and then left. Further progress notes at 2:05 p.m. indicated R1 was medically cleared and would be appropriate for discharge back to the nursing home at this time. At 2:52 p.m. the progress note indicates the ombudsman has told the facility staff that R1 should be returned to their facility, but they continued to refuse to accept R1 back. R1 would require further state intervention/appeal now so R1 cannot be returned there until legal proceedings force the issue, likely next week. During an interview on 12/28/22, at 4:21 p.m. the ombudsman confirmed R1/R1's resident representative was not provided a discharge notice explaining his rights prior to discharge. Further stated the discharge notice that she received did not meet the statutory requirements and has requested the letter in its entirety but has not received any additional information. During an interview on 12/27/22, at 12:30 p.m. the facility's SW indicated they knew when they dropped him off at the ER that they would not be taking him back. SW further stated R1 would not have understood the discharge notice and she did attempt to call family but no proof of contact attempts was provided or noted in the medical record. A discharge notice was sent to the ombudsman. During an interview on 12/27/2022, at 1:10 p.m. the Administrator indicated she was aware of the emergency discharge of R1 but did not comment on the discharge notice.	F 622			

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F 622	Continued From page 5	F 622			
F 623 SS=D	Facility Resident Transfer and Discharge Policy and Procedure copywrite 2022, indicate the facility will maintain a transfer and discharge process that complies with regulatory requirement and maintains the resident's quality of care. Further indicates the discharge notice shall be provided at least 30 days before the resident is transferred or discharged. If the transfer or discharge is urgent due to the safety, health of individuals in the Facility would be endangered or an immediate transfer or discharge is required by the resident's urgent medical needs the discharge notice must be made as soon as practicable. The policy does not specify what information is required on the discharge notice. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623			1/31/23

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F 623	Continued From page 6 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623			

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F 623	Continued From page 7 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify and provide appropriate transfer/discharge notifications to the Long-Term	F 623	.It is the policy of Wabasso Rehabilitation and Wellness Center to inform all residents and /or POA of their rights prior		

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F 623	Continued From page 8 Care (LTC) Ombudsman for 3 of 3 residents (R1, R2, and R3) reviewed for discharge rights. This failure had the potential to decrease support/direction from the Ombudsman related to resident rights to appeal. Findings include: R1's Hospital Preadmission Referral faxed to the facility on 12/5/22, indicated R1 required short term rehabilitation and chemical dependency treatment. R1's Admission Summary Progress Noted dated 12/6/22, at 4:47 p.m indicated R1 was admitted to the facility and noted to be alert and oriented to person and place with some periods of confusion noted. A Discharge Progress Note dated 12/9/22, at 1:00 p.m. indicated R1 was discharged to the emergency department (ED) on 12/9/22. R2's Admission Summary Progress Note dated 10/31/22, at 3:39 p.m. indicated R2 was readmitted to the facility. A social service progress note dated 12/6/22, at 3:44 p.m. indicated during an outing, R2 did not get on the facility bus when it was time to leave and could not be located. R2 will be DC (discharged) AMA (against medical advice). R2's case manager notified, and appointments cancelled. Facility records did not identify rational of R2's AMA or evident R2 was offered return to facility prior to discharging. R3's Admission Summary Progress Note indicated R3 was admitted to the facility on 9/6/22. The facility's Admission/Discharge Report	F 623	to transfer or discharge. R1 has been discharged and placed in another facility. All residents reviewed for risk of transfer/ discharge. All residents have the potential of being affected by a transfer or discharge from the facility. All residents being transferred to the hospital or having a facility-initiated discharge will be given a copy of the transfer or discharge form prior or at the time of event. This will include information as stated in the regulations. The Ombudsman will be notified of facility-initiated discharges on the day of occurrence per regulation. Discharges for the last 30 days will be reviewed for proper discharge procedure and any discharged found to not have proper notice will be sent a discharge notice via mail. Social Services and Nursing staff will be educated on the policy and procedure process. Audits of discharges will be done 2x/ week for 3 weeks and then weekly x 3 weeks then monthly x 3 months. All results will be brought to the QAPI committee for review.		

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F 623	Continued From page 9 indicated R3 discharged AMA on 11/23/22 although, details surrounding R3's AMA were not evident in the record. A review of the facility's Admission/Discharge Report for the dates 10/19/22 to 12/27/22, identified the following: -4 discharges in October 2022 -13 discharges in November 2022 -15 discharges in December 2022 Of these discharges, five were AMA discharges; five were discharged to an acute care medical facility, and 22 discharges to home or another long-term care setting. During an interview on 12/28/22, at 12:30 p.m. social worker (SW) indicated the facility would not notify the Ombudsman of AMA discharges. They would report AMAs through the State Agency Vulnerable Adult Reporting System. She reported all other discharges to the Ombudsman. SW indicated she did not save the listing and receipt of confirmation of the transfer/discharge reports submitted to the Ombudsman, therefor could not provide them. During an interview on 12/28/22, at 4:20 p.m. the Regional Ombudsman indicated when the facility did send her the discharge reports, the reports did not meet statutory requirements. Ombudsman explained she has attempted to educate administrative staff at the facility however they did not respond or return her phone calls. A follow-up email received from Regional Ombudsman dated 1/3/23, included the list for October discharges was not received on 11/1/22, but did not include the required information and only provided names and discharge dates. She did not receive any resident discharge notices in November. For	F 623			

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F 623	Continued From page 10 December the only notice she received was for R1, which did not meet statutory requirements. Ombudsman indicated she did not have access to the VA reports submitted by the facility so was unaware of any AMA discharges. The facility policy titled Resident Admission Policy and Procedure copywrite 2020, indicates before the facility transfers or discharges a resident, the facility shall send a copy of the [discharge] notice to a representative of the Office of State Long-Term Care Ombudsman. The contents of the notice shall included the following: reasons for transfer or discharge; specific location to which the resident is transferred or discharged; a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receive such requests and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.	F 623			
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first	F 626			1/31/23

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F 626	Continued From page 11 availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow proper transfer/discharge requirements to emergency room (ER) for 1 of 1 resident (R1) reviewed for transfer/discharge rights. Findings include Vulnerable Adult Report submitted to the State Agency on 12/9/22, at 3:15 p.m. and 3:50 p.m. alleged caregiver neglect and violation of resident rights when the facility's director of nursing (DON) and social worker (SW) transported R1 in their	F 626	It is the policy of Wabasso Rehabilitation and Wellness Center to inform all residents and /or POA of their rights prior to transfer or discharge. R1 has been discharged and placed in another facility. All residents reviewed for risk of transfer/ discharge. All residents have the potential of being affected by a transfer or discharge from the facility. All residents being transferred to the hospital or having a facility-initiated discharge will be given a copy of the transfer or discharge form prior or at the time of event. This will		

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F 626	Continued From page 12 personal vehicle to (name of hospital) Emergency Room, which was not the closest facility for emergency situations. The report indicated the DON and SW dropped R1 off at the ER and stated they would not take him back. R1's medical evaluation was negative, and he was cleared to return to the nursing home three hours later, but the DON and SW stated they did an emergency discharge and would not take him back. R1 did not require hospitalization so remained in the ER until they could find placement for him essentially leaving him homeless. Further indicated had caused "much unneeded stress" to R1. R1's facility Admission Record identified R1 was admitted to the facility on 12/6/2022, with diagnoses that included sepsis and alcohol abuse disorder. R1 was admitted for short term rehabilitation and chemical dependency treatment. R1's Brief Interview for Mental Status date 12/8/2022, identified R1 had severe cognitive impairment. R1's Admission Functional Abilities and Goals dated 12/8/2022, identified R1 required staff assistance with dressing, bathing, using the toilet, transferring, and walking. R1's admission summary progress note dated 12/6/2022, at 2:32 p.m. indicated R1 was alert and oriented to person and place with some confusion noted. Pleasant and cooperative with no agitation or behaviors. R1 was "very figity" (sic), moving often, and dropping things. R1's progress note dated 12/7/22, at 5:19 p.m.	F 626	include information as stated in the regulations. The Ombudsman will be notified of facility-initiated discharges on the day of occurrence per regulation. All transfers or discharges to the hospital will be reevaluated for returning to the facility when the hospital notifies SNF that the resident is medically stable. Discharges for the last 30 days will be reviewed for proper discharge procedure and any discharged found to not have proper notice will be sent a discharge notice via mail. Social Services and Nursing staff will be educated on the policy and procedure process. Audits of discharges will be done 2x/ week for 3 weeks and then weekly x 3 weeks then monthly x 3 months. All results will be brought to the QAPI committee for review.		

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F 626	Continued From page 13 R1 tested positive for COVID. R1 was provided with a mask and attempted to keep R1 in his room. R1's progress note dated 12/8/22, at 1:30 a.m. indicated R1 was found sitting on the floor at 8:20 p.m. and 8:40 p.m. and was sent to the ER by ambulance at 9:00 p.m. for repeated falls. Per progress note on 12/8/22, at 3:35 a.m. R1 returned from the ER. R1's progress note dated 12/8/22, at 5:45 p.m. R1 has no active signs or symptoms of COVID; all cares provided in room with precautions. R1's discharge progress note dated 12/9/22, at 1:00 p.m. indicated R1 had been awake all night with multiple falls and requiring 1:1 staffing to ensure safety, agitated, attempting to leave facility, and not able to understand need to remain in isolation or wear a mask. Spoke with ER nurse who stated R1 was alert and oriented when he was discharged the ED earlier that morning. ER nurse stated R1's current change in cognition since hospital discharge warranted further medical evaluation. An emergency discharge form was emailed to ombudsman and attempts were made to call family. Resident was transported to the ER at 11:00 a.m. and hospital staff were informed by the director of nursing (DON) and social worker (SW) R1 had been emergently discharged from the facility to the hospital. R1's ER physician progress note dated 12/9/2022, at 11:42 a.m. indicated R1 presented for evaluation after multiple falls at the nursing home and testing positive for COVID-19. The note also indicated nursing home staff brought	F 626			

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F 626	Continued From page 14 patient to ER in a private car and told the hospital staff, R1 "was too much work for us to be able to care for him", and then left. ER progress notes at 2:05 p.m. identified R1 was medically cleared and would be appropriate for discharge back to the nursing home at this time. Progress note at 2:52 p.m. indicated the ombudsman had told the facility staff that R1 should be returned to their facility, but they continued to refuse. R1 would require further state intervention/appeal now so R1 could not be returned until legal proceedings force the issue, likely next week. R1's ER progress note by hospital licensed social worker (LSW) dated 12/9/2022, at 2:45 p.m. included Wabasso nursing home is refusing to take R1 back. They were filing for emergency discharge due to the fact patient has COVID-19 and will not keep a mask on or stay in his room, they feel he is a danger to other residents. LSW had been in contact with ombudsman who reported the facility's administration team were refusing to discuss readmitting R1, were not taking R1 back, and have discharged him. R1's facility record did not include nor was evident the facility re-evaluated R1's clinical/behavioral status for re-admission after the ER medically cleared and stabilized R1. During an interview on 12/27/22, at 12:30 p.m. the facility's SW stated R1 was admitted with confusion and could not walk. He then tested positive for COVID and couldn't grasp that he needed to stay in his room and keep a mask on. Further stated R1 required 1:1 supervision and they weren't staffed for that. SW stated they knew when they dropped him off at the ER that they would not be taking him back. They were	F 626			

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F 626	Continued From page 15 told by the ombudsman to take him back but would not accept him back even though the ER said he was medically stable. During a return call interview on 1/9/22, at 2:00 p.m. family member (FM)-A indicated R1 had been in the hospital for 18 days after the facility dropped him off. FM-A stated R1 had been bored and "antsy" to go home. Email communication dated 12/27/22, at 12:00 p.m. ER hospital licensed social worker (LSW) wrote R1 was hospitalized with no medical reason for 18 days. All 18 days of R1's hospital stay were spent trying to find him a place for him to live and secure funding (for payment). Further indicated they did not see any of the behaviors that the nursing home described. R1 had some confusion but was easily directed and physical therapy cleared him the day after hospitalization to be independent with ambulation in his room. Stated R1's family chose not to appeal due to the way the facility discharged/dumped him. During a follow-up telephone interview on 1/10/22, with hospital LSW stated while R1 was waiting for placement he was clearly bored. He was confined to a small area limited to his room and the lounge. The only people he got to have conversations with was hospital staff. He was very lonely and "bummed" he had to stay there. LSW referred to hospital record; After about a week, he started having problems with sleep, he started feeling more confined, and anxious so his Seroquel (antipsychotic) had to be increased from 25 mg (milligrams) to 50 mg every night at bedtime. Psychiatry followed-up on 12/23/22, he had improved sleep however, still was feeling confined and bored. He was very excited to leave.	F 626			

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F 626	Continued From page 16 During an interview on 12/27/22, at 1:00 p.m. the DON indicated the facility does not provide 1:1 staffing and R1 wouldn't comply with the COVID restrictions. Further indicated the ombudsman contacted her and asked them to take R1 back after he was medically cleared but had already discharged him to protect the other residents (related to COVID). The DON further indicated R1 was not reevaluated for readmission to the NH although medically cleared for admission by the ED. During an interview on 12/27/2022, at 1:10 p.m. the Administrator indicated she was aware of the emergency discharge of R1. Further indicated R1 was belligerent, on the floor constantly, restless, and delusional about where he was during his stay at the facility. During an interview on 12/28/22, at 4:21 p.m. Ombudsman indicated she had contacted the facility SW and DON and told them this was an inappropriate discharge and they needed to take R1 back once he had been medically cleared. DON and SW told her R1 had already been discharged and were not taking him back and refused to discuss the matter any further. Facility Assessment Tool dated 8/2022, included a listing of diseases and conditions for which the facility could manage, treat, and had resources to meet the resident's needs with specified diseases and conditions. Section 1.3 included identified those diseases and conditions which include impaired cognition, mental disorders, behaviors that need interventions. Section 1.4 indicates if the facility cannot meet the resident's needs, we refer them to a facility which can meet their needs if the facility has an opening for a new resident.	F 626			

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F 626	Continued From page 17	F 626			
	Facility Bed-Hold and Return to Facility Policy and Procedure copywrite 2020, indicates the facility will permit resident to return to the facility after they are hospitalized or placed on therapeutic leave.				
	Facility Resident Transfer and Discharge Policy and Procedure copywrite 2022, indicates the purpose is to ensure the residents being transferred or discharge are subject to a standardized process which ensure regulatory compliance and ethics as well as maintenance of the resident's quality of care.				
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed determine and provide adequate supervision for offsite outings, and failed conduct adequate search activities to ensure safety for 1 of 1 residents (R2) who had a history of elopement, was at risk for elopement, and left the premises without staff ' s knowledge. Findings include: R2's hospital discharge referral dated 9/16/22,	F 689	It is the policy of Wabasso Rehabilitation and Wellness Center to report all resident elopements to the Minnesota Department of Health and Ombudsman. A log of all discharges will be kept by Social Services and reported to the Ombudsman on a monthly bases. Elopement assessments and elopement care plans will be audited for completion within 48 hours of admission and quarterly. Level of supervision will be audited at the time of		1/31/23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	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
F 689	Continued From page 18 indicates R2 was on a court ordered commitment until June 2023. The referral also included R2 had eloped from an assisted living (AL) facility which resulted in hospitalization for alcohol intoxication. R2's Admission Summary progress note dated 9/28/22, indicated R2 was admitted to the facility with diagnoses that included osteomyelitis (infection in the bone), diabetes, alcohol dependence, and depression. R2's Admission Minimum Data Set dated 10/5/22, indicated R2 had moderate cognitive impairment and was independent with activities of daily living. R2's progress note dated 10/31/22, included R2 readmitted after discharging AMA approximately a week ago and was hospitalized after one night of drinking. R2 wanted to return here to complete his chemical dependency (CD) program. R2's Elopement Risk Evaluation dated 10/31/22, identified R2 was at risk for elopement. Interventions included recreational activities of interest, check in and out, and staff aware of elopement risk. Care plan updated. R2's elopement care plan initiated on 11/2/22, identified R2 was at risk for elopement related to history of attempts to leave facility unattended and impaired safety awareness. R2's goals included, safety would be maintained and R2 would not leave facility unattended through the review date. Interventions put into place were to assess elopement status quarterly and as needed. R2's triggers for eloping were his desire to consume alcohol and anxiety; de-escalate by talking with R2 and administer as needed	F 689	each outing. Residents found to be an elopement risk will remain in view of staff during outings. All Licensed staff and all other staff will be educated on the elopement policy and proper reporting through the MDH reporting page. Audits of elopement assessments and care plans as well as supervision requirement on outings prior to each outing will be audited 2 x per week x 3 then weekly x 3 and then monthly x 3. Results will be brought to the QAPI committee for review.		

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F 689	Continued From page 19 anti-anxiety medication. R2's Physician Order dated 12/5/22, directed speech therapy to evaluate and treat for cognition. A facility social service progress note dated 12/6/22, indicated R2 was on a facility outing at Walmart and went outside to talk with someone. However, when it was time to leave the activities, director could not locate him. An overhead page was done at Walmart however R2 did not respond. R2 will be discharged AMA. but when it was time to leave and return to the facility, the activity director (AD) was unable to locate R2, an overhead page was done at Walmart but R2 did not respond. R2 will be discharged AMA. Case Manager notified and cancelled appointments. R2's record did not include an assessment and/or address level of supervision R2 required during off campus activity outings to keep R2 safe and to prevent R2 from leaving unattended in accordance with R2's elopement care plan goals. Facility Reported Incidents submitted to the State Agency were reviewed; it was not evident a vulnerable adult report was completed for R2. During an interview on 12/28/22, at 10:45 a.m. AD indicated she accompanied the residents on their outing, and she was present on both 10/25/22 and 12/6/22. On 10/25/22, R2 talked with her about not returning to the facility because of wanting to see a sick family member. On 12/6/22, we were at Walmart when another resident had told her R2 had left the building about 15 minutes ago. AD walked around the parking lot, had an overhead page done, and	F 689			

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F 689	Continued From page 20 walked around the store. After 45 minutes, the AD and the rest of the residents got into the bus and returned to the facility. She notified the DON and SW that R2 was not located prior to leaving. The AD felt she handled the situation as an elopement, however, did not call the police for assistance in finding R2. AD explained unless a resident's guardian does not provide permission to go on outings, all residents were invited. Staff to resident ration during outings was two (2) staff to about 6-7 residents. Residents were not directly supervised during the outings. The AD indicated the facility did not have a policy/protocol for resident outings and did not have knowledge of any assessment to evaluate the individual resident supervision required based on the safety risk factors. During an interview on 12/27/22, at 12:30 p.m. SW indicated R2 left during a facility outing twice. The first time R2 left he got into a car with someone and told the AD he was leaving. The second time was on 12/6/22, during an outing at Walmart. We couldn ' t find him, so he was discharged AMA. SW explained R2 did not pack up any of his "stuff" and gave no indication to anyone he was leaving. Since he was on commitment the facility notified his case manager and commitment person he had not returned to the facility. The SW stated she was not aware of what happened to R2, where he went, or if R2 was safe. During an interview on 12/28/22, at 12:35 p.m. the DON indicated there was not a system or policy in place that determined level of supervision required based on individual risk factors during offsite outings. Further indicated if there was a concern about a resident during an	F 689			

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F 689	Continued From page 21 outing an extra staff member would join, however we weren ' t concerned about R2. The DON was unaware of R2's current whereabouts or if he was safe. The facility policy titled, Resident Elopement, last reviewed 6/7/22, indicates if an employee discovers that a resident is missing from the facility [this would include a facility sponsored outing], he/she shall: determine if the resident is out on an authorized leave or pass; if the resident was not authorized to leave, initiate a search of the building(s) and premises; if the resident is not located, notify the Administrator, DON, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.) and state agency; provide search teams with resident identification information and initiate an extensive search of the area.	F 689			

Minnesota Department of Health

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2 000	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 12/27/22 and 12/28/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000			

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/23

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54006569C (MN00089273 and MN00089274), with a licensing order issued at 0830 and 1925. 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 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	2 000			

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2 000	Continued From page 2 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.	2 000			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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 MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure proper supervision for 1 of 1 resident (R2) reviewed for discharge and identified at risk for elopement due to a history of leaving the facility without notice. The facility also failed to adequately attempt to locate the resident. Findings include: R2's Medical Record indicated R3 was admitted to the facility on 9/28/22, with diagnoses that	2 830	corrected	1/31/23	

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2 830	Continued From page 3 included osteomyelitis (infection in the bone), diabetes, alcohol dependence, chronic kidney disease, and depression. R2's hospital discharge referral dated 9/16/22, indicates R3 is on commitment until next June, eloped from an assisted living (AL) facility resulting in hospitalization for alcohol intoxication. R2's BIMS (brief interview of mental status) dated 9/30/22, indicated moderate cognitive impairment. R2's Elopement Risk Evaluation dated 9/28/22, indicated R3 was a low risk for elopement with the question "has the resident ever eloped from this setting or a previous setting?" marked as "no". No interventions identified. A facility progress note dated 10/25/22 at 3:31 p.m. indicates R2 was on a facility outing and told the activity director (AD) that he was not going back to the facility and walked away from the transport bus. Further indicating R2 was discharged AMA. A facility progress note dated 10/31/22, titled Admission Summary indicates R2 readmitted after discharging AMA approximately a week ago and was hospitalized after one night of drinking. He has many health conditions and did not take any medication with upon discharge. R2 wanted to return here to complete his chemical dependency (CD) program. R2's Elopement Risk Evaluation dated 10/31/22, indicates R2 is at risk for elopement with interventions applied marked as recreational activities of interest, check in and out, and staff is aware of elopement risk. Care plan updated.	2 830			

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2 830	Continued From page 4 R2's Care Plan initiated on 11/2/22, indicates R2 is an elopement risk related to history of attempts to leave facility unattended and impaired safety awareness. Goals identified were that the resident's safety will be maintained through the review date and the resident will not leave facility unattended through the review date. Interventions put into place were to assess elopement status quarterly and as needed and the resident's triggers for eloping are the desire to consume alcohol/anxiety. The resident behavior is de-escalated by talking with the resident and administering PRN (as needed) anti-anxiety medication. A facility Physician Progress Note dated 12/2/22, indicated chief complaint was a "follow-up psychiatric visit" and indicated R2 was cognitively intact. R2's Physician Order dated 12/5/22, indicated an order for speech therapy to evaluate and treat for cognition. A facility social service progress note dated 12/6/22, indicated R2 was on a facility outing at Walmart and went outside to talk with someone but when it was time to leave and return to the facility, the AD was unable to locate R2, an overhead page was done at Walmart but R2 did not respond. R2 will be discharged AMA. Case Manager notified and cancelled appointments. During an interview on 12/27/22, at 12:30 p.m., the SW indicated R2 left during a facility outing twice. The first time R2 left the outing, he got into a car with someone and told the AD he was leaving. On 12/6/22 when they left Walmart, they couldn't find him, so we discharged him AMA.	2 830			

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2 830	Continued From page 5 Further stated, R2 did not pack up any of his "stuff" and gave no indication to anyone he was leaving. He is on a commitment, so we let his case manager and commitment person know that he didn't come back to the facility. The SW stated she did not know where what happened to R2 after that and did not know his safety status as he was discharged. A confirmation of the vulnerable adult report submitted was requested but not provided. During an interview on 12/28/22, at 10:45 a.m. the AD indicated she accompanied the residents on their outing, and she was present on both 10/25/22 and 12/6/22. On 10/25/22, R2 talked with her about not returning to the facility because of wanting to see a sick family member and he has the right to leave so didn't "chase him down". On 12/6/22, we were in Walmart and another resident told the AD that R2 had left the building about 15 minutes before. The AD state she walked around the parking lot, had an overhead page done, and walked around the store but after 45 minutes, the AD and the rest of the residents got into the bus and returned to the facility. The AD felt she handled the situation as an elopement. The DON and SW were notified of R2 not being located prior to leaving. The AD further indicated unless a resident's guardian states they cannot go on facility outings, everyone is invited. The ratio of staff to resident is two (2) staff to about 6-7 residents and the residents are not directly supervised while out. The AD denied having a policy on resident outings and denied knowledge of any assessment to evaluate the individual resident supervision required based on the safety risk factors. During an interview on 12/28/22, at 12:35 p.m. the DON indicated there is not a system or policy	2 830			

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2 830	Continued From page 6 in place that determines how much supervision a resident requires on outings based on their individual risk factors. Further indicated if they have a concern about a resident going on an outing, we send an extra person, but we didn't have any concerns about R2. The DON denied knowing of R2's whereabouts or safety status. The facility policy titled, Resident Elopement, last reviewed 6/7/22, indicates if an employee discovers that a resident is missing from the facility [this would include a facility sponsored outing], he/she shall: determine if the resident is out on an authorized leave or pass; if the resident was not authorized to leave, initiate a search of the building(s) and premises; if the resident is not located, notify the Administrator, DON, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.) and state agency; provide search teams with resident identification information and initiate an extensive search of the area. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occurring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			

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21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to follow proper transfer/discharge requirements to emergency room (ER) for 1 of 1 resident (R1). The facility's failure resulted in harm when the facility discharged R1 to the ER and refused to re-admit after R1 was medically cleared which resulted in R1 spending an unnecessary 18 days in the ER.	21925	corrected	1/31/23	

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21925	Continued From page 8 Findings include Vulnerable Adult Report submitted to the State Agency on 12/9/22, at 3:15 p.m. and 3:50 p.m. alleged caregiver neglect and violation of resident rights when the facility's director of nursing (DON) and social worker (SW) transported R1 in their personal vehicle to (name of hospital) Emergency Room, which was not the closest facility for emergency situations. The report indicated the DON and SW dropped R1 off at the ER and stated they would not take him back. R1's medical evaluation was negative, and he was cleared to return to the nursing home three hours later, but the DON and SW stated they did an emergency discharge and would not take him back. R1 did not require hospitalization so remained in the ER until they could find placement for him essentially leaving him homeless. Further indicated had caused "much unneeded stress" to R1. R1's facility Admission Record identified R1 was admitted to the facility on 12/6/2022, with diagnoses that included sepsis and alcohol abuse disorder. R1 was admitted for short term rehabilitation and chemical dependency treatment. R1's Brief Interview for Mental Status date 12/8/2022, identified R1 had severe cognitive impairment. R1's Admission Functional Abilities and Goals dated 12/8/2022, identified R1 required staff assistance with dressing, bathing, using the toilet, transferring, and walking. R1's admission summary progress note dated 12/6/2022, at 2:32 p.m. indicated R1 was alert	21925			

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21925	Continued From page 9 and oriented to person and place with some confusion noted. Pleasant and cooperative with no agitation or behaviors. R1 was "very figity" (sic), moving often, and dropping things. R1's progress note dated 12/7/22, at 5:19 p.m. R1 tested positive for COVID. R1 was provided with a mask and attempted to keep R1 in his room. R1's progress note dated 12/8/22, at 1:30 a.m. indicated R1 was found sitting on the floor at 8:20 p.m. and 8:40 p.m. and was sent to the ER by ambulance at 9:00 p.m. for repeated falls. Per progress note on 12/8/22, at 3:35 a.m. R1 returned from the ER. R1's progress note dated 12/8/22, at 5:45 p.m. R1 has no active signs or symptoms of COVID; all cares provided in room with precautions. R1's discharge progress note dated 12/9/22, at 1:00 p.m. indicated R1 had been awake all night with multiple falls and requiring 1:1 staffing to ensure safety, agitated, attempting to leave facility, and not able to understand need to remain in isolation or wear a mask. Spoke with ER nurse who stated R1 was alert and oriented when he was discharged the ED earlier that morning. ER nurse stated R1's current change in cognition since hospital discharge warranted further medical evaluation. An emergency discharge form was emailed to ombudsman and attempts were made to call family. Resident was transported to the ER at 11:00 a.m. and hospital staff were informed by the director of nursing (DON) and social worker (SW) R1 had been emergently discharged from the facility to the hospital.	21925			

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21925	Continued From page 10 R1's ER physician progress note dated 12/9/2022, at 11:42 a.m. indicated R1 presented for evaluation after multiple falls at the nursing home and testing positive for COVID-19. The note also indicated nursing home staff brought patient to ER in a private car and told the hospital staff, R1 "was too much work for us to be able to care for him", and then left. ER progress notes at 2:05 p.m. identified R1 was medically cleared and would be appropriate for discharge back to the nursing home at this time. Progress note at 2:52 p.m. indicated the ombudsman had told the facility staff that R1 should be returned to their facility, but they continued to refuse. R1 would require further state intervention/appeal now so R1 could not be returned until legal proceedings force the issue, likely next week. R1's ER progress note by hospital licensed social worker (LSW) dated 12/9/2022, at 2:45 p.m. included Wabasso nursing home is refusing to take R1 back. They were filing for emergency discharge due to the fact patient has COVID-19 and will not keep a mask on or stay in his room, they feel he is a danger to other residents. LSW had been in contact with ombudsman who reported the facility's administration team were refusing to discuss readmitting R1, were not taking R1 back, and have discharged him. R1's facility record did not include nor was evident the facility re-evaluated R1's clinical/behavioral status for re-admission after the ER medically cleared and stabilized R1. During an interview on 12/27/22, at 12:30 p.m. the facility's SW stated R1 was admitted with confusion and could not walk. He then tested positive for COVID and couldn't grasp that he needed to stay in his room and keep a mask on.	21925			

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21925	Continued From page 11 Further stated R1 required 1:1 supervision and they weren't staffed for that. SW stated they knew when they dropped him off at the ER that they would not be taking him back. They were told by the ombudsman to take him back but would not accept him back even though the ER said he was medically stable. During a return call interview on 1/9/22, at 2:00 p.m. family member (FM)-A indicated R1 had been in the hospital for 18 days after the facility dropped him off. FM-A stated R1 had been bored and "antsy" to go home. Email communication dated 12/27/22, at 12:00 p.m. ER hospital licensed social worker (LSW) wrote R1 was hospitalized with no medical reason for 18 days. All 18 days of R1's hospital stay were spent trying to find him a place for him to live and secure funding (for payment). Further indicated they did not see any of the behaviors that the nursing home described. R1 had some confusion but was easily directed and physical therapy cleared him the day after hospitalization to be independent with ambulation in his room. Stated R1's family chose not to appeal due to the way the facility discharged/dumped him. During a follow-up telephone interview on 1/10/22, with hospital LSW stated while R1 was waiting for placement he was clearly bored. He was confined to a small area limited to his room and the lounge. The only people he got to have conversations with was hospital staff. He was very lonely and "bummed" he had to stay there. LSW referred to hospital record; After about a week, he started having problems with sleep, he started feeling more confined, and anxious so his Seroquel (antipsychotic) had to be increased from 25 mg (milligrams) to 50 mg every night at bedtime. Psychiatry followed-up on 12/23/22, he	21925			

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21925	Continued From page 12 had improved sleep however, still was feeling confined and bored. He was very excited to leave. During an interview on 12/27/22, at 1:00 p.m. the DON indicated the facility does not provide 1:1 staffing and R1 wouldn't comply with the COVID restrictions. Further indicated the ombudsman contacted her and asked them to take R1 back after he was medically cleared but had already discharged him to protect the other residents (related to COVID). The DON further indicated R1 was not reevaluated for readmission to the NH although medically cleared for admission by the ED. During an interview on 12/27/2022, at 1:10 p.m. the Administrator indicated she was aware of the emergency discharge of R1. Further indicated R1 was belligerent, on the floor constantly, restless, and delusional about where he was during his stay at the facility. During an interview on 12/28/22, at 4:21 p.m. Ombudsman indicated she had contacted the facility SW and DON and told them this was an inappropriate discharge and they needed to take R1 back once he had been medically cleared. DON and SW told her R1 had already been discharged and were not taking him back and refused to discuss the matter any further. Facility Assessment Tool dated 8/2022, included a listing of diseases and conditions for which the facility could manage, treat, and had resources to meet the resident's needs with specified diseases and conditions. Section 1.3 included identified those diseases and conditions which include impaired cognition, mental disorders, behaviors that need interventions. Section 1.4 indicates if the facility cannot meet the resident's needs, we	21925			

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21925	Continued From page 13 refer them to a facility which can meet their needs if the facility has an opening for a new resident. Facility Bed-Hold and Return to Facility Policy and Procedure copywrite 2020, indicates the facility will permit resident to return to the facility after they are hospitalized or placed on therapeutic leave. Facility Resident Transfer and Discharge Policy and Procedure copywrite 2022, indicates the purpose is to ensure the residents being transferred or discharge are subject to a standardized process which ensure regulatory compliance and ethics as well as maintenance of the resident's quality of care. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21925			