

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 05/21/2024
NAME OF PROVIDER OR SUPPLIER Wabasso Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 660 Maple Street Wabasso, MN 56293	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998</p> <p>Based on interview and document review the facility failed to report an allegation of abuse to the State Agency (SA) for 1 of 1 resident (R1) reviewed for allegations of neglect.</p> <p>Findings include:</p> <p>A Vulnerable Adult Maltreatment Report submitted to the State Agency on 4/26/24, by an undisclosed person alleged R1 was sexually and physically abused in the facility.</p> <p>R1's Quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment and no noted behaviors. R1 required staff assist with eating, toileting, and transferring.</p> <p>The facility's Incident Report Log identified on 4/29/24, alleged abuse of R1 with the comment, MAARC report filed against us.</p> <p>The facility's investigative note dated 4/29/24, indicated the social service designee (SSD) was notified by the county's sheriff department of the allegation of abuse at 11:48 a.m. The director of nursing and administrator were notified.</p> <p>During an interview on 5/21/24 at 12:15 p.m., the SSD stated the county sheriff came to the facility on [DATE] and informed them of a report of alleged abuse against R1. Further stated it [allegation of abuse] had already been reported [to the SA] so we did not need to [report it to the SA]. The SSD initiated a facility internal investigation of the abuse allegation.</p> <p>During an interview on 5/21/24 at 1:35 p.m., the director of nursing (DON) indicated on 4/29/24, they were informed that R1 was allegedly being abused. Further stated, we did not know we had to [report to the SA] because it had already been reported by an outside facility.</p> <p>During an interview on 5/21/24 at 2:43 p.m., the administrator indicated she was notified of the allegation of abuse on 4/29/24. Further stated her team discussed reporting the allegation to the SA but concluded the SA already knew about the allegation so initiated an investigation of the allegation but did not report to the SA.</p> <p>(continued on next page)</p>

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.

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

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 05/21/2024
NAME OF PROVIDER OR SUPPLIER Wabasso Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 660 Maple Street Wabasso, MN 56293	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program last revised 4/2021, indicated the facility was to investigate and report any allegations within timeframes required by federal requirements.</p>