STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wabasso Restorative Care Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review the facility failed to ensure residents were free and protected from physical abuse for 2 of 3 residents (R2 and R3) reviewed for resident-to-resident abuse when on two separate occasions R1 physically abused R2 and R3. Additionally failed to implement protection measures according to R1's care plan to prevent re-current physical abuse. Findings Include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, did not have sign/symptoms of delirium, and did not have behaviors. The MDS further indicated R1 was independent with walking, toileting, transferring, and personal cares with no upper or lower body impairments. Diagnoses included anemia, diabetes, depression, histrionic personality disorder (a mental health condition characterized by overwhelming desire to be noticed and dramatic behavior), nicotine dependence, and mild cognitive impairment. R1's care plan last updated 6/7/24, indicated R1 was at risk for abuse due to vulnerable adult status. Interventions included to anticipate and meet needs as able and not to have me near others who disturb me. The care plan also identified R1 had a potential to be verbally aggressive, yelling, and had an actual physical altercation with another resident. R1's Social Service Note dated 8/29/24 at 5:27 p.m., identified R1 was told she was not able to smoke anymore due to doctor's orders. R1 became verbally and physically upset. R1's daughter and guardian were notified R1 was to stop smoking due to safety reasons and R1's cigarettes were removed from her room. R1's Nursing Note dated 8/31/24 at 5:47 p.m., indicated residents reported R1 hit R3 in the ankle three times with a rock. R1 admitted to hitting R3 with the rock because R3 would not allow R1 to sit next to her. Staff notified the sheriff's department and R1 was transported to the emergency department (ED) for evaluation. Further indicated, prior to this incident around 12:00 p.m., a resident had reported to the nurse that R1 had a rock. R1 told the nurse she wanted to us [use] the rock to hurt someone if she needed to but also said that she wanted to decorate it. The nurse took the rock from R1. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nursing Note dated 8/31/24 at 11:00 p.m., indicated R1 returned from the ED with new medication orders for and antibiotic for cystitis and Remeron at bedtime for aggressive behaviors. Further stated R1 will be alone in her room for the safety of others and placed on 15-minute checks. R1's care plan was revised on 9/1/24 to include R1 needed 1:1 staff supervision at all times when resident was outside in the smoking area and 15-minute checks were to be completed until a new safety plan was established/evaluated as needed. Staff were also to remove any objects that could potentially cause resident injury or cause resident to injure others with her personal belongings. Review of the facility reported incident dated 8/31/24, indicated R1 hit R3 on the ankle with a rock while in the designated smoking area. R3's Quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had severe cognitive impairment, used a walker independently, and had diagnoses that included nicotine dependence and anxiety. Facility internal investigation submitted the State Agency (SA) identified R1 was put on 15-minute checks, moved closer to the nursing station, and removed any rocks bigger than a fist from the rock garden in the smoking area. R1's Nursing Noted dated 9/1/24 at 11:34 a.m., indicated the nurse was informed by other residents in the smoking area that R1 hit R2 in the face while out in the outside smoking area. Staff removed R1 from the smoking area and was placed in the facility's lobby area but due to R1's crying, agitation, and disruption staff took her to her room with 1:1 supervision until R1 transferred to the ED. R1 was noted to have a bloody nose and stated that R2 had also hit her in the nose. Review of the facility reported incident dated 9/1/24, indicated R1 punched R2 in the face during an altercation in the designated smoking area. R2 then punched R1 in the face as a response resulting in R1 having a bloody nose. The facility also identified staff were to supervise all residents during designated smoking times. R2's significant change MDS indicated R2 did not have cognitive impairment, required the use of a wheelchair, had range of motion impairment to one lower extremity, and had diagnoses of nicotine dependence and anxiety disorder. The facility internal investigation submitted to the SA identified R1 was sent to the hospital for evaluation and denied hitting anyone. R1 was moved to a different room and supervised during smoking. In addition, an all-resident meeting was held, and resident's rights reviewed. R1's Behavior Charting dated 9/2/24 at 8:36 a.m., identified R1 went to another resident's room and took cigarettes. R1 returned to room and started smoking the cigarettes. During observation and interview on 9/24/24 at 11:55 a.m., R1 was sitting on the bed with a pack of cigarettes and a lighter sitting next to her on the bed. R1 stated a friend gave them to her. R1 admitted to going outside to smoke about 4-5 times a day and did not have staff with her when she smokes. R1 denied knowing that she was not to smoke and denied any difficulties with any of the other residents while out in the smoking area. During an observation on 9/24/24 at 1:17 p.m. R1 wheeled independently outside to the designated smoking area, R3 immediately came into the facility from the smoking area. R1 was observed sitting in her wheelchair on the sidewalk by the rock garden, lighting, and smoking two cigarettes with no observation of staff supervision. Five other residents were outside smoking in the same area. R1 re-entered the facility at 1:36 p. m. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/24 at 2 p.m., R2 described R1 punching her in the nose. R2 indicated the facility took R1's cigarettes away so R1 tries to beg or steal other resident's cigarettes. R2 further explained that on 9/1/24, she was putting her cigarette butt into the disposal receptacle when R1 tried to take the butt out of the receptacle, R2 attempted to put an ice cube in it and R1 punched her in the face. Then out of reflex, R2 punched R1 in the face. R2 indicated as a result she experienced a headache for a couple of days. R2 denied any staff supervision while R1 was smoking. During an interview on 9/23/24 at 1:35 p.m., R3 shared an incident that occurred on 8/31/24, when R1 and R3 were in the outside smoking area and R1 took a big rock and smashed my ankle three times. Further indicated staff were not present at the time of the incident and the facility staff continued to allow R1 go out to the smoking area 3-4 times a day without supervision. R3 indicated the facility took away everyone's smoking privileges because of R1's behavior by limiting the times they could smoke. R3 continued to explain she feared R1 and after the incident with the rock, will come back in the building as soon as R1 comes outside to the smoking area. R3 indicated there were about 20 residents that went out regularly to smoke and no one wanted to be near R1 because of her unpredictable anger. R3 indicated she felt the facility did not do anything to correct R1's behavior and had observed R1 grabbing rocks out of the rock garden in the smoking area the previous day (9/22/24). R3 further clarified R1 was not supervised by staff while smoking and picking up the rocks. During an interview on 9/23/24 at 3:30 p.m., R4 indicated he felt safe in the smoking area unless R1 was outside. R4 further indicated R1 is a ticking timebomb. R4 explained R1 did not always have staff supervision outside, would try to steal other resident's cigarettes and lighters, and had unpredictable anger outbursts. R4 identified R1 hit R2 with a rock and the next day hit R3 in the face because she would not give R1 a cigarette. During an interview on 9/23/24 at 3:35 p.m., R5 indicated R1 did not have staff supervision when she smoked outside, and he did not feel safe when R1 was outside. R5 did not elaborate any further. During an interview on 9/23/24 at 3:49 p.m., R6 indicated R1 was a danger to herself and others because we never know when she is going to explode and start threatening us. R6 further indicated staff do not supervise R1 while smoking outside. During an interview on 9/24/24 at 2:54 p.m., R7 indicated he recently discharged from the facility but, witnessed the incident regarding R1 and R3 on 8/31/24. R7 identified R1 was outside smoking when the director of nursing (DON) took cigarettes away from R1. R1 became upset and started hitting the DON so the DON took the cigarettes and went back into the facility. R1 was upset and started backing her wheelchair between R7 and R3 but there was not enough room and R1 keep pushing back and running over their feet. R3 then put her foot up on the wheel of the wheelchair to prevent R1 from rolling back when R1 took a fist sized rock out of her wheelchair and hit R3 ankle three times. An unidentified resident opened the door to hell at staff for help. R7 stated staff responded and R1 threw herself to the ground and started banging her head on the cement. (continued on next page)

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	245400	A. Building B. Wing	09/24/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/24 at 2:50 p.m., nursing assistant (NA)-A indicated did not witness either incident, but it was reported to her that R1 hit R3 with a rock and then hit R2 and busted her glasses the next day. Further indicated she thought R1 had a motivated plan, she [R1] is mean. NA-A further identified there were about 25 residents who smoke outside in the designated smoking area, but many will not go out there when R1 is there smoking. The facility set up a staff supervised smoking schedule after the incidents but that caused more arguments among the residents, so it was discontinued. NA-A further explained that R1 was observed falling asleep with a lit cigarette and ashes would drop on her clothes so R1 was supposed to wear a smoking apron but refused. NA-A identified the new plan was to check on R1 every 5 minutes or so but she is quick, and we do not always know she is out there [smoking area]. During an interview on 9/24/24 at 11:22 a.m., NA-B indicated R1 did go outside to smoke independently but after the first incident, the facility started 1:1's but R1 was quick and got outside without staff knowing. Further identified that R1 continued to smoke outside without supervision and stated, nobody said anything to me, so I have not been physically watching her smoke. NA-B indicated R1 hits and punches staff and other residents and the behaviors were getting worse. During an interview on 9/24/24 at 12:06 p.m., NA-C stated if R1 goes outside to smoke, we are supposed to check on her every so often to make sure she is safe and that everyone else around her is ok having her (R1) around. NA-C further indicated there was not a certain time limit to check on her, just every so often so it depended how busy the staff were. During an interview on 9/24/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated, R1 had her own cigarettes and staff tried to catch her when she went outside to smoke and check on her once in a while. LPN-A indicated R1 did not have 15-minute safety checks and did not know where the safety checks would be documented. During an interview on 9/23/24 at 3:04 p.m., registered nurse (RN)-A indicated the facility had tried to take R1's cigarettes away but she keeps getting them. Further identified R1 is not safe to smoke independently and they try to have someone with her but that is not always possible. During an interview on 9/23/24 at 4:00 p.m., Social Service Designee (SSD) indicated R1's behaviors all surround smoking and the doctor had ordered R1 not to smoke because of R1's health and safety. The SSD further identified R1 should not have a lighter or cigarettes, but the facility cannot control what gets brought into the building. R1 has been noted to smoke in the building at times. Further indicated the facility investigation identified R1 did hit R2 with a rock and punched R3 in the face with full intent. SSD further explained after the incident on 9/1/24, the facility implemented designated smoking times for all residents so staff could supervise all of them but lifted that restriction on the Friday after the incident (9/6/24). SSD indicated R1 could go outside to the smoking area to smoke without supervision but had to be monitored by staff. SSD identified she did not know how often the staff were monitoring R1 smoking. During an interview on 9/24/24 at 9:14 a.m., R1's primary medical doctor (MD) indicated he did not recall writing an order that R1 could not smoke but was concerned more about her safety risk for smoking. R1's MD further indicated R1 is a danger to the other residents and herself and staff should always be supervising R1 during smoking. (continued on next page)

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	245400	A. Building B. Wing	09/24/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/24 at 11:55 a.m., the DON indicated she became aware of the incident on 8/31/24 when the residents were yelling for help in the designated smoking area. Further explained R1 had a huge rock with sharp edges in her hand and had hit R3 in the ankle three times. Further indicated R1's behaviors ebb and flow and they are at a loss at what to do. R1 was noted to have smaller rocks under her wheelchair cushion that were provided to law enforcement when they arrived. The DON further indicated R1 was medicated with an antianxiety medication and transported to the ED for evaluation then upon R1's return, staff did 15-minute checks on R1 but was not sure if R1 had more cigarettes or a lighter in her possession. The DON further indicated staff are supposed to physically be with R1 when outside smoking, but staff cannot always catch R1 when she goes out to smoke. The facility's undated policy, Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure indicates the facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in the policy. Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to , verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating; Physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; rummaging through others properties and wandering into other's rooms/spaces. The policy further identifies the abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately: the facility will increase enforcement action, including but not limited to: Taking steps to prevention further potential abuse. Conducting a thorough investigation of the alleged violation Taking appropriate corrective action Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on observation, interview, and document review the facility failed to implement and provide adequate supervision and safety interventions for 1 of 3 residents (R1) reviewed for smoking. Findings include R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, did not have sign/symptoms of delirium, and did not have behaviors. The MDS further indicated R1 was independent with walking, toileting, transferring, and personal cares with no upper or lower body impairments. Diagnoses included anemia, diabetes, depression, histrionic personality disorder (a mental health condition characterized by overwhelming desire to be noticed and dramatic behavior), nicotine dependence, and mild cognitive impairment. R1's care plan last updated 8/29/24, indicated R1 had been deemed unsafe to smoke by her physician. The goal was that R1 will not smoke. The interventions were to review smoking policy as needed and with any changes, R1 cannot smoke unsupervised and independently, and notify charge nurse immediately if it is suspected R1 has violated facility smoking policy. The care plan also identified R1 had a potential to be verbally aggressive, yelling, and had an actual physical altercation with another resident. The interventions updated on 9/1/24, identified R1 needed 1:1 staff supervision always when resident was outside in the smoking area. R1's Smoking Review dated 8/16/24, indicated R1 smoked 3-4 times a day and had a history of smoking related incidents such as burning clothing, smoking in bed, and dropping ashes on self. The recommendation was R1 not safe to smoke and provider notified. R1's Nursing Note on 8/28/24 at 1:44 p.m., indicated R1 was informed of the safety concerns observed while smoking and not passing the smoking assessment. Offered nicotine patches/gun [gum] but refused. Will continue to monitor/educate on safe smoking. R1's Physician's Note dated 8/28/24 at 10:42 p.m., identified R1 was observed falling asleep while walking with a cigarette in her mouth. Plan was to notify R1's guardian of the need to revoke smoking privileges due to safety concerns and of the possible need for new placement as R1 was likely to refuse cessation of smoking privileges. R1's Social Service Note dated 8/29/24 at 5:27 p.m., identified R1 was told she was not able to smoke anymore due to doctor's orders. R1 became verbally and physically upset. R1's daughter and guardian were notified R1 was to stop smoking due to safety reasons and R1's cigarettes were removed from her room. R1's Behavior Charting dated 9/2/24 at 8:36 a.m., identified R1 went to another resident's room and took cigarettes. R1 returned to her room and started smoking the cigarettes. (continued on next page)

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	245400	A. Building B. Wing	09/24/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 9/24/24 at 11:55 a.m., R1 was sitting on the bed with a pack of cigarettes and a lighter sitting next to her on the bed. R1 stated a friend gave them to her. R1 admitted to going outside to smoke about 4-5 times a day and did not have staff with her when she smokes. R1 denied knowing that she was not to smoke. During an observation on 9/24/24 at 1:17 p.m., R1 wheeled independently outside to the designated smoking area. R1 was observed sitting in her wheelchair on the sidewalk by the rock garden, lighting, and smoking two cigarettes with no observation of staff supervision. Five other residents were outside smoking in the same area. R1 re-entered the facility at 1:36 p.m. During an interview on 9/23/24 at 2:00 p.m., R2 described R1 punching her in the nose on 9/1/24. R2 indicated the facility took R1's cigarettes away so R1 would beg or steal other resident's cigarettes. R2 further explained she was putting her cigarette butt into the disposal receptacle when R1 tried to take the butt out of the receptacle, R2 attempted to put an ice cube in the receptacle when R1 punched her in the face. R2 denied any staff supervision while R1 was smoking that day. During an interview on 9/23/24 at 1:35 p.m., R3 shared an incident occurred on 8/31/24, when R1 and R3 were in the outside smoking area and R1 took a big rock and smashed my ankle three times. Further indicated staff were not present at the time of the incident and the facility staff continued to allow R1 go out to the smoking area 3-4 times a day without supervision. During an interview on 9/23/24 at 2:50 p.m., nursing assistant (NA)-A indicated that R1 was observed falling asleep with a lit cigarette and ashes would drop on her clothes. Further indicated R1 was supposed to wear a smoking apron but refused. NA-A identified the new plan was to check on R1 every 5 minutes or so but she is quick, and we do not always know she is out there [smoking area]. During an interview on 9/23/24 at 3:04 p.m., registered nurse (RN)-A indicated the facility has tried to take R1's cigarettes away but she keeps getting them. Further identified R1 is not safe to smoke independently and they try to have someone with her but that is not always possible. During an interview on 9/23/24 at 3:30 p.m., R4 indicated R1 did not always have staff supervision outside and would try to steal other resident's cigarettes and lighters. During an interview on 9/23/24 at 3:35 p.m., R5 indicated R1 did not have staff supervision when smoking outside. During an interview on 9/23/24 at 3:49 p.m., R6 indicated staff do not supervise R1 while smoking outside. During an interview on 9/23/24 at 4:00 p.m., Social Service Designee (SSD) indicated R1 should not have a lighter or cigarettes, but the facility cannot control what gets brought into the building. R1 has been noted to smoke in the building at times. SSD indicated R1 could go outside to the smoking area to smoke without supervision but had to be monitored by staff. The SSD explained she did not know how often the staff were monitoring R1 while smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/24 at 9:14 a.m., R1's primary medical doctor (MD) indicated he did not recall writing an order that R1 could not smoke but was concerned more about her safety risk for smoking. R1's MD further indicated R1 is a danger to the other residents and herself and staff should always be supervising R1 during smoking. During an interview on 9/24/24 at 11:22 a.m., NA-B indicated R1 did go outside to smoke independently but after the first incident the facility started 1:1's but R1 was quick and got outside without staff knowing. Further identified that R1 continued to smoke outside without supervision and stated, nobody said anything to me, so I have not been physically watching her smoke. During an interview on 9/24/24 at 12:06 p.m., NA-C stated if R1 goes outside to smoke, we are supposed to check on her every so often to make sure she is safe and that everyone else around her is ok having her (R1) around. NA-C further indicated there was not a certain time limit to check on her, just every so often so it depended how busy the staff were. During an interview on 9/24/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated, R1 had her own cigarettes and staff tried to catch her when she went outside to smoke and check on her once in a while. LPN-A indicated R1 did not have 15-minute safety checks and did not know where the safety checks would be documented. During an interview on 9/24/24 at 11:55 a.m., director of nursing (DON) indicated R1 could go out and smoke independently until the 9/1/24 incident (resident to resident abuse). The DON further indicated after that incident, staff were supposed to physically be with R1 when outside smoking, but staff cannot always catch R1 when she goes out to smoke. The facility's policy titled, Resident Smoking Policy last revised 8/24, indicated it is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protection apply to smoking and non-smoking residents. Compliance guidelines include: Residents who smoke will be further assessed using the Resident Assessment to determine whether supervision is required for smoking, or if resident is safe to smoke at all. Any resident who is deemed safe to smoke with or without supervision, will be allowed to smoke in designated smoking areas, at designated times, and in accordance with his/her care plan. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or evaluated whether any additional safety measure are indicated. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. The interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by including the resident, family, or representative regarding the risk associated with smoking; offering pharmacological and/or behavioral interventions to assist with smoking cessation; developing a safe smoking plan, or an individualized plan to quit smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated policy titled Smoking Policy-Residents, indicated the facility has established and maintains safe resident smoking practices. Cigarette butts and lighters are not permitted in the building. Violations will result in smoking privileges being revoked. Personal lighters will be held at the nurse's station. Resident smoking status is evaluation upon admission. If a smoker, the evaluation includes current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). The staff consults with the attending physician and the DON to determine if safety restrictions need to be placed on a resident's smoking privileges based on . this was the end of the policy with no further information provided by facility.