

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 11/18/2024
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 0586</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not prohibit or in any way discourage a resident from communicating with federal, state, or local officials.</p> <p>34083</p> <p>Based on interview and document review, the facility failed to ensure 1 of 1 resident (R18) was provided communication with the county care coordinator (CC) and those communications were not discouraged or obstructed, when multiple attempts were made to contact R18 without success.</p> <p>Findings include:</p> <p>Review of a 5/20/24, State Agency (SA) report identified on 5/26/24 the care coordinator (CC) for R18 had telephoned the facility and spoke with an unidentified charge nurse leaving contact information for R18 to return the call. The social services designee (SSD) then emailed CC that R18 had attempted to return her call, but she was on another line. The CC then received another email from the SSD, which stated, I have asked you repeatedly to direct these types of needs to me and only me, please honor and respect this. Our nurses are extremely busy providing cares to our resident and cannot be available to get resident for phone calls that are not time sensitive or family members. If I am out of the office, you will get a notification who to direct your request to. If you have any questions or concerns, I have cc' d our director of nursing (DON) on this message SSD.</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
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<p>F 0586</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and email correspondence review on 11/15/24 at 8:44 a.m. with the CC reported she had difficulty contacting her clients to review a change, and when she had attempted to contact the SSD as directed on 5/17/24 at 2:31 p.m., 3:42 p.m., 4:01 p.m., and 4:22 p.m. the SSD failed to answer and there was no notification of who should be contacted as she was out of the office. This resulted in R18 not being able to receive calls from his CC as there was no response. The CC reported she had attempted to call her client again on 5/20/24 at 9:27 a.m., and 2:43 p.m., there was no answer and she received the same voicemail as prior attempts. The 7th attempt to contact the SSD was transferred by unknown facility staff and the SSD was finally able to be reached at 2:51 p.m. and reported R18 was not available for the next half hour and contact information was left to have him return the call. The CC failed to receive a return call and as a result went to the facility later that afternoon to meet with R18 in person. R18 reported, only time I received a message to call you was last week. I just got your voicemail from [5/16/24]. R18 reported he had not received any notification of a call from the CC on 5/20/24, nor had he received any of the seven messages left by the CC. The CC expressed her frustration when her clients were not able to be accessed, or receive and make calls at the facility. She reported she believed her client was being denied access to services due to the call restrictions and it was possible this could also effect other residents in the facility. Review of the email dated 5/16/24 from the SSD to the CC identified she was informed by the SSD she was the only person to be contacted for follow-up to contact a client. The CC reported she had attempted to contact administration and left a message, but she had not received a return a call from the administrator either.</p> <p>Interview on 11/13/24 at 9:54 a.m. with R18 identified he was not aware of problems with making or receiving phone calls and identified he was not told about the repeated contact attempts from CC. He did have his own cell phone and was able to make or receive calls if aware he needed to call someone or receive a call. He was unaware if the CC had attempted to contact him on his personal cell or if they even had his personal cell information.</p> <p>Interview on 11/13/24 at 10:32 a.m., interview with trained medication aid (TMA)-A reported phone calls were answered by nursing staff and a resident was able to take the call in the Salon room where there was privacy. R18 was independent with Activities of Daily Living (ADL) and no behaviors noted. She reported she was not aware of any directive to forward calls to the SSD from CC's.</p> <p>Interview on 11/12/24 at 1:30 p.m. interview with licensed practical nurse (LPN)-A reported nursing staff and other staff answer the phone and would inform the resident they had a call or they could return a call to the requested person on the private line in salon if they desired. LPN-A denied any requirement to refer a call to any staff or had been directed by the SSD to only leave a message with a specific facility staff person.</p> <p>Interview 11/13/24 at 3:43 p.m. with the SSD reported the facility had a resident phone line, and a resident could choose who they wanted to speak with. The SSD reported a CC, a guardian, etc could call and speak with anyone and she handled questions that pertained to areas she was responsible for. The SSD reported anyone could answer the phone and calls could also be forwarded to her if staff needed to do so. She reported Resident Rights were provided to residents in the admission packet and they had the right to receive phone calls, unless they identified someone they did not want to receive calls from. Case managers, county social workers, etc were to be able to call and speak with anyone. Resident rights are provided to residents at the time of admission.</p> <p>(continued on next page)</p>		

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<p>F 0586</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Resident Rights information provided in the Resident [NAME] of Rights identified residents may communicate privately with persons of their choice. There is to be access to a telephone where residents can make and receive calls as well as speak privately.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>39988</p> <p>Based on interview and document review, the facility failed to ensure the required number of staff determined by their facility assessment had been scheduled and maintained on the weekends.</p> <p>Findings include:</p> <p>Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D quarter 3 (April 1st through June 30th) identified excessively low weekend staffing had triggered.</p> <p>Review of the August 2024, Facility Assessment identified the facility had only 2 shifts day shift 6:00 a.m. to 6:00 p.m. and night shift 6:00 p.m. to 6:00 a.m., the staffing plan for basic number of staff, the departments' daily staff, except the manager's position was as follows:</p> <p>Day shift 6:00 a.m. to 6:00 p.m.</p> <p>Registered nurse (RN) or licensed practical nurse (LPN) charge nurse=2</p> <p>Trained medication aide (TMA) and/or nursing assistant (NA) direct care staff =3</p> <p>Night shift 6:00 p.m. to 6:00 a.m.</p> <p>RN or LPN = 1</p> <p>TMA/NA direct care staff =2</p> <p>Review of the working schedules and timecards for weekend days during quarter 3 identified less than the amount of identified staff worked for 12 of 26 weekend dates.</p> <ol style="list-style-type: none"> 1) 4/13/24 (Saturday) Day shift had 1 RN or LPN charge. 2) 4/14/24 (Sunday) Day shift had 1 RN or LPN charge 3) 4/27/24 (Saturday) Day shift had 1 RN or LPN charge 4) 4/28/24 (Sunday) Day shift had 1 RN or LPN charge 5) 5/11/24 (Saturday) Day shift had 1 RN or LPN charge 6) 5/12/24 (Sunday) Day shift had 1 RN or LPN charge 7) 5/25/24 (Saturday) Day shift had 1 RN or LPN charge 8) 5/26/24 (Sunday) Day shift had 1 RN or LPN charge <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9) 6/8/24 (Saturday) Day shift had 1 RN or LPN charge</p> <p>10) 6/9/24 (Sunday) Day shift had 1 RN or LPN charge</p> <p>11) 6/22/24 (Saturday) Day shift had 1 RN or LPN charge</p> <p>12) 6/23/24 (Sunday) Day shift had 1 RN or LPN charge</p> <p>There was no second nurse on duty these dates per the facility assessment.</p> <p>Interview on 11/14/24 at 4:30 p.m., with the administrator reported she reached out to the person in charge of PBJ in the company and he reported to her that the low weekend staffing was a result of the census, and the facility did not cut hours anymore since COVID. She further revealed he had reported to her that there was only a 3-minute difference of time between weekday staffing and weekend staffing. Additional interview on 11/18/24, identified she would expect the staffing to be followed according to the facility assessment however, she was unaware that the facility assessment identified 2-day licensed nurses. She stated the PBJ could not have triggered low weekend staffing as it was the same all the time. Following discussion and review of time punches for RN-A it was identified that every other weekend had 2 licensed nurses on duty during the day shift and the opposite weekend had 1 licensed nurse on the day shift. The administrator reported that should not matter because RN-A punched in as a manager like she did during the week, so she felt there had to be some sort of inaccurate data submitted however, she was unsure of what that might be. She further stated she needed to correct the facility assessment because the facility had never scheduled 2 licensed nurses on the day shift.</p> <p>Review of undated, Payroll Based Journal policy identified the facility was to electronically submit to CMS complete and accurate direct care staffing information, including agency and contracted staff, based on payroll and other verifiable and auditable data according to specifications established by CMS. The administrator, HR director, and director of nursing were responsible for verifying accuracy of the staffing data that was submitted to CMS using various facility audit forms and/or payroll vendor reports. The business office manager was responsible for verifying the accuracy of the census data. Reports through CASPER may be utilized to assist with verifying data. The administrator was responsible for reviewing and ensuring that any needed corrections are made before the quarterly deadline.</p>		