

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 12/24/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336</p> <p>Based on observation, interview, and document review, the facility failed to assess 1 of 1 resident (R1) with a known history of substance use/abuse to identify signs and symptoms and potential affects from substance abuse, identify efforts to prevent substance use, and revise his care plan when R1 was found to be intoxicated from alcohol after having been on day-leave from the facility.</p> <p>Findings include:</p> <p>Review of the [DATE] at 5:17 p.m., report to the State Agency (SA), identified R1 was wheelchair bound when he had left the facility. R1 was discovered by law enforcement at the bar and was found to be intoxicated. R1 had left the bar and proceeded to make his way back to the facility in his wheelchair and was found 3 blocks away, from the nursing home, in the middle of the road. Law enforcement had assisted R1 to the nursing home when facility staff did not assist R1 back to the facility.</p> <p>R1's [DATE] at 7:42 p.m., progress note identified R1 had arrived at the facility intoxicated and was asleep. The facility had orders to hold R1's medication that evening. There was no mention of monitoring R1's condition related to the state of his intoxication. In addition, the facility had lacked documentation of protocols that were implemented to potentially prevent the occurrence.</p> <p>Interview on [DATE] at 10:43 p.m., with licensed practical nurse (LPN)-A identified she was the charge nurse on duty on [DATE]. She was not aware that R1 had signed out of the facility that afternoon. She was aware R1 had arrived to the facility between 5:00 p.m. and 6:00 p.m., alone, before the shift change had occurred. R1 was noted by staff to have had the smell of alcohol on his clothing and was asleep in his bed. During handover report to the oncoming night nurse, she had informed the nurse to observe and monitor R1 during the night for changes in his condition.</p> <p>R1's [DATE], admission Minimum Data Set (MDS) identified R1 was cognitively intact and had no behaviors. R1 had used a wheelchair and was independent with most of his Activities of Daily Living (ADL). R1 had little interest or pleasure in doing things and had felt down, depressed, or hopeless, never to 1 day. R1 had diagnoses of anxiety, depression, and post-traumatic stress disorder (PTSD).R1 also was noted to have histories of opioid abuse, cocaine abuse, and other stimulant abuse.</p> <p>R1's vital sign report identified staff had taken his vital signs on the following dates. On:</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1) [DATE] at 11:10 p.m., a blood pressure (BP) ,d+[DATE] millimeters of mercury (mm/hg), temperature of 97.8 degrees Fahrenheit (F), respirations 18 per minute, and an oxygen saturation (SpO2) of 94 % via nasal cannula on oxygen.</p> <p>2) [DATE] at 3:40 a.m., (2 days after the incident) staff noted R1 had a BP of ,d+[DATE] mm/hg, temperature of 97.6 degrees F, respirations of 16 per minute, and an SpO2 of 96% on room air.</p> <p>There was no documentation to support staff had obtained vital signs or performed assessments to monitor R1 after he had returned to the facility on [DATE].</p> <p>Interview on [DATE] at 12:37 p.m., with R1 identified he along with 2 other residents, had signed out of the facility on [DATE] and had wheeled themselves to the local bar in town. The social service designee (SSD) and the director of nursing (DON) had arrived at the bar and scolded him in front of other patrons at the bar. He was upset and had left the bar and was told to wheel himself back to the facility. The SSD had followed behind him on the road in a vehicle back to the facility. While this was occurring, law enforcement had pulled up next to him in their vehicle on the side of the road and asked if he needed assistance. R1 had informed law enforcement he needed assistance back to the facility and upon his arrival, he had passed out.</p> <p>R1's [DATE] sign in and out form identified R1 had left the facility at 1:24 p.m There was time stamped on the form verifying when R1 had returned to the facility.</p> <p>Interview on [DATE] at 1:37 p.m., with nursing assistant (NA)-A identified she was informed during handover report from the off-going shift that several residents were found to be intoxicated at the facility. NA-A stated if a resident was found by NA's to be intoxicated, they would inform the charge nurse.</p> <p>Interview on [DATE] at 2:19 p.m., with registered nurse (RN)-A identified most residents admitted to the facility have a history of substance abuse. She agreed R1's care plan lacked interventions to prevent potential substance abuse, what staff should do if substance abuse was suspected, or what staff should monitor for or how long they would be require to monitor a resident with potential for or actual substance abuse.</p> <p>R1's undated, care plan identified had substance abuse/dependence of opioid, cocaine and other stimulant abuse and was in remission. Interventions was for staff to encourage R1 to identify self-stabilizing activities during group activities, identify and model health activities to combat boredom and lack of self-stimulation, and redirect inappropriate behaviors as needed. There were no interventions identified on what signs and symptoms staff should observe for in order to prevent potential abuse, monitoring if abuse of substances occurred, or interventions placed. There was also no update to R1's care plan following the incident on [DATE].</p> <p>Interview on [DATE] at 3:48 p.m., with the social services designee (SSD) was in her vehicle and had observed R1, who wheeled himself on 854 pine street, heading towards the facility. She had offered to assist R1 back to the facility and confirmed that R1 had refused on several occasions. She identified the local law enforcement officer had parked on the side of the street. R1 allowed the officer to assist him back to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further interview on [DATE] at 4:37 p.m., with LPN-A stated she would complete vital signs on a resident who was intoxicated, call the physician of her findings, and would wait for instructions from the provider. In addition, she was not aware of how long staff needed to monitor the resident. LPN-A was unaware of any interventions placed to help prevent substance abuse for R1.</p> <p>Further interview on [DATE] at 4:39 p.m., with RN-A stated the facility does not have a protocol in place to monitor residents who were under the influence of alcohol or drugs. She assumed nurses would need to check and monitor a resident, possibly every 2 hours but was unsure.</p> <p>Review of February 2023 Safety for Residents with Substance Use Disorder indicated the facility staff would be prepared to address emergencies related to substance use, initiation of Cardio Pulmonary Resuscitation (CPR) and was to contact emergency medical services. There was no mention in the policy how the facility would address specific interventions for potential or actual substance abuse, interventions to prevent further substance abuse, or interventions if the substance abuse occurred.</p>		