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	05/28/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on interview, observation and document review, the facility failed to ensure adequate supervision and a comprehensive assessment was completed to help prevent resident to resident sexual abuse. As a result of the facilities failures an immediate jeopardy (IJ) situation was identified when resident (R2) wrote unwanted paper notes that were sexual in nature and hand delivered them to R1, resulting in psychosocial harm related to triggering symptoms of PTSD (Post-Traumatic stress disorder) derived from childhood sexual abuse and feelings of insecurity for 1 of 2 residents (R1) reviewed for abuse. The IJ began on 3/27/25 when three residents reported inappropriate behavior by R2, including writing notes that were sexual in natural and touching residents. The facility administrator and director of nursing (DON) were notified of the IJ on 5/22/25 at 4:10 p.m. The IJ was removed on 5/28/25 at 11:09 a.m., but non-compliance remained at the lower scope and severity of D. Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency (SA) on 5/16/25 at 12:00 p.m., alleged abuse and neglect to R1 when R1 reported feeling unsafe at the facility due to R2 being sexually inappropriate, sexually harassing, and making unwanted sexual advances by writing letters and talking about sexual desires R2 had with R1. Several of the female residents stated they did not feel safe in the facility because of R2's behaviors. A Nursing Home Incident Report (NHIR) submitted to the SA on 5/16/25 at 1:57 p.m., alleged abuse when a resident (R1) reported during resident council on 5/15/25 that they did not feel safe because a resident (R2) stares at them. R1 R1's New admission Information dated 10/15/24, indicated R1 had diagnoses of Alcoholic encephalopathy, Post Traumatic Stress Disorder (PTSD), anxiety, and depression. R1's cognition was confused, and behaviors were confused but pleasant. The form also identified R1 was independent with activities of daily living (ADLs). The facility was to provide occupational therapy (OT), speech therapy (ST), and substance abuse treatment. R1 was admitted with a commitment order (court ordered mandate to be involuntarily place in an institution for treatment or care). Additional information included R1 had poor cognition, very forgetful, needs reminders that R1 had completed tasks. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's admission Trauma Informed Care History dated 10/16/24 identified R1 was molested as a child. Triggers that make it worse were indicated as use to have a lot of them but overcame them with counseling. R1's care plan initiated on 10/16/24, identify a potential for ineffective coping related to PTSD and reported history of traumatic event(s) from her childhood attention seeking behavior of sexual comments towards men. Goal was to feel safe and enjoy daily activities of her choice for the next 90 days. Interventions included allow to express feeling, communicate with them that they are safe, it's not their fault, you are sorry this happened and you are glad they are alive; identify support system and us them as appropriate; and provide a safe therapeutic environment where they can regain control as needed. R1 is a smoker and can smoke unsupervised. R1 has impaired cognitive function/dementia or impaired thought processes related to Wernicke's encephalopathy (brain and memory disorder), diagnoses and BIMS (brief interview of mental status) score. Interventions included administer medications, cue, reorient, and supervise as needed; has a pad of paper in her room to put information on for her to remember; and has a sign on the wall to remind her that her wallet is with her husband and nursing has her cigarettes. R1's safety is at risk and there is a potential for abuse due to anxiety, chemical dependency, current medical condition, use of medications and need for assistance with cares and mobility. Interventions were to remove R1 from potentially dangerous situations. R1's Preadmission Screening and Resident Review (PASARR) screening dated 11/11/24, identified serious mental disorder, intellectual disability or related disorder existed. R1's Vulnerability and Susceptibility to Abuse assessment dated [DATE], indicated R1 was at risk for abuse related to cognitive impairment, alcohol/substance abuse, physical impairment. R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver). R1's Montreal Cognitive Assessment (MoCA) dated 3/4/25, indicated R1 had higher mild cognitive impairment. R1's Cognitive care area assessment (CAA) dated 3/10/25, identified risk for psychosocial well-being changes d/t recent hospitalization and factors of cognitive loss and ETOH (alcohol) abuse. At risk for further clinical declines, re-hospitalization if psychosocial well-being is not addressed. R1's Nursing Note dated 5/4/25 at 2:24 a.m., identified R1 and another resident approached writer at 7:40 p. m., and stated that they did not feel safe as R2 was harassing them by calling them offensive names when they were out in the smoking area. R1 further stated that the harassing resident [R1] stays at his door and when they go out to smoke, he follows them. Writer request R1 to stay away from the other resident as much as they could. Writer offered an alternative smoking area for the meantime and in the event [R1] wanted to go to the regular smoking area to inform staff so they could be with staff all the time. Law enforcement involved. Director of nursing DON was notified and social worker to be informed. (no other mention of feeling unsafe in the notes) R1's Resident Location charting dated 4/27/25, 4/28/25, and 4/29/25 indicate 15-minute checks for protection. (no other information given) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's psychiatry Therapy note dated 5/23/25, identified R1 reported getting letters from a male resident a couple of months ago and have become inappropriate over time and R1 notified staff of this. R1 now feels uneasy around the person. R1 further reports feelings of unease like tension in her chest when wondering if she will see that person and brings up feelings like when she was sexually abused as a child. R1 feels she needs to watch her back and protect herself since reporting her concerns about the peer. R1 reports it is taking a long time to get to sleep and waking up 2-3 times a night. R1 requested to increase her session frequency to two times a week for additional support at this time. R1's record lacked indication a comprehensive assessment was completed to determine psychosocial harm, interventions put in place to ensure safety, supportive services provided, or monitoring systems for supervision and mood/behavior changes were implemented to keep R1 safe from ongoing abuse. R2 R2's quarterly MDS dated [DATE], identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly. R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply). R2's care plan initiated 1/25/25 indicates potential for ineffective coping related to reported history of traumatic event no triggers noted. Interventions included allow to express feelings, provide a safe therapeutic environment where they can regain control as needed; prefers female caregivers; does not want male caregivers for intimate cares. R2 requires assist of staff with bed mobility, toileting, transferring, and dressing lower body. R2 does not ambulate. R2 is a smoker and can smoke unsupervised. R2 used psychotropic medications related to depression and anxiety. Interventions included monitor/record occurrence of target behavior symptoms of rapidly shifts between different emotions, self-isolation, sense of impending doom, and hyper-fixation. Target behavioral interventions is journalling, talk therapy, distractions/redirections, remind to focus on what is controllable, and drawing. R2 is at risk and there is a potential for abuse due to anxiety, and chemical dependency. Interventions include: ensure I am safe around others that might take advantage of my confusion, encourage participation in separate meaningful activity, provide positive reinforcement when resident handle conflicts appropriately. R2's care plan lacked updates or potential sexual behaviors toward others. R2's progress notes dated 3/27/25 at 4:28 p.m., three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed feeling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them [R1], who had shown interest in him. Education given to the resident, verbalize understanding. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. R2's 15-30-60 Minute Monitoring Flowsheet dated 5/3/25 and 5/4/25, identified R2 was on 15-minute checks for safety reasons, started 5/3/25 at 2:45 p.m. to 5/4/25 at 11:30 a.m. R2 flowsheet lacked monitoring on 5/4/25 between 11:45 a.m. to 6:00 p.m. then resumed on 5/4/25 at 6:00 p.m., with last entry at 5/5/25 at 5:45 a.m. R2's record lacked additional behavior management, assessments or monitoring to mitigate risk of R2's alleged sexual behaviors towards R1. During an interview on 5/19/25 at 1:42 p.m., the business office manager (BOM) indicated she attended the resident council meeting on 5/15/25 and concerns were expressed about feeling unsafe at the facility related to R2 writing some notes to R1 and R2 watching and waiting for R1 to go out to the smoking area and R1 did not want to be by R2. The BOM reported the ombudsman was in the meeting and was going to follow up on the concern and did report their concerns to the DON and administrator. The BOM denied having prior knowledge of the letters. During an observation and interview on 5/19/25 at 2:15 p.m., R2 identified he was in trouble at the facility because he had a relationship with R1 and wrote her some love notes. R1 decided she did not want them anymore; they called the cops and we were supposed to stay away from each other. Law enforcement returned on Friday 5/16/25 and talked to me again. R2 stated, all the staff knew about it and the social worker told R2 that he was stalking R1 but could not remember when that conversation occurred. R2 reported writing love notes to R1 for approximately two months. During observation and interview on 5/20/25 at 8:55 a.m., R1 stated she had concerns about her safety because of R2 saying stuff to me like he likes me and started passing me some sexual notes. R1 indicated being married and would not consent to a relationship with R2. R1 further identified the notes started to get disturbing and showed staff the notes a week or so ago, can't remember. R1 indicated R2 would usually approach her in the smoking area, which was unsupervised by staff. During an interview on 5/20/25 at 9:05 a.m., R4 indicated R2 was obsessed with R1 and would sit in the doorway and stare at her, write letters to R1, and play love songs for R1 to hear. R4 further indicated about a month ago, R1 and R3 told the DON about the letters and the DON made copies of the letters and they moved R2 to a room even closer to R1. R4 indicated the DON told them they were all adults and needed to work it out. During an interview on 5/20/25 at 9:20 a.m., R3 indicated R2 sexually harasses R1 and has read the letters that R2 had written to R1, and they were sexual and graphic. R3 stated, R2 is scaring the [expletive] out of her. R3 indicated the allegation was reported to the social worker and nursing staff about six weeks to two months ago but moved R2's room even closer to R1. R3 said after the resident council meeting on 5/15/25, R1 and R2 were to go to two different smoking areas. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/20/25 at 9:50 a.m., NA-B indicated the conflict between R1, R2, and R3 is an everyday thing. NA-B indicated night shift had reported seeing R2 in R1's room and reported it to the charge nurse. NA-B identified R1 expressed concerns with the letters from R2 a couple of weeks ago that R1 continued to receive letters from R2 and that R1 wanted them stopped, stating R1 felt stalked. NA-B reported to the charge nurse. NA-B identified they were told to supervise the hallways as much as we can but there are no restrictions on what R1 and R2 can do but, R1 is good about not being in the same area as R2. During an interview on 5/20/25 at 10:15 a.m., R5 indicated being upset because of the sexual harassment to R1 by R2 and stated, it has to stop. R5 reported she had read the letters and found them to be sexual harassment but not threatening. R5 further indicated R1 had expressed her concerns with the letters and given them to registered nurse (RN)-A and the DON about six weeks ago and the facility made copies of the letters but did nothing to help R1. During an interview at 5/20/25 at 10:30 a.m., RN-A indicated she was made aware of the letters to R1 written by R2 sometime in April. RN-A described the letters she read to be kind letters, like you are beautiful, and want you to be my friend. RN-A identified she talked to R2, and he did not feel the letters were inappropriate for their relationship. RN-A stated R1 was concerned enough about the letters that she brought them to us and law enforcement was called a couple of times. RN-A identified she did not feel R1 had the capacity to consent and needed to figure something out [related to the relationship between R1 and R2]. During an interview on 5/20/25 at 11:08 a.m., the director of nursing (DON) indicated she was aware that R1 and R2 had an off and on relationship that had been ongoing for a while. Indicated R1 has memory issues but R2 does not. The DON indicated R1 brought the letters to her back in April sometime, did an investigation, interviewed both R1 and R2, and determined R1 knows what she is doing so did not report the concern to the State Agency. The DON was not sure how they determined R1's capacity to consent. The DON indicated she was not made aware of any further concerns about the letters until resident council meeting on 5/15/25. After the resident council meeting, implemented 15-minute checks on R1 and told staff to make sure R1 and R2 are not seen together. During an interview on 5/20/25 at 11:32 a.m., family member (FM-A) identified R1 calls her about eight times a day and had concerns about R1's safety and security related to the unwanted letters, treats, snacks, and gifts from R2. FM-A further indicated R1 had called her crying because the abusive situation is triggering R1's PTSD symptoms from earlier childhood trauma. FM-A indicated the facility has talked to R2 and told him to stop but, it was just ramping it up. FM-A shared concerns that the facility was not following through with their safety plan because he was still writing R1 letters and handing them to her. During an interview on 5/20/25 at 1:04 p.m., the activity director (AD) reported R1 felt unsafe around R2 and received letters from in the past. The AD indicated the letters were given to management and grievances were written. The AD indicated the letters were given to the social worker and R2 did stop writing letters for a while. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SW identified she was aware of a mutual relationship between R1 and R2 and described the relationship as R2 is infatuated and R1 enjoys the attention. The SW further indicated R1 and R2 are close friends and two adults but their relationship depends on the day. The SW did not know when the letters first started but did not think they had all the letters because she felt the letters that were copied were friendly in nature with some drawings. The SW identified the letters were in a soft file. The SW based R1's capacity to consent off the brief interview for mental status (BIMS) which indicated a score of seven which equated to severe cognitive impairment and the totality of knowing [R1]. The SW indicated she felt R1 could make decisions in the moment but 5-6 hours later would not be confident in her choices. During a follow up interview on 5/22/25 at 11:05 a.m., R1 reported receiving letters from R2 for at least a few months and brought her concerns and the notes to staff at least twice before bringing her concerns to the resident council meeting with the ombudsman in attendance. R1 identified the first time she reported her concerns about the notes written by R2, she was told (by facility staff) they would talk to him; the second time she approached staff about the notes, she did not receive any follow up on what had happened. R2 continued to write, and hand deliver the notes to R1 in the designated smoking area or in the hallway. R1 stated, I would hold my breath going down the hallway, hoping he didn't see me. R1 stated, the sexual abuse PTSD really amped up and brought it back. R1 reported informing her counselor of the PTSD and the unwanted attention and the doctor was going to look at adjusting one of my medications but don't know if that happened. R1 was tearful and continued to report trouble sleeping since the notes started as R1 worried about R2 coming into her room at night when the staff was not looking. R1 stated R2's notes made her feel disgusting, unsettled, and disturbed. R1 indicated the letters from R2 stopped after the resident council meeting on 5/15/25. The letters provided by the facility are as follows: 3/27/25: My Luv Bug, you are my favorite addiction Miss Lovely in every xxxxxx way. BTW: I love your tight [NAME]. Yummy to my tummy. Any ways I'm leaving here when you leave becuz [unreadable] I need, want, and love will be gone when you depart my lady. I love you [R1] Undated letter: I just hope you know I am taking an onslaught of haters by expressing my affection for you Lovely. I am about ready to tap out. It doesn't mean I don't love you, but I am gonna let off the gas pedal soon. I can only hope you still wanna lay in my arms someday. All night, All night. 4/2/25: Baby I still love you [R1] always will. [phone number written] Last letter circled. Letters provided by R1: 4/10/25 at 9:26 p.m.: [R1] I love you always [R2]. I will give U [NAME] love 4 a lifetime if I can trade u my heart for your beautiful body baby bunz. 4/21/25 at 7:57 p.m.: Love [R2] I want 2 kiss you forever and a day [R1]! I will always love you. U lifted up baby 4/23/25 at 9:56 p.m.: I want to kiss your smile smile. I'm falling 4 you [R1] badly. I love you so much I feel you in my bones baby. I want to kiss you forever. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	4/26/25 at 7:35 p.m.: 4 ever love [R2] I will never stop adoring you everything you do drives me crazy 4 you [R1] and I love you 4 it more. Undated: Happy May Day my lady. Good morning my lover and best friend you were so amazingly perfect to my eyes. I just longed to touch you everywhere on your baby silk smooth flawless skin. You allowing me to touch you and massage your back and legs gave me a soothing peace I need every day. You are my darling and will and always enjoy pleasuring you anywhere any day {R1]. [heart sign] R2 Undated: Happy may day baby - to [R1] we need a night 2getherness. Good morning [R1] I love you more today than before. Thank you for letting me touch you and caress your [unreadable] last night. I need to touch you more. Your body is so silky smooth is soothing you know for me more than it probably is too you. Love [R2] Undated: Baby Bunz, you look so absolutely stunning today. I want to kiss you until me and you both feel loved. [R1] you look more beautiful than ever before. U make me wanna .69 long .until .cream. Undated: [R1} I love u and I know it! I have fallen 4 you [R1] 2 me through my eyes u are the most beautiful women I have ever had a soul connection with by far. No matter what happens you will never be forgotten and will always have a special piece of my [arrow drawn]. There is just something about you baby. Undated: Zangi.com(a private messaging app) [R2's number is listed] Undated: I feel better just being in love with you Undated: P.S .I [heart drawn]U [R1]! I hope someday we can be alone so I can kiss and hold you until you feel my love. Undated: To my lady [R1] my lover, my lady, my friend, my woman, my wife, my life, my love, yours always [R2] Undated: I need you to know how I feel about you. Its not even funny you're the first and the last thought in my head every day even when we [unreadable] together, just cant get enough of you. The look on your face when you are telling me how you feel about me makes me about melt or when your pushing my buttons trying to be cute makes my head swim even though its frustrating as xxxx it doesn't bother me. The hardest part is trying to not let how I feel show on my face all day long. I selfish and want you all to myself for the remainder of the time we have together. I guess what Im really saying is that I love you and everything about you. Facility documents R1's Grievance Form dated 4/2/25, indicated R1 did not want letters from R2 anymore. The investigation summary identified the DON spoke with R2 about letter writing and R2 wrote his last letter. Attached to the grievance form was a letter written by R1dated 4/2/25, indicated last letter with baby, I still love you, always will with phone numbers written on the note. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A county sheriff's office Incident Report dated 5/3/25 at 8:15 p.m., indicated the sheriff's office received a 911 call indicated residents harassing each other and one feels unsafe. Residents were separated and advised to leave each other alone. The residents involved were R1, R2, and R3. The facilities Resident Council Minutes dated 5/15/25, identified social services concerns were resident feelings of being stalked and harassed by other residents and social worker stretched thin (over worked). The facility's undated policy titled, Abuse, Neglect and Exploitation identified it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implanting written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will make efforts to ensure all resident are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The facility's undated policy titled, Resident Right, identifies the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The resident has the right to voice grievances to the facility or other agency without discrimination or reprisal. Such grievance includes those with respect to care and treatment which has been furnished as well as that which has not been furnished; the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The immediacy of the IJ was removed on 5/28/25 at 11:09 a.m., when it was verified, the facility had implemented the following: 1) R1 immediately assessed by nursing and social service staff for psychological impact related to PTSD, behavioral changes, mood, and cognitive status. 2) R1 had an appointment over the phone with rural psychiatry services on 5/23/25 at 11:00 a.m. 3) R1 and R2 were placed on 15-minute checks by facility staff. R1's 15-minute checks were to monitor for signs of distress, anxiety, or change in behavior. R2's 15-minute checks were for behavior monitoring. 4) R1 reassured of right to safety and privacy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	5) R1 was offered emotional support services and a counseling session was scheduled for 5/23/25 at 11:00 a.m. 6) Mental health provider will be completing a capacity to consent. The facility is in the process of finding a provider that is able to complete this. 7) Primary care provider and rural psychiatry services were updated of the sexual abuse of R1 by R2 on 5/22/25. 8) Social service designee had routine check-in's with R1 on 5/22/25 and 5/23/25. Check-in's will continue on Tuesday, Thursday, and Saturday evenings. 9) IDT meeting held on 5/22/25 which included increased supervision for R1 and R2, ensure supervising staff are briefed on relevant background and IJ findings, review of current living/social environment for safety and appropriateness, offer relocation to a different facility if resident wishes, remove or limit access to triggering individuals or settings where possible, remove or limit access to triggering individuals or settings where possible, counseling arranged to occur as needed, engage family or guardians where/when appropriate, engage commitment manager/relocation, worker/therapist/clergy when/where appropriate. 10) R2's care plan and behavioral intervention plans updated to include all written and verbal communications with R1 would be monitored by staff to ensure appropriateness and maintain a respectful, safe environment. 11) All residents were assessed to ensure no others were impacted by similar behavior from R2. 12) Abuse policy was revised to include written/verbal communications and resident to resident sexual harassment procedures. 13) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Mandatory in-service training on 5/22/25, including definitions and examples of sexual abuse including written communications and mandated reporting. 14) System in place to determine capacity to consent on admission for all residents. 15) Weekly audits of resident interactions both written and verbal for 4 weeks, monthly for 3 months, and reviewed at quality assurance and performance improvement (QAPI) meetings. 16) All allegations of abuse will be reviewed immediately by IDT and brought to QAPI.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report allegations of abuse timely to the State Agency for 1 of 1 resident (R1) reviewed for allegations of abuse and neglect. The allegations occurred on 3/27/25, 4/2/25, 4/27/25, 5/3/25, and 5/15/25. Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency (SA) on 5/16/25 at 12:00 p.m., alleged abuse and neglect to R1 when R1 reported feeling unsafe at the facility due to R2 being sexually inappropriate, sexually harassing, and making unwanted sexual advances by writing letters and talking about sexual desires that he had with R1. Several of the female resident stated they did not feel safe in the facility because of R2's behaviors. Residents stated that the Director of Nursing Services told the residents that she will not be babysitting and that they are all adults and that this other resident [R2] has the right to Freedom of Speech. After [R1] reported her concerns to staff they moved [R2] closer to her room which makes her even more uncomfortable. Several of the other resident's report that [R2] is also stealing things from them out of their rooms. The residents report that nothing is done by staff to stop these things from occurring. A Nursing Home Incident Report (NHIR) submitted to the SA on 5/16/25 at 1:57 p.m., alleged abuse when a resident (R1) reports during resident council on 5/15/25 that they did not feel safe because a resident (R2) stares at them. The report further indicated the ombudsmen was onsite and told the facility they were mandated reporters. Administrator was notified 5/15/25 at 1:16 p.m. R1's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver). R1's Vulnerability and Susceptibility to Abuse assessment dated [DATE], indicated R1 was at risk for abuse related to cognitive impairment, alcohol/substance abuse, physical impairment. R2's quarterly MDS assessment dated [DATE], identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly. R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress notes dated 3/27/25 at 4:28 p.m., three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed felling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding. A facility Grievance Form submitted by R1 dated 4/2/25, indicated R1 did not want letters from R2 anymore. The investigation summary identified the DON spoke with R2 about letter writing and R2 wrote his last letter. Attached to the grievance form was a letter written by R1 dated 4/2/25, indicated last letter with baby, I still love you, always will with phone numbers written on the note. R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. A county sheriff's office Incident Report dated 5/3/25 at 8:15 p.m., the sheriff's office received a 911 call indicated residents harassing each other and one feels unsafe. Residents were separated and advised to leave each other alone. The residents involved were R1, R2, and R3. The facilities Resident Council Minutes dated 5/15/25, identified social services concerns were resident feelings of being stalked and harassed by other residents. During an interview on 5/20/25 at 11:08 a.m., the director of nursing (DON) indicated she was aware that R1 and R2 had an off and on relationship that had been ongoing for a while. Indicated R1 has memory issues but R2 does not. The DON indicated R1 brought the letters to her back in April sometime, did an investigation, interviewed both R1 and R2, and determined R1 knows what she is doing so did not report the concern to the State Agency. The DON was not sure how they determined R1's capacity to consent. During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SW identified she was aware of a mutual relationship between R1 and R2 and described the relationship as R2 is infatuated and R1 enjoys the attention. The SW further indicated R1 and R2 are close friends and two adults but their relationship depends on the day. The SW did not know when the letters first started but did not think they had all the letters because she felt the letters that were copied were friendly in nature with some drawings. The SSD and administrator denied awareness of the 5/3/25 incident and verified they did not report any of the allegations to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Abuse, Neglect and Exploitation policy identified it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implanting written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will make efforts to ensure all resident are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The policy further directs reporting of all alleged violations to the administrator, state agency, adult protective services, and all other required agencies within specified timeframes: immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to thoroughly investigate and protect residents for an allegation of sexual abuse for 1 of 3 residents (R1) reviewed for abuse. Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency (SA) on 5/16/25 at 12:00 p.m., alleged abuse and neglect to R1 when R1 reported feeling unsafe at the facility due to R2 being sexually inappropriate, sexually harassing, and making unwanted sexual advances by writing letters and talking about sexual desires that he had with R1. Several of the female resident stated they did not feel safe in the facility because of R2's behaviors. Residents stated that the Director of Nursing Services told the residents that she will not be babysitting and that they are all adults and that this other resident [R2] has the right to Freedom of Speech. After [R1] reported her concerns to staff they moved [R2] closer to her room which makes her even more uncomfortable. Several of the other resident's report that [R2] is also stealing things from them out of their rooms. The residents report that nothing is done by staff to stop these things from occurring. A Nursing Home Incident Report (NHIR) submitted to the SA on 5/16/25 at 1:57 p.m., alleged abuse when a resident (R1) reports during resident council on 5/15/25 that they did not feel safe because a resident (R2) stares at them. The report further indicated the ombudsmen was onsite and told the facility they were mandated reporters. Administrator was notified 5/15/25 at 1:16 p.m. R1's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment and diagnoses of Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver). R2's quarterly MDS dated [DATE], indicated moderately impaired cognition with verbal behaviors directed towards others 1to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly. R2's diagnosis list includes emotional lability, alcohol use, depression, and anxiety disorder. R2's progress notes dated 3/27/25 at 16:28 (4:28 p.m.), three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed felling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding. The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings. A facility Grievance Form submitted by R1dated 4/2/25, indicated R1 did not want letters from R2 anymore. The investigation summary identified the DON spoke with R2 about letter writing and R2 wrote his last letter. Attached to the grievance form was a letter written by R1dated 4/2/25, indicated last letter with baby, I still love you, always will with phone numbers written on the note. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 provided the following letters to registered nurse (RN)-A and the director of nursing (DON): 3/27/25: My Luv Bug, you are my favorite addiction Miss Lovely in every [expletive] way. BTW: I love your tight [NAME]. Yummy to my tummy. Any ways I'm leaving here when you leave becuz [unreadable] I need, want, and love will be gone when you depart my lady. I love you [R1] Undated letter: I just hope you know I am taking an onslaught of haters by expressing my affection for you Lovely. I am about ready to tap out. It doesn't mean I don't love you, but I am gonna let of the gas pedal soon. I can only hope you still wanna lay in my arms someday. All night, All night. 4/2/25: Baby I still love you [R1] always will. [phone number written] Last letter circled. The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings. R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings. A county sheriff's office Incident Report dated 5/3/25 at 8:15 p.m., the sheriff's office received a 911 call indicated residents harassing each other and one feels unsafe. Residents were separated and advised to leave each other alone. The residents involved were R1, R2, and R3. The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation, prevention of further abuse, or corrective actions related to investigative findings. The facilities Resident Council Minutes dated 5/15/25, identified social services concerns were resident feelings of being stalked and harassed by other residents. The facility investigation was requested but not provided. The facility lacked documentation and evidence of a thorough investigation. R1 continued to receive letters from R2 on 4/10/25, 4/21/25, 4/23/25, 4/26/25, and nine undated letters after submitting the facility grievance form on 4/2/25. During an interview on 5/20/25 at 10:20 a.m., registered nurse (RN)-A identified R1 had concerns about letters that she was receiving from R2 and provided the letters to her in April sometime. RN-A identified she notified the administrator at that time. RN-A indicated they interviewed a few of the residents but determined the letters to be kind letters and talked to R2 about the letter writing. RN-A denied seeing any sexual letters. RN-A denied having documentation of the interviews. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 11:08 a.m., the director of nursing (DON) indicated she was aware of the letters back in April sometime. R1 and R2 were interviewed but did not have documentation of the interviews or evidence of a thorough investigation. The DON indicated the investigation concluded R1 knows what she is doing but did not know how that was determined. The DON also indicated R1 was put on 15-minute checks over the weekend but did not know where the documentation was. During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SSD indicated she was aware of some of the letters R1 had received from R2 but felt the letters had been friendship in nature and contained some drawings. The SSD did acknowledge receiving a grievance from R1 regarding the letters in April. The SSD and the administrator both stated they were not aware of the sheriff's department being dispatched to the facility on 5/3/24 related to reported harassment among R1, R2, and R3 but that the DON was notified. The documentation's and timelines of the investigations were requested related to the letters, but the SSD only provided copies of three letters from a soft file. The administrator did not have any further information. The facility's undated Abuse, Neglect and Exploitation policy directed an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation, identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause and providing complete and thorough documentation of the investigation. Protection of the resident: The facility will make efforts to ensure all resident are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: responding immediately to protect the alleged victim and the integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and others; room or staffing changes if necessary, to protect the resident(s) from the alleged perpetrator; protection from retaliation; providing emotional support and counseling to the resident during and after the investigation, as needed; revision of 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide 1 of 2 residents (R2) with choices for discharge, right to an appeal process, ability to stay at facility during an appeal process, review and take into account substance use disorder and mental health diagnoses that would impair judgement on the decision to transfer, and allow the resident time to process the discharge prior to discharging. R2's face sheet dated 5/23/25, identified diagnoses of emotional lability (tendency to shift rapidly and dramatically between different emotional states), alcohol use, cognitive communication deficit (challenges with language comprehension, expression, reasoning, attention, memory, and organization), depression, anxiety disorder, and osteonecrosis (death of the bone due to lack of blood supply) to right and left femur. R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R2 had moderately impaired cognition, no hallucinations or delusions, and had verbal behaviors directed towards others one to three days weekly and behavioral symptoms not directed at others one to three days weekly. R2 required assist of staff with bed mobility, toileting, transferring, and dressing lower body. R2 does not ambulate. R2's care plan dated 1/25/25, identified ineffective coping related to reported history of traumatic event with no triggers noted. Interventions included to allow R2 to express feelings, provide a safe, therapeutic environment to regain control as needed, R2 preferred female caregivers and did not want male caregivers for intimate cares. A focus dated 1/29/25, identified R2 had a behavior problem of story telling and embellishing the truth. Interventions included to discuss the behavior, explain/reinforce why behavior is inappropriate or unacceptable. On 5/22/25, an intervention of 15-minute safety checks for behavior monitoring was initiated. A focus dated 1/27/25, identified R2 wished to return to his prior living arrangements when able to discharge, interventions included to evaluate and discuss the prognosis for independent or assisted living, no additional interventions were identified past 1/27/25. R2's Trauma Informed Care History dated 1/27/25, identified traumata history from physical abuse. The response to triggers that make things worse was, not really and the Lord and prayer helped R2 manage. R2's psychosocial care area assessment (CAA) dated 1/27/25, identified R2 was at risk for psychosocial wellbeing changes due to recent hospitalization and factors noted in worksheet. At risk for further rehospitalization if psychosocial well-being not addressed. Care plan to address psychosocial wellbeing and strategies to reduce and manage risk. No behaviors. R2's Treatment Administration Record (TAR) dated 5/1/25 to 5/31/25, identified targeted behaviors included negative statements, isolating self, sad, crying, and anxiety. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress note dated 4/27/25 at 4:51 p.m., identified R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R2 was interviewed and identified that sexual behavior occurred with R1. R1's safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. Director of Nursing (DON) and social worker notified. R2's progress note dated 5/3/25 at 2:35 p.m., identified a conflict between R2 and another resident had occurred in the designated smoking area. The residents were separated and educated on observing facility rules and were advised to remain apart from each other for the safety of themselves and other residents. Conflict de-escalated. R2's progress note dated 5/4/25 at 2:47 p.m., identified R2 talked with law enforcement for allegation raised by another resident that R2 was harassing them while they were outside smoking. R2 is on 15-minute checks from a prior incident and was educated to inform staff when he went outside to smoke and not go outside when the other resident was outside. DON and social worker notified. R2's progress note dated 5/22/25 at 8:36 p.m., identified R2 had exhibited a pattern of writing notes directed toward a female peer. Due to concerns regarding boundary issues and to promote a safe, respectful environment, R2's care plan has been updated to obtain approval from charge nurse or designated staff member before sharing written communication with female residents. Additionally, all interpersonal interactions with the female residents will be monitored by staff. R2 was informed of this change and provided education regarding appropriate social boundaries. Additionally, R2 remains on 15-minute safety checks for behavioral monitoring. R2 agreed and verbalized understanding of the education provided. R2's progress note dated 5/23/25 at 3:00 p.m., identified: discussed with R2 that the referral to a sister facility had been accepted and a transfer is now possible. R2 expressed understanding and agreed to the transfer. R2 inquired about the timeline and was informed the transfer could occur today. R2 consented to a same day move. Staff offered assistance with packing; R2 accepted and requested that staff use the suitcase located in his closet. Discharge orders obtained from R2's primary care physician and transfer coordination is underway. R2's progress note dated 5/23/25 at 3:39 p.m., identified R2 discharged to sister facility around 3:30 p.m. R2 got a ride through the facility's transportation. R2 used a wheelchair, declined a vital sign check, is alert and orientated. Sent medications and medication sheet with the driver. R2's visual check sheet every 15 minutes dated 5/22/25, identified the checks began on 5/22/25 at 5:45 p.m. and ended on 5/23/25 at 4:00 p.m. with discharge. The discharge/transfer notice dated 5/23/25, identified this notice was to notify of the transfer or discharge to the sister facility. The box was checked that R2 requested the transfer or discharge with the reason to be closer to surgery site/fresh start. The notice was signed by the administrator on 5/23/25. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/25 at 11:54 a.m., registered nurse (RN)-A stated the DON had asked her to talk to R2 and see if he would transfer to the sister facility as they had accepted him as a transfer. R2 agreed to the transfer but made a comment that he would like to return once another resident discharged from this facility. RN-A stated that would be something that would have to be discussed with the interdisciplinary team (IDT). During a phone interview on 5/27/25 at 12:18 a.m., regional Ombudsman (RO)-A stated she was unaware that R2 had discharged to another facility until she received an email from the DON on 5/27/25. If this was a facility initiated discharge the Ombudsman must be contacted immediately and R2 has the right to appeal and remain where he is at during the appeal process. If R2 agreed with the transfer/discharge he should have signed the form that he agreed to the discharge. During a phone interview on 5/27/25 at 12:28 p.m., R2 stated registered nurse (RN)-A came to his room and said maintenance worker (MW)-A was getting the bus to transfer to the sister facility and nursing assistant (NA)-A and NA-C packed his belongings up and he was in the bus in a matter of 10-12 minutes time. The NA's threw out a note pad that had passwords on it during the process, and R2 is unable to use his phone until he can purchase more minutes to change his phone number. The facility got rid of me. They said I could have better care at the new facility. They said the higher-ups decided but R2 was not allowed to discuss it with them and when R2 asked if he had to leave, they told him Yeah, in a certain way so R2 believed them. R2 asked to return to the facility when certain residents discharged . Something does not feel right when they get you out of there as fast as they can like Caeser washing his hands from Jesus Christ, and it came from the administrator. R2 stated the facility got him to verbally say he would move and if he did not like it, they could hopefully help him return but did not let him talk to an advocate. Now that R2 is at the current facility, he wants to go back. This is a real nursing home and R2 does not feel he belongs at it. There are rules in place at the current facility that are not in place at the facility. R2 feels penned up at the current facility. R2 cried and has been crying in his room and feeling very depressed since the transfer. R2 keeps waking up from sleep and realizing that it is not a dream, and he is not at the facility he wants to be at. R2 stated his medical appointments are now 45 minutes farther to get too. During an interview on 5/27/25 at 2:07 p.m., DON stated social service designee (SSD)-A initiated discharge for R2 and sent the referral to the sister facility and thought it occurred a couple of days prior to R2's discharge. Both R1 and R2 were aware that they may be discharged to a sister facility. The discharge notice was completed on 5/23/25 and sent to the Ombudsman on 5/27/25 after it was found on SSD-A's desk. The doctor was aware of the referrals sent and gave the order to discharge to the sister facility. During a phone interview on 5/27/25 at 2:16 p.m., DON-B, from the sister facility, stated she received an email referral for R2 on 5/23/25 at 1:55 p.m. and that was the first contact she had about R2 transferring to the facility. The information came from SSD-A and DON. DON had stated the facility needed placement for R2. DON-B stated DON and SSD-A did not provide information about R2's sexual abuse allegations but she was aware through working for the same company. R2 was antsy about being at the new facility on 5/23/25 after he arrived but DON-B had talked through the transfer with him. Verification of emails identified SSD-A sent an email on 5/23/25 at 1:55 p.m. that included R2's face sheet and progress notes, at 1:57 a second email from SSD included R2's care plan, and at 2:57 p.m. DON sent paperwork including order summary from emergency department, discharge summary, physician visit, and doctor note from 5/12/25 visit. (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 2:36 p.m., MW-A stated he was informed at approximately 2:40 p.m. on 5/23/25, about R2 discharging to a sister facility because R1 felt unsafe with R2 at the facility. The transfer happened very suddenly and MW-A transported R2 to the sister facility around 3:00 p.m. During the transport, R2 was not in his normal mood, no big smile on his face, very monotone and emotionless, not reacting as he normally would to MW-A. During a phone interview on 5/28/25 at 3:42 p.m., SSD-A stated she had left the facility for the day, without access to the building or her email around 1:00 p.m. on 5/23/25. SSD-A did not have any part of the discharge preparing or planning for R2 and had not had a conversation with R2 about discharging. SSD-A did not send emails or have communication with the sister facility about R2's transfer. During an interview on 5/28/25 at 3:04 p.m., Administrator stated R1 and R2 were both offered discharge to other facilities. R1 said no to the discharge. R2 was upset about being accused of sexual abuse from R1 and the 15-minute checks on him that were put in place and wanted a fresh start. R2 approached the possibility of being transferred to the SSD-A. The sister facility was 39 miles from the current facility and would be closer to R2's surgery location (88 miles from sister facility). Administrator was unable to articulate other facilities that R2 was offered for relocation. R2 did not sign the discharge form and was pretty upset during the relocation process. It was a big change in 1.5 hours for R2. R2 stated he wanted to return to the facility. The physician was notified and gave orders to discharge to the sister facility but was not made aware of the reason for the discharge. The Ombudsman was not notified of the discharge until 5/27/25. During a follow-up phone interview on 5/28/25 at 4:15 p.m., RN-A stated she was told a referral had been sent to the sister facility earlier during the week before 5/23/25. RN-A attended all the IDT meetings but was unsure if discharging R2 to the sister facility was discussed. RN-A told R2 he could transfer that day (5/23/25) and that it was closer to doctor appointments and that the facility could pack his belongings. R2 had talked about it being a fresh start at a different facility. R2's demeanor to the discharge appeared like he was frustrated. The facility's undated Resident Right policy, identifies the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The resident has the right to voice grievances to the facility or other agency without discrimination or reprisal. Such grievance includes those with respect to care and treatment which has been furnished as well as that which has not been furnished; the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. During a return phone call on 6/6/25 at 10:14 a.m. from 5/28/25 at 11:40 a.m., family friend (FF)-A stated R2 has contacted her since being at the new facility. R2 made statements that he was being left at the facility to die and voiced frustration of not seeing any type of future for himself. The facility Transfer and Discharge policy dated 4/21/25, identified it is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: necessary for the residents welfare, residents needs cannot be met, safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The facilities transfer/discharge notice will be provided to the resident and residents representative and include: specific reason for the transfer, effective date of discharge, specific location to which the resident is to be transferred/discharged , an explanation of the appeal rights to the State, for residents with mental illness or related disability the notice will include the name, mailing and email addresses and phone number of the state agency responsible for protection and advocacy of these populations. Generally, the notice must be provided at least 30 days prior to the transfer or discharge of the resident. Exemptions to the 30-day requirement apply when: health/safety of individuals in the facility would be endangered due to clinical or behavioral status of the resident, urgent medical needs, resident has not resided at the facility for 30 days. In these exceptional cases, the notice must be provided to the resident, resident representative and LTC Ombudsman as soon as practicable before the transfer or discharge.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to implement trauma-informed care for 2 of 3 residents (R1, R2) identified with a diagnosis of post-traumatic stress disorder (PTSD) reviewed for PTSD-related care. Findings include: R1's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver). R1's admission Trauma Informed Care History dated 10/16/24 identified R1 was molested as a child. Triggers that make it worse were indicated as use to have a lot of them but overcame them with counseling. R1's care plan initiated on 10/16/24, identify a potential for ineffective coping related to PTSD and reported history of traumatic event(s) from her childhood attention seeking behavior of sexual comments towards men. Goal was to feel safe and enjoy daily activities of her choice for the next 90 days. Interventions included allow to express feeling, communicate with them that they are safe, it's not their fault, you are sorry this happened and you are glad they are alive; identify support system and us them as appropriate; and provide a safe therapeutic environment where they can regain control as needed. R1's care plan, initiated 10/16/24, did not contain updated interventions for PTSD-related triggers, symptoms, or interventions. R1's Nursing Note dated 5/4/25 at 02:24 (2:24 a.m.) identified R1 and another resident approached writer at 7:40 p.m., and stated that they did not feel safe as R2 was harassing them by calling them offensive names when they were out in the smoking area. R1 further stated that the harassing resident [R2] stays at his door and when they go out to smoke, he follows them. Writer request R1 to say away from the other resident as much as they could. Writer offered an alternative smoking area for the meantime and in the event [R1] wanted to go to the regular smoking area to inform staff so they could be with staff all the time. Law enforcement involved. Director of nursing DON was notified and social worker to be informed. There were no further notes related to monitoring for symptoms of PTSD symptoms. R1's record lacked indication a comprehensive assessment was completed to determine psychosocial harm, interventions were put in place to ensure safety, supportive services were provided, or monitoring systems for supervision and mood/behavior changes were implemented to keep R1 safe, recognize potential exacerbation of PTSD from ongoing abuse, and re-assess or review triggers that may be stressors or prompt recall of previous traumatic event. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's quarterly MDS assessment dated [DATE], identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly. R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply). R2's psychosocial care area assessment (CAA) dated 1/27/25, identified R1 was at risk for psychosocial wellbeing changes due to recent hospitalization and factors noted in worksheet. At risk for further re-hospitalization if psychosocial well-being not addressed. Care plan to address psychosocial wellbeing and strategies to reduce and manage risk. No behaviors. R2's Trauma Informed Care History dated 1/27/25, indicated traumatic history included being beat up and kicked in the ribs. The response to triggers that make things worse was, not really and the lord and prayer helped R2 manage. R2's Psychiatry Provider Note dated 2/11/25, indicated R2's trauma history included sexual abuse as a child by a family member. R2's care plan initiated 1/25/25, indicates potential for ineffective coping related to reported history of traumatic event no triggers noted. Interventions included allow to express feelings, provide a safe therapeutic environment where they can regain control as needed; prefers female caregivers; does not want male caregivers for intimate cares. Did not include care plan updates, potential sexual behaviors toward others. R2's progress notes dated 3/27/25 at 4:28 p.m., three female residents approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed felling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding. R2's Nursing Note dated 4/27/25 at 4:51 p.m., R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. R2's Treatment Administration Record dated 5/1/25 to 5/31/25, indicated targeted behaviors included negative statements, isolating self, sad, crying, and anxiety. R2's record lacked indication behavior management or monitoring was implemented to mitigate risk of R2's identified sexual behaviors towards R1. Further lacked identification of assessment of need for or implementation of supervision or monitoring of the potential for re-triggering PTSD related to childhood sexual abuse. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 5/20/25 at 8:55 a.m., R1 stated she had concerns about her safety because of R2 saying stuff to me like he likes me and started passing me some sexual notes. R1 indicated being married and would not consent to a relationship with R2. R1 further identified the notes started to get disturbing and showed staff the notes. R1 indicated R2 would usually approach her in the smoking area, which was unsupervised by staff. During an interview on 5/20/25 at 11:32 a.m., family member (FM-A) identified R1 calls her about eight times a day and had concerns about R1's safety and security related to the unwanted letters, treats, snacks, and gifts from R2. FM-A further indicated R1 had called her crying because the abusive situation is triggering R1's PTSD symptoms from earlier childhood trauma. FM-A indicated the facility has talked to R2 and told him to stop but, it was just ramping it up. FM-A shared concerns that the facility was not following through with their safety plan because he was still writing R1 letters and handing them to her. During an interview on 5/20/25 at 11:58 a.m., the director of nursing (DON) stated a Trauma Informed Care Assessment is completed upon admission and take information from progress notes, provider notes and care plan interventions to meet the resident needs. The DON further identified the social service designee is responsible for completing the assessments and care planning interventions. During an observation and interview on 5/20/25 at 2:15 p.m., R2 was lying on the bed and identified he was in trouble at the facility because he had a relationship with R1 and wrote her some love notes. R1 decided she did not want them anymore; they called the cops, and we were supposed to stay away from each other. Law enforcement returned on Friday 5/16/25 and talked to me again. R2 stated, all the staff knew about it and the social worker told R2 that he was stalking R1 but could not remember when that conversation occurred. R2 reported writing love notes to R1 for approximately two months. R2 identified he has been shunned by the staff and feels the need to alienate due to the harassment he was receiving by the staff and other residents because of the letters he wrote to R1. During a follow up interview on 5/22/25 at 11:05 a.m., R1 reported receiving letters from R2 for at least a few months and brought her concerns and the notes to staff at least twice before bringing her concerns to the resident council meeting with the ombudsman in attendance. R1 identified the first time she reported her concerns about the notes written by R2, she was told (by facility staff) they would talk to him; the second time she approached staff about the notes, she did not receive any follow up on what had happened. R2 continued to write, and hand deliver the notes to R1 in the designated smoking area or in the hallway. R1 stated, I would hold my breath going down the hallway, hoping he didn't see me. R1 stated, the sexual abuse PTSD really amped up and brought it back. R1 reported informing her counselor of the PTSD and the unwanted attention and the doctor was going to look at adjusting one of my medications but don't know if that happened. R1 was tearful and continued to report trouble sleeping since the notes started as R1 worried about R2 coming into her room at night when the staff was not looking. R1 stated R2's notes made her feel disgusting, unsettled, and disturbed. R1 indicated the letters from R2 stopped after the resident council meeting on 5/15/25. 1. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Trauma Informed Care undated, identified the facility would provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. The facility will work to facilitate the principles of trauma informed care which include: a. Safety - Ensuring residents have a sense of emotional and physical safety. b. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident. c. Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals. d. Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. e. Empowerment, voice, and choice - Ensuring that resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: f. Experiencing a lack of privacy or confinement in a crowded or small space. g. Exposure to loud noises, or bright/flashing lights. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Certain sights, such as objects that are associated with their abuser. i. Sounds, smells, and physical touch. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents who were seen during routine physician visits every 30-60-90 days had physician documentation in the medical record for 1 of 1 (R1) resident, reviewed during the extended survey. Findings include: R1's significant change MDS dated [DATE]; indicated severe impaired cognition; diagnoses of anxiety, depression, post traumatic stress disorder (PTSD). Required supervision with walking greater than 150 feet and set up for shower/bathe. Took antidepressants. R1's medical record identified R1 had physician visits on 10/29/24, 11/18/24, 2/6/25, 3/18/25, and 4/23/25. R1's medical record lacked documentation of routine 60-90-day routine visits from 11/18/24 to 2/6/25. During an interview on 5/29/25 at 11:05 a.m., director of nursing (DON) stated the physician saw the resident and signed the physician orders but did not know why he did not write a note. DON verified with physician that he saw resident, knew he had to write a note but did not remember why he did not. Facility undated policy titled Physician visits and Physician Delegation, indicated: a. See resident within 30 days of admission to the facility. b. The resident must be seen at least once every 30 calendar days for the first 90 days after admission and at least every 60 days thereafter. h. At the option of the physician, required visits in SNF's, after the initial visit, may alternate between personal visits by the physician and visits by a non-physician provider, which is acting within their scope of practice.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review, the facility failed to implement comprehensive assessment and person-centered planning to ensure residents individualized behavioral health needs were met for 2 of 2 residents (R1, R2) reviewed for behavioral health services. Findings include: R1's New admission Information dated 10/15/24, indicated R1 had diagnoses of Alcoholic encephalopathy, Post Traumatic Stress Disorder (PTSD), anxiety, and depression. R1's cognition was confused, and behaviors were confused but pleasant. The form also identified R1 was independent with activities of daily living (ADL'S). The facility was to provide occupational therapy (OT), speech therapy (ST), and substance abuse treatment. R1 was admitted with a commitment order (court ordered mandate to be involuntarily place in an institution for treatment or care). Additional information included R1 had poor cognition, very forgetful, needs reminders that R1 had completed tasks. R1's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had severe cognitive impairment, minimal depression, no behaviors, and no hallucinations or delusions. Diagnoses included Wernicke's encephalopathy (brain and memory disorder), insomnia, history of suicidal behavior, anxiety, depression, post-traumatic stress disorder (PTSD), and alcoholic hepatitis (inflammation of the liver). R1's admission Trauma Informed Care History dated 10/16/24 identified R1 was molested as a child. Triggers that make it worse were indicated as use to have a lot of them but overcame them with counseling. R1's care plan initiated on 10/16/24, identified the following: A potential for ineffective coping related to PTSD and reported history of traumatic event(s) from her childhood attention seeking behavior of sexual comments towards men. Goal was to feel safe and enjoy daily activities of her choice for the next 90 days. Interventions included allow to express feeling, communicate with them that they are safe, it's not their fault, you are sorry this happened and you are glad they are alive; identify support system and us them as appropriate; and provide a safe therapeutic environment where they can regain control as needed. R1 has impaired cognitive function/dementia or impaired thought processes related to Wernicke's encephalopathy diagnoses and brief interview of mental status (BIMS) score. Interventions included administer medications, cue, reorient, and supervise as needed. R1's safety is at risk and there is a potential for abuse due to anxiety, chemical dependency, current medical condition, use of medications and need for assistance with cares and mobility. Interventions were to remove R1 from potentially dangerous situations. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 had a substance abuse/dependence of substances as evidenced by diagnoses of alcohol and cannabis [abuse]. Goal was to complete assessment with licensed alcohol and drug counselor (LADC) within 30 days and comply with commitment requirements while in care. Interventions listed as encourage to identify self-stabilizing activities during group activities; staff will assess vital signs, mental status, and physical symptoms if substance use is suspected or identified; contact R1's physician and follow order provided; and engage in therapeutic groups four times weekly to express/explore sobriety. R1 has a psychosocial well-being problem related to being away from her children with interventions identified as assist/encourage support her to set realistic goals; encourage participation from resident who depends on others to make own decisions; increase communication between resident/family/caregivers about care and living environment. Explain all procedures, treatments, medications, results of labs/tests, condition, all changes, rules, and options. R1's care plan lacked evidence the facility identified R1's responses to stressors and utilize person-centered interventions developed by the IDT to support R1 and did not review and revise behavioral health care plans that had not been effective and when R1 had a change in condition related to the ongoing abuse. R1's Nursing Note dated 5/4/25 at 2:24 a.m., identified R1 and another resident approached writer at 7:40 p. m., and stated that they did not feel safe as R2 was harassing them by calling them offensive names when they were out in the smoking area. R1 further stated that the harassing resident [R1] stays at his door and when they go out to smoke, he follows them. Writer request R1 to say away from the other resident as much as they could. Writer offered an alternative smoking area for the meantime and in the event [R1] wanted to go to the regular smoking area to inform staff so they could be with staff all the time. Law enforcement involved. Director of nursing DON was notified and social worker to be informed. R1' s psychiatry Therapy note dated 5/23/25, identified R1 reported getting letters from a male resident a couple of months ago and have become inappropriate over time and R1 notified staff of this. R1 now feels uneasy around the person. R1 further reports feelings of unease like tension in her chest when wondering if she will see that person and brings up feelings like when she was sexually abused as a child. R1 feels she needs to watch her back and protect herself since reporting her concerns about the peer. R1 reports it is taking a long time to get to sleep and waking up 2-3 times a night. R1 requested to increase her session frequency to two times a week for additional support at this time. R1's record lacked indication a comprehensive assessment was completed to determine psychosocial harm, interventions were put in place to ensure safety, supportive services were provided, or monitoring systems for supervision and mood/behavior changes were implemented to keep R1 safe from ongoing abuse. During observation and interview on 5/20/25 at 8:55 a.m., R1 stated she had concerns about her safety because of R2 saying stuff to me like he likes me and started passing me some sexual notes. R1 indicated being married and would not consent to a relationship with R2. R1 further identified the notes started to get disturbing and showed staff the notes a week or so ago, can't remember. R1 indicated R2 would usually approach her in the smoking area, which was unsupervised by staff. (continued on next page)

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	05/28/2025

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 11:32 a.m., family member (FM-A) identified R1 calls her about eight times a day and had concerns about R1's safety and security related to the unwanted letters, treats, snacks, and gifts from R2. FM-A further indicated R1 had called her crying because the abusive situation is triggering R1's PTSD symptoms from earlier childhood trauma. FM-A indicated the facility has talked to R2 and told him to stop but, it was just ramping it up. FM-A shared concerns that the facility was not following through with their safety plan because he was still writing R1 letters and handing them to her. R2 R2's quarterly MDS assessment dated [DATE], identified R2 had moderately impaired cognition, with no hallucinations or delusions, no wandering or rejection of cares. R2 had verbal behaviors directed towards others 1 to 3 days weekly and behavioral symptoms not directed at others 1 to 3 days weekly. R2's diagnosis list includes emotional lability, alcohol use, depression, anxiety disorder, osteonecrosis (death of the bone due to lack of blood supply). R2's progress notes dated 3/27/25 at 16:28 (4:28 p.m.), three female residents [R1, R3, and unknown discharged resident] approached writer and another nurse manager to report that a male resident has been acting inappropriately toward them. They shared that the resident writes notes to them and follows them to the smoking area. The residents expressed felling uncomfortable with his behavior. The writer and other nurse spoke with R2 about the concerns and R2 explained he only wrote letters to one of them, who had shown interest in him. Education given to the resident, verbalize understanding. R2's Nursing Note dated 4/27/25 at 16:51 (4:51 p.m.), R2 was reported being sexual [sexually] inappropriate to R1. Per R1 she has been sexually abused by this resident and does not feel comfortable. R1 safety is being ensured by checking on R1 when she goes out to smoke. R2 was educated on sexual abuse and verbalized understanding. During an observation and interview on 5/20/25 at 2:15 p.m., R2 identified he was in trouble at the facility because he had a relationship with R1 and wrote her some love notes. R1 decided she did not want them anymore; they called the cops, and we were supposed to stay away from each other. Law enforcement returned on Friday 5/16/25 and talked to me again. R2 stated, all the staff knew about it and the social worker told R2 that he was stalking R1 but could not remember when that conversation occurred. R2 reported writing love notes to R1 for approximately two months. During an interview on 5/20/25 at 2:36 p.m., social service designee (SSD) with administrator present during interview. The SSD identified she was aware of a mutual relationship between R1 and R2 and described the relationship as R2 is infatuated and R1 enjoys the attention. The SSD further indicated R1 and R2 are close friends and two adults but their relationship depends on the day. The SSD did not know when the letters first started but did not think they had all the letters because she felt the letters that were copied were friendly in nature with some drawings. based R1's capacity to consent off the brief interview for mental status (BIMS) which indicated a score of seven which equated to severe cognitive impairment and the totality of knowing [R1]. The SW indicated she felt R1 could make decisions in the moment but 5-6 hours later would not be confident in her choices. The SSD stated R1 received talk therapy once a month and received psychiatry care but denied awareness of R1's increased PTSD symptoms. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 5/22/25 at 11:05 a.m., R1 reported receiving letters from R2 for at least a few months and brought her concerns and the notes to staff at least twice before bringing her concerns to the resident council meeting with the ombudsman in attendance. R1 identified the first time she reported her concerns about the notes written by R2, she was told (by facility staff) they would talk to him; the second time she approached staff about the notes, she did not receive any follow up on what had happened. R2 continued to write, and hand deliver the notes to R1 in the designated smoking area or in the hallway. R1 stated, I would hold my breath going down the hallway, hoping he didn't see me. R1 stated, the sexual abuse PTSD really amped up and brought it back. R1 reported informing her counselor of the PTSD and the unwanted attention and the doctor was going to look at adjusting one of my medications but don't know if that happened. R1 was tearful and continued to report trouble sleeping since the notes started as R1 worried about R2 coming into her room at night when the staff was not looking. R1 stated R2's notes made her feel disgusting, unsettled, and disturbed. R1 indicated the letters from R2 stopped after the resident council meeting on 5/15/25. R1 further denied any further action or offers of emotional support by facility staff during the ongoing abuse further identifying the facility staff made R1 feel like it was her fault [the abuse occurred]. The facility policy Trauma Informed Care undated, identified the facility would provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. The facility will work to facilitate the principles of trauma informed care which include: a. Safety - Ensuring residents have a sense of emotional and physical safety. b. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident. c. Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals. d. Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. e. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Empowerment, voice, and choice - Ensuring that resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: f. Experiencing a lack of privacy or confinement in a crowded or small space. g. Exposure to loud noises, or bright/flashing lights. h. Certain sights, such as objects that are associated with their abuser. i. Sounds, smells, and physical touch. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. The facility did not provide any additional policies related to behavioral health services.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and document review, the facility failed to identify specific care or practices necessary to meet identified care needs regarding post-traumatic stress disorder (PTSD). This had the potential to affect all residents currently residing in the facility with a diagnosis or history of PTSD. Furthermore, the facility failed to implement 1 of 1 facility assessment (FA) and ensure the identified number of staff deemed required to provide social services to residents had been maintained. The number of social services designee (SSD) was equal to 1 full time position. Findings include: The FA, dated 4/2025, indicated the purpose of the assessment was to identify the care required by the resident population using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments. Resident feedback and Community resources facilitates the development of a personalized plan of care for each resident. The facility dose have a specialty of providing Outpatient Chemical Dependency Treatment. This has the impact of making typical resident of this facility to be younger and more mobile. The services offered for mental health and behavior indicated management of the medical conditions and medication related issues causing psychiatric symptoms and behaviors, identify and implement interventions to help support individual with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder (PTSD), other psychiatric diagnoses, intellectual or developmental disabilities. The facility tries to adhere to the following plan for the basic number of staff; the department's daily staff, except for the manager's positions: Social Services Designee (SSD)- 1 FT. During an interview on 5/28/25 at 3:04 p.m., administrator stated the SSD is divided between two facilities about equal time and felt the time SSD put in at the facility was sufficient. Review of the undated facility policy titled Facility Assessment, indicated a facility assessment is conducted and documented to determine what resources are necessary to care for their residents competently during both day-to-day operations and the purpose was to establish responsibilities and procedures for the facility assessment process Furthermore, the policy indicated the administrator is responsible for ensuring the completion of the FA and maintaining all documents that pertain to the assessment. The administrator serves as the leader of the FA process, or may designate someone to lead the process. The assessment included a detailed review of the care required by the resident population using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments.