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	07/24/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were informed of medication changes for 1 of 3 residents (R1) reviewed for pharmacy services.Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had diagnoses including fracture of shaft of left femur (broken thigh bone), anxiety disorder, and opioid dependence. R1 received scheduled and as needed (PRN) pain medication and took opioid medication. R1 had intact cognition, understood others, and made herself understood.R1's physician order dated 6/12/25, was for oxycodone hydrochloride (HCl) (an opioid medication used to treat moderate to severe pain) oral tablet 5 milligrams (mg) with direction to give 5 mg by mouth every eight hours as needed for pain related to fracture of shaft of left femur. The order was discontinued on 6/24/25.R1's medication administration record (MAR) dated 6/1/25 through 6/30/25, identified the 5 mg PRN oxycodone order was last administered on 6/24/25 at 7:13 a.m.R1's provider note dated 6/24/25, indicated R1 was seen by nurse practitioner (NP)-A. The medication list included oxycodone HCl 5 mg oral tablet, give 5 mg by mouth every eight hours as needed for pain. The note indicated R1 was seen for evaluation of anemia. The plan for left femur fracture included oxycodone and stable. It did not indicate R1's oxycodone dose was changed from 5 mg to 1.5 mg or R1 was informed of this medication change. R1's physician order dated 6/24/25, was for oxycodone HCl oral tablet 5 mg with direction to give 2. 5 mg by mouth every eight hours as needed for pain related to fracture of shaft of left femur.R1's MAR dated 6/1/25 through 6/30/25, identified the 2.5 mg PRN oxycodone order was first administered on 6/24/25 at 3:20 p.m.R1's progress note dated 6/24/25 written by the assistant director of nursing (ADON), indicated R1's provider decreased her oxycodone from 5 mg to 2.5 mg every eight hours as needed. The note did not include evidence that R1 was notified of this change.During an interview on 7/23/25 at 11:23 a.m., R1 stated she had previously taken 2.5 mg of oxycodone but had increased pain because of her broken left femur and NP-A had increased her oxycodone to 5 mg every eight hours as needed. R1 stated that one day recently all of a sudden the evening nurse told her there had been a change in her oxycodone when she requested it, R1 said what are you talking about, and the nurse informed her the oxycodone had been decreased again to 2.5 mg. R1 stated she had a change in her medication and the evening nurse informed her, but NP-A had not discussed it with her nor other facility staff. In a follow-up interview at 5:03 p.m., R1 stated this made her feel very upset because she had been having increased pain and NP-A decreased her oxycodone but didn't come tell her and hadn't mentioned decreasing it when she had seen him. She spoke to him about it a few days later along with the ADON and was very upset. It made her feel disrespected, uninformed, and like her pain was invalidated. She felt like this wasn't proper and a patient shouldn't have their medications changed without being told.During an interview on 7/23/25 at 2:26 p.m., the ADON stated when a provider changed a medication order, nursing staff needed to tell the resident about the medication change. This notification would be documented in a progress note. The ADON usually went on rounds with NP-A and he would discuss changes with residents during his visit. The ADON confirmed R1's oxycodone order was changed from 5 mg to 2.5 mg every eight hours as needed on 6/24/25, and confirmed this change was not identified in NP-A's note dated 6/24/25. The ADON stated she did not see documentation indicating R1 was informed of this medication change. The ADON stated standard of practice was for residents to be informed of changes in care and treatment. It was important for resident to be informed so they were aware and they had the right to be informed.During an interview on 7/23/25 at 12:33 p.m., the director of nursing (DON) stated NP-A usually did rounds before changing any medications. There should be a note from the provider and a progress note from whoever input the medication order, including documentation that a resident was notified of a medication change. The DON stated the provider was responsible for notifying the residents of medication changes and explaining signs and symptoms they may experience and effects that could happen related to the change. During a follow-up interview at 3:26 p.m., the DON stated it was not in NP-A's note dated 6/24/25 that he was changing R1's oxycodone. She did not see evidence elsewhere that R1 was notified of the change or documentation of why the medication was decreased. Residents needed to be notified of changes because they needed to be involved in their care, know what they were taking, and had a right to be informed and notified. The DON stated she would get upset if she was a resident and her pain medication was decreased without being informed. Facility policy titled Medication Administration dated 6/12/24, indicated medications were administered by licensed nurses or legally authorized staff as ordered

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the resident's physician of multiple missed administrations of an opioid pain medication for 1 of 3 residents (R1) reviewed for pharmacy services. Findings include:R1's facesheet dated 7/24/25, indicated she had diagnoses including fracture of shaft of left femur (broken thigh bone), opioid dependence, neuralgia (pain caused by nerve damage or irritation) and neuritis (nerve inflammation), osteoarthritis of left knee, and fibromyalgia (chronic condition causing wide-spread pain throughout the body). R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1 received scheduled and as needed (PRN) pain medication, took opioid medication, and had intact cognition. R1's physician order dated 1/14/25, was for methadone hydrochloride (HCl) (an opioid pain medication used to treat severe pain) oral tablet 5 milligrams (mg). It directed, give 0.5 tablet (2.5 mg) by mouth two times a day for pain.R1's medication administration record (MAR) dated March 2025 and corresponding administration progress notes for the Methadone were reviewed. The record included the following:- 3/9/25 at 8:00 a.m., charted as code 9 indicating other/see progress notes; corresponding administration progress note at 7:14 a.m. identified NO SUPPLY. - 3/9/25 at 8:00 p.m., charted as code 9; corresponding administration progress note at 7:22 p.m. identified On back order. - 3/10/25 at 8:00 a.m., charted as code 9; corresponding administration progress note at 7:19 a.m. identified ON BACK ORDER - 3/10/25 at 8:00 p.m., charted as code 9; corresponding administration progress note at 8:58 p.m. was struck out with strike out reason of Declined Order and strike out date of 3/10/25 at 8:01 p.m. Additional note at 9:01 p.m. initiated however without additional information. - 3/11/25 at 8:00 a.m., charted as administered, R1's record did not include a corresponding administration note that could be identified for the morning dose. - 3/11/25 at 8:00 p.m., charted as administered. - 3/11/25 at 8:00 p.m. a second time, charted as code 9. Administration progress note at 7:06 p.m. included NO MED- on back order. Additional note at 9:57 p.m. did not include additional information. Review of facility narcotics logbook entry number 16 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The last entry was dated 3/8/25 at 7:20 p.m. with amount on hand of one, amount used of one, and amount left of zero.Review of facility narcotics logbook entry number 38 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The first entry was dated 3/11/25 with no time and indicated 60 tablets were received. The following entry indicated the first administration of the new supply of medication was on 3/11/25 at 9:55 p.m.Review of R1's progress notes did not identify notification of R1's physician regarding the missed administrations of methadone from 3/9/25 through 3/11/25. Email dated Sunday 3/9/25 at 3:30 p.m., provided to the surveyor was from nurse practitioner (NP)-A to the facility's nursing email account in response to an email sent from the nursing account on 3/9/25 at 2:25 p.m. Email from the nursing account included, Methadone is on backorder and [R1] is running out of it very soon. Is it possible to order something else as we wait for the back order? The email did not identify the author. NP-A's emailed response included, I can switch to something for [R1] and will talk to her Tuesday. The facility's email did not identify that R1's supply of methadone had already run out with last dose administered on 3/8/25 at the 8:00 p.m. as documented in the MAR and narcotics logbook. No further emails or replies regarding R1's methadone were identified and provided to the surveyor by the facility. During an interview on 7/23/25 at 12:33 p.m., the director of nursing (DON) stated if a medication was not available staff should call the provider who would give an order for an alternative medication or order to hold the unavailable medication. Notification of the provider would be documented in the MAR progress notes or in emails. If there was no supply of a medication, staff should call the provider. In a follow-up interview at 3:26 p.m., the DON reviewed R1's MAR and narcotic book logs and confirmed R1 missed doses of her methadone twice on 3/9/25, twice on 3/10/25, and the morning of 3/11/25. The DON confirmed the email to NP-A dated 3/9/25 did not identify R1 had no supply of methadone and did not identify the 8:00 a.m. administration that day was missed. The DON stated she did not see documentation R1's provider was notified her methadone was unavailable and not given from 3/9/25 through 3/11/25.During an interview on 7/24/25 at 11:57 a.m., NP-A stated he was part of the primary care team for all residents at the facility along with a medical doctor. NP-A believed R1's methadone had been on backorder with the pharmacy previously. He did not remember being notified but assumed it would have been via email. He did not recall being notified that R1 was actually out of the methadone, and if it was not in the email dated 3/9/25 provided by the surveyor for his review, then he did

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure resident grievances were provided with a written response for 2 of 4 residents (R1, R3) reviewed for grievances. Findings include:R1's face sheet dated 6/24/25, identified diagnoses of depression (a mood disorder that causes persistent sadness) and anxiety (an emotion that causes feelings of fear, dread, and unease).R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact and had no behaviors.During an interview on 7/23/25 at 11:23 a.m., R1 stated the week prior she had completed two different grievance forms about concerns with two staff members. One of the grievances was regarding a staff member performing wound care on a resident in a public area and not performing proper hand hygiene. The second grievance was about a staff member with body odor and being on their personal cell phone for an extended period, while they were supposed to be working. R1had given one of the grievances to an unidentified staff member to place on the social worker's desk, and the other grievance form was given to the assistant director of nursing (ADON). R1 further stated that the ADON had spoken with her regarding the grievance of the staff member performing wound care in a public area, however she never received a written response from the facility on what was done about it. R1 also stated she had not received a written response to the filed grievance about a staff member with body odor/being on their phone while working. Review of the facility grievances from May 2025 through July 2025, only identified one grievance form had been filed by R1. Review of a facility Grievance Form dated 7/16/25. Identified R1 had voiced concerns about a nurse that completed wound care on another resident at the nursing station and did not performing hand hygiene. The investigation indicated staff was observed doing wound care and giving insulin by the nursing station. Education had been done previously, and staff member was given a written discipline on 7/16/25. Plan of resolution was staff was educated to do all cares and insulin in resident's room or in a private area and verbalized understanding. Follow up on R1's 7/16/25 grievance form was left blank. R3's face sheet dated 7/24/25, identified diagnoses of generalized anxiety disorder, explosive disorder (a mental disorder characterized by explosive outbursts of anger/violence), and affective mood disorder (a serious mental illness that causes persistent and intense changes in mood, energy, and behavior).R3's significant change MDS dated [DATE], identified R1 was cognitively intact and had no behaviors. Review of a facility Grievance Form dated 6/12/25, identified R1 had voiced concerns about an inheritance check he was supposed to have received, and the business office manager would not give him his check. Investigation summary was that R3 did not receive any inheritance check and only received a direct express card in his account. Plan of resolution was to talk to psychiatry about the episodes and continue to monitor. Follow up was to change medication regime and continue to see psychiatry.During an interview on 7/23/25 at 10:45 a.m., R3 stated he filled out a grievance form last month regarding an inheritance check that he was supposed to have received, however, had not received it. R3 further stated he had not heard or received a written response on what the facility found out about his inheritance check, and I guess it is none of my business on what was found out about what they did. R3 said there is a stereotype in the facility, that the people that live here do not even have enough memory to recall what was told to the facility and that is why we do not get a response. During an interview on 7/24/25 at 8:33 a.m., long term care ombudsman (OMB) stated she attends the monthly resident council meetings and the concerns from the residents each month continue to be the same, that their grievances that they file always go unanswered. Residents will fill out the grievance forms, turn them in, however, do not get a response from the facility on the resolution. OMB stated she had requested from the administrator on how the grievances are managed in the facility and requested the grievance policy, however, did not get a response from the administrator. During an interview on 7/24/25 at 11:55 a.m., administrator stated that all grievances from residents are to be responded to within five business days, however, the grievances that R1 and R3 filed did not identify a date/time or copy of the written response regarding their grievances. Administrator further stated she will be adding a signature line on the current grievance forms where the resident can sign/date the form from now on and this will ensure the facility has documentation that the resident being informed of the resolution of the filed grievance and can use this to provide the resident with written response. Review of the facility's Resident and Family Grievances Policy dated 11/18/24, identified the following: In accordance with the resident's right to obtain a written decision regarding his or her grievance, the grievance official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to revise the care plan for wake-up and/or medication administration times for 1 of 4 residents (R4) who demonstrated new behaviors when her medications were not provided in accordance with her preferences. Findings include R4's face sheet dated 7/24/25, identified diagnoses of anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear) , borderline personality disorder (a mental disorder characterized by unstable moods and behaviors), and delusional disorder (a serious mental disorder where a person cannot tell what is real from what is imaginary).R4's annual Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and no behaviors. During an observation on 7/23/25 at 11:29 a.m., R4 was in the day room standing next to the medication cart talking in a loud voice to trained medication aide (TMA)-A, I want my medications, it is my right to get my medications that are prescribed. R4 further began saying no staff came in and woke her up to take her medications today and why are you not giving them to me. Clinical registered nurse consultant (CRNC) informed R4 that her meds could not be given to her because it was beyond the time limit, and staff needed to follow the doctor's orders. R4 then began hitting her fist on the chair in the dayroom yelling I need my medications, and it is a state law for you to give them to me. R4 continued to state, I need my medications, and it is my right to get them. R4 was pacing up and down the hallway during this time and continued to return to the medication cart multiple times. CRNC then placed a phone call to the on-call physician and obtained an order to administer R4's morning medications. Once R4 had received her medications she began to speak in a normal tone and then began asking staff to get a lunch ready for her to take to an outside appointment in a normal tone.In review of R4's current care plan it did not address her preferences for wake-up times and/or preferences to be woken up for her morning medications. During an interview on 7/23/25 at 12:07 p.m., TMA-A stated she attempted to go into R4's room three times that day, however R4 was sleeping each time, so she signed them off in the medication administration record as not given due to R4 sleeping. When R4 came to her around 11:20 a.m., she requested her morning medication, however when she told her it was too late for me to give them to her R4 became upset and began yelling. During an interview on 7/23/25 at 12:30 p.m., TMA-D stated R4 will normally get up around 9:00 to 9:30 a.m. daily, and when she is due to get her meds, if R4 is still in bed she will go in and gently wake her up, and tell her tell her it is time for her morning medications and she will take her pills and then go back to sleep if she wants to. That is how she like to take her pills, and it seems to work for her. During an interview on 7/24/25 at 10:15 a.m., R4 stated that she normally gets up around 9:00 a.m., however, sometimes she likes to sleep longer, and, on those days, most staff will wake her up and tell her it is time for her morning medication, then she will wake up and take her pills and then go back to sleep. It is my right to get my medication, and it is their job to make sure I get it on time. R4 stated the facility told her that they have fixed it now and will be ensuring they will be giving her medication the way she likes to receive it nowDuring an interview on 7/24/25 at 11:37 a.m. registered nurse (RN)-B stated R4's focus behavior care plan that outlined her medication administration preferences had not been created and updated until 7/23/25 after R4 been upset for not being woken up for her morning medications. RN-B stated she participates in the care planning process for R4 but was not aware of R4's preferences regarding her medication administration.During an interview on 7/23/25 at 2:51 p.m., director of nursing (DON) stated R4's behavior that occurred in the morning regarding not getting her medications, was not a normal behavior for her and was out of the ordinary. R4 likes to sleep in and will always get her medications late and thought it had been care planned for her choices but was uncertain if R4's care plan was reflective of this. Review of the facility's Comprehensive Care Plan policy dated, 4/21/25, identified the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident was appropriately assessed and monitored for potential effects of an opioid pain medication that was not administered as ordered for two and a half days for 1 of 3 residents (R1) reviewed for pharmacy services.Findings include: R1's facesheet dated 7/24/25, indicated she had diagnoses including fracture of shaft of left femur (broken thigh bone), opioid dependence, neuralgia (pain caused by nerve damage or irritation) and neuritis (nerve inflammation), generalized anxiety disorder, insomnia, other muscle spasm, osteoarthritis of left knee, and fibromyalgia (chronic condition causing wide-spread pain throughout the body). R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1 received scheduled and as needed (PRN) pain medication, took opioid medication, and had intact cognition.R1's care plan focus dated 8/6/24, identified R1 had pain related to muscle spasms, left femur fracture, migraine, hammer toe, fibromyalgia, and osteoarthritis of left knee. Interventions included: monitor/record/report to nurse resident complaints of pain or requests for pain treatment dated 8/6/24, monitor/document for side effects of pain medication dated 8/11/24, non-pharmacological pain interventions dated 4/17/25, and opioid side effect monitoring dated 4/27/25. R1's physician order dated 1/14/25, was for methadone hydrochloride (HCl) (an opioid medication used to severe pain) oral tablet 5 milligrams (mg). It directed, give 0.5 tablet (2.5 mg) by mouth two times a day for pain. Review of facility narcotics logbook entry number 16 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The last entry was dated 3/8/25 at 7:20 p.m. with amount on hand of one, amount used of one, and amount left of zero. R1's medication administration record (MAR) dated March 2025 and corresponding administration progress notes for the Methadone were reviewed. The record included the following: - 3/9/25 at 8:00 a.m., charted as code 9 indicating other/see progress notes; corresponding administration progress note at 7:14 a.m. identified NO SUPPLY. - 3/9/25 at 8:00 p.m., charted as code 9; corresponding administration progress note at 7:22 p.m. identified On back order. - 3/10/25 at 8:00 a.m., charted as code 9; corresponding administration progress note at 7:19 a.m. identified ON BACK ORDER - 3/10/25 at 8:00 p.m., charted as code 9; corresponding administration progress note at 8:58 p.m. was struck out with strike out reason of Declined Order and strike out date of 3/10/25 at 8:01 p.m. Additional note at 9:01 p.m. initiated however without additional information. - 3/11/25 at 8:00 a.m., charted as administered, R1's record did not include a corresponding administration note that could be identified for the morning dose. - 3/11/25 at 8:00 p.m., charted as administered. - 3/11/25 at 8:00 p. m. a second time, charted as code 9. Administration progress note at 7:06 p.m. included NO MED- on back order. Additional note at 9:57 p.m. did not include additional information. Review of R1's progress notes dated 3/9/25 through 3/11/25 did not identify additional notes regarding R1's missed administrations of methadone or related assessment and monitoring. Review of R1's assessments dated 3/9/25 through 3/11/25 did not identify any completed assessments.R1's vital signs section in the electronic health record (EHR) dated 3/9/25 through 3/11/25 included the following:- Pain levels (on scale of one to 10) on 3/9/25: 0, 7, 3, 5, 3, 6, 8, and 5.- Pain levels (on scale of one to 10) on 3/10/25: 9, 5, 8, 8, 6, 6, 8, 6, 8, 9, and 5.- Pain levels (on scale of one to 10) on 3/11/25: 7, 8, 8, 3, 8, 3, 8, and 4.Vital signs did not include any associated recorded blood pressure, oxygen saturation level, heart rate, respiratory rate, or temperature.During an interview on 7/23/25 at 11:23 a.m., R1 stated there was a time about four months ago when she did not receive her methadone for about two days, she took it twice a day and thought she had missed maybe six doses. She took the medication for pain. During a continued interview at 5:03 p.m., R1 stated when she did not receive her methadone, she felt like she was crawling out of her skin, had increased pain, increased irritability, sweatiness, restlessness, sleeplessness, and definitely felt like she was having withdrawal. She informed staff that she was having increased pain, but stated staff did not monitor her more than usual or take her vital signs to identify an increase in her pain levels.During an interview on 7/23/25 at 4:40 p.m., licensed practical nurse (LPN)-A stated R1 had previously run out of methadone for a few days, and he thought the facility ran out of supply and it was back-ordered at the pharmacy. If a medication was not available to be given as ordered, he would notify the provider for direction. For missed administrations of methadone, LPN-A would monitor for withdrawals, take vital signs, and inform the provider that they did not have the medication. Specific monitoring would include watching for things like shakes, is someone in pain, headaches, changes in vital signs, and sweatiness. LPN-A stated he didn't think he knew what type of vital

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	07/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medications were available to be administered in accordance with physician orders and failed to identify and report a medication error for 1 of 3 (R1) residents reviewed for pharmacy services. Findings include:R1's facesheet dated 7/24/25, indicated she had diagnoses including fracture of shaft of left femur (broken thigh bone), opioid dependence, neuralgia (pain caused by nerve damage or irritation) and neuritis (nerve inflammation), generalized anxiety disorder, insomnia, other muscle spasm, osteoarthritis of left knee, and fibromyalgia (chronic condition causing wide-spread pain throughout the body). R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated . R1 received scheduled and as needed (PRN) pain medication, took opioid medication, and had intact cognition.R1's physician order dated 1/14/25, was for methadone hydrochloride (HCl) (an opioid medication used to severe pain) oral tablet 5 milligrams (mg). It directed, give 0.5 tablet (2.5 mg) by mouth two times a day for pain. R1's medication administration record (MAR) dated March 2025 in conjunction with administration notes, included the following documentation for administrations of the ordered methadone:- 3/9/25 at 8:00 a.m., charted as code 9 indicating other/see progress notes; corresponding administration progress note at 7:14 a.m. identified NO SUPPLY. - 3/9/25 at 8:00 p.m., charted as code 9; corresponding administration progress note at 7:22 p.m. identified On back order. - 3/10/25 at 8:00 a.m., charted as code 9; corresponding administration progress note at 7:19 a.m. identified ON BACK ORDER - 3/10/25 at 8:00 p.m., charted as code 9; corresponding administration progress note at 8:58 p.m. was struck out with strike out reason of Declined Order and strike out date of 3/10/25 at 8:01 p.m. Additional note at 9:01 p.m. initiated however without additional information. - 3/11/25 at 8:00 a.m., charted as administered, R1's record did not include a corresponding administration note that could be identified for the morning dose. - 3/11/25 at 8:00 p. m., charted as administered. - 3/11/25 at 8:00 p.m. a second time, charted as code 9. Administration progress note at 7:06 p.m. included NO MED- on back order. Additional note at 9:57 p.m. did not include additional information.Review of facility narcotics logbook entry number 16 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The last entry was dated 3/8/25 at 7:20 p.m. with amount on hand of one, amount used of one, and amount left of zero.Review of facility narcotics logbook entry number 38 identified the page was for tracking R1's methadone 5 mg with direction to give half tablet two times a day. The first entry was dated 3/11/25 with no time and indicated 60 tablets were received. The following entry indicated the first administration of the new supply of medication was on 3/11/25 at 9:55 p.m.In an email dated 7/24/25 at 2:30 p.m., the administrator noted there were no facility medication errors for the month of March 2025.During an interview on 7/23/25 at 11:23 a.m., R1 stated there was a time about four months ago when she did not receive her methadone for about two days, she took it twice a day and thought she had missed maybe six doses. She took the medication for pain. During a continued interview at 5:03 p.m., R1 stated when she did not receive her methadone, she felt like she was crawling out of her skin, had increased pain, increased irritability, sweatiness, restlessness, sleeplessness, and felt like she was having withdrawal.During an interview on 7/23/25 at 12:07 p.m., trained medication assistant (TMA)-A stated if a medication was scheduled for administration but not available, she would see if it was in the facility's medication bank. If it wasn't there, she would call the pharmacy. She was not sure if it was a medication error if a medication administration was missed because the medication was unavailable. During an interview on 7/23/25 at 4:40 p.m., licensed practical nurse (LPN)-A stated if a medication was back ordered the provider should be notified. He remembered R1 had previously run out of her methadone and it was on backorder at the pharmacy. He did not recall if he had notified R1's provider of this or followed up when he was unable to administer R1's methadone as ordered. When asked if a provider order was needed to hold a medication if it was unavailable for administration, he stated he had never seen or been told that. He was not sure if it was a medication error if a dose of a medication was missed without a provider order to hold it. During an interview on 7/23/25 at 3:04 p.m., pharmacy general manager (PM) at the facility's pharmacy stated methadone was not currently and had not previously been stocked in the facility's medication bank. PM noted the pharmacy first received a refill request for R1's methadone on 2/25/25 and had notified the facility the medication was out of stock due to a national shortage and requested the provider change to an alternative form or medication. The notification was sent again on 3/4/25 when a second refill request was made. PA did not see any response from the facility or order for an alternative. The methadone