STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. Building B. Wing	09/02/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and document review, the facility failed to ensure both recertification survey results, complaint investigations, and facility plans of correction were available for review. This had the potential to affect all forty-three (43) residents residing in the facility, as well as family, visitors, and staff. Findings include:R5's brief interview for mental status (BIMS) dated 8/11/25, indicated R5 had moderately impaired cognition.On 8/27/25 at 3:50 p.m., R5 indicated he would like to see the results of the surveys that the State Agency (SA) conducted however, did not know where to locate them.On 8/27/25 at 4:00 p.m., a binder titled facility survey results was located in a plastic wall file by the front entrance behind the resident council minutes. The survey results included in the binder consisted of the recertification survey results for 4/25/24, and complaint investigation results for 5/21/24, and 5/28/25.A review of Aspen Central Office (ACO-an online computerized federal document site which contains the surveys completed for facilities, including both recertification surveys, and complaint investigation) identified recertification surveys were completed on 6/29/23, 4/25/24, and 11/18/24. Additionally, complaint investigations were completed and noted to have citations issued on the following dates: 12/28/22, 3/23/23, 7/12/23, 7/26/23, 2/28/24, 5/21/24, 9/24/24, 12/24/24, and 5/28/25.The facility survey result binder lacked the following: recertification surveys completed 6/29/23, and 11/18/24; facility's plan of correction for 4/25/24; complaint surveys completed 12/28/22, 3/23/23, 7/12/23, 7/26/23, 2/28/24, 9/24/24, and 12/24/24; facility's plan of correction for 5/21/24. During an interview on 8/28/25 at 11:54 a.m., the corporate clinical care coordinator (CCCC) indicated the survey results were public knowledge and should contain all state agency surveys with facility plan of corrections. The CCCC verified the facility survey binder did not contain all the required surveys or facility plans of correction. During an interview on 9/2/25 at 4:39 p.m., the administrator was unable to locate the facilities survey binder however, indicated the residents take them and stated, they [survey results] disappear as fast as we put them out. A facility policy was requested for posting of survey results however, was not provided.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 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, observation, and document review, the facility failed to protect 1 of 1 resident (R1) from resident-to-resident physical abuse. Findings include: A Vulnerable Adult Maltreatment report submitted to the State Agency (SA) on 8/21/25 at 9:35 p.m., identified alleged physical abuse when it was reported that at approximately 8:00 a.m. that morning, R2 had pulled R1's hair, struck her in the back of the head, and pushed her wheelchair. R2 admitted that he had pulled R1's hair during a verbal altercation outside in the smoking area however, denied hitting or pushing R1. A Facility Reported Incident (FRI) submitted to the SA on 8/22/25 at 11:35 a.m., alleged abuse when R2 tugged R1's hair and hit her head while outside. The alleged abuse occurred on 8/21/25 at approximately 10:00 a.m.During an interview with R1 on 9/2/25 at 5:55 p.m., R1 indicated on 8/21/25 at approximately 8:00 a.m., R2 hit her in the back of the head, pulled her hair, and pushed her wheelchair into the fence in the smoking area. R1 stated, I immediately got a headache and got a Tylenol. R1 further identified she told several nursing staff immediately after it happened however, could not remember who she had talked to. R1 identified the next day on 8/22/25, R2 scared her when he told her he was going to kill her. R1 stated she immediately called a family member to come and pick her up because she did not feel safe. R2 stated she discharged from the facility and was not going back. During an interview with family member (FM)-A on 9/2/25 at 5:30 p.m., FM-A stated R1 was upset when she called to report that R2 had punched her in the back of the head and hit her head on the back of the fence. FM-A called the facility but did not get any one to answer so called the Sheriff's department to do a well check on R1 to assure her safety. FM-A stated the next morning, R1 called her again to request FM-A to pick her up from the facility immediately because she did not feel the facility was doing enough to protect her and that R2 had threatened her that morning. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and no behaviors. Identified R1 used a wheelchair for mobility and required substantial staff assist with dressing, transferring, bed mobility, and personal hygiene. A follow up brief interview for mental status on 8/22/25, indicated R1 had moderately impaired cognition. R1's Care Plan Report identified R1 had a potential for abuse due to current health condition that required assistance with activities of daily living (ADL)'s and cognition. Diagnoses included alcohol dependence, tobacco dependence, major depressive disorder and repaired fracture of femur and pelvis. R1's Medication Administration Record identified on 8/21/25, R1 complained of a pain level of ten (10) and received Acetaminophen 500 milligram (mg) two tablets at 8:02 a.m. R1's Discharge Assessment indicated R1 left the facility against medical advice (AMA) on 8/22/25 at 11:30 a.m.During an observation and interview on 8/28/25 at 10:01 a.m., R2 was lying in bed coloring and watching television. R2 stated, she [R1] called me a [expletive] so I grabbed her by the scruff of the hair and shook her a little bit and then let her go. R2 further stated, she [R1] must have been scared of me because she left the next day. R2 further indicated the staff talked to him the next day and had him sign a paper that he would agree to not have any further physical altercations and had not. R2's quarterly MDS dated [DATE], indicated R2 had intact cognition and no behaviors. Identified R2 had no upper extremity impairment however, had lower extremity impairment and used a manual wheelchair. R2 was independent wheeling his wheelchair. Diagnoses included paraplegia (paralysis of the legs and lower body), alcohol dependence, and adjustment disorder with mixed anxiety and depressed mood. R2's care plan updated 8/22/25, indicated R2 had a behavior problem as evidenced by previous episodes of yelling, throwing things, and alleged physical aggression. The care plan identified triggers as pain and disrespect. Facility incident report dated 8/17/25 at 1:15 p.m., identified R2 had a verbal altercation and made a threat of violence with an unidentified resident. The facility identified R2 had a decrease in a medication that caused R2 to have increased discomfort, and he became more short-tempered. The facility placed R2 on 30-minute checks for mood monitoring from 8/17/25 to 8/22/25. During an interview on 9/2/25 at 2:08 p.m., nursing assistant (NA)-A indicated she was working on 8/21/25 when the alleged incident occurred. Further identified R1 told her at approximately 8:00 a.m. that R2 had pulled her hair and punched her while outside in the smoking area. NA-A identified she told the assistant director of nursing and the charge nurse about the allegation immediately after R1 reported it and they placed R1 and R2 on 15-minute checks.During an interview on 9/2/25 at 2:02 p.m., NA-B identified R1 reported that R2 had pulled her hair and punched or slapped her on the head. NA-B stated they started 15-minute checks on R1 and R2 for safety. During an interview on 9/2/25 at 2:36 p.m., NA-C indicated she

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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 an allegation of abuse timely to the State Agency (SA) for 1 of 1 resident (R1) reviewed for allegations of abuse.Findings include: A Facility Reported Incident (FRI) submitted to the State Agency (SA) on 8/22/25 at 11:35 a.m., alleged abuse when R2 tugged R1's hair and hit her head while outside. The alleged abuse occurred on 8/21/25 at approximately 10:00 a.m. (Approximately 25 1/2 hours prior to reporting to the SA). R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and no behaviors. Identified R1 used a wheelchair for mobility and required substantial staff assist with dressing, transferring, bed mobility, and personal hygiene. A follow up brief interview for mental status on 8/22/25, indicated R1 had moderately impaired cognition. R1's Care Plan Report identified R1 had a potential for abuse due to current health condition that required assistance with activities of daily living (ADL)'s and impaired cognition. Diagnoses included alcohol dependence, tobacco dependence, major depressive disorder and repaired fracture of femur and pelvis. During an interview with R1 on 9/2/25 at 5:55 p.m., R1 indicated on 8/21/25 at approximately 8:00 a.m., R2 hit her in the back of the head, pulled her hair, and pushed her wheelchair into the fence in the smoking area. R1 stated, I immediately got a headache and got a Tylenol. R1 further identified she told several nursing staff immediately after it happened but could not remember who she had talked to. R1 identified the next day (8/22/25), R2 threatened her again and she called a family member to come and pick her up. R2 stated she discharged from the facility and was not going back. R2's quarterly MDS dated [DATE], indicated R2 had intact cognition and no behaviors. Identified R2 had no upper extremity impairment, had lower extremity impairment and used a manual wheelchair. R2 was independent wheeling his wheelchair. Diagnoses included paraplegia (paralysis of the legs and lower body), alcohol dependence, and adjustment disorder with mixed anxiety and depressed mood. During an interview on 9/2/25 at 2:08 p.m., nursing assistant (NA)-A indicated she was working on 8/21/25, when the alleged incident occurred. NA-A stated at approximately 8:00 a.m., R1 reported that R2 had pulled her hair and punched her while outside in the smoking area. NA-A identified she told the assistant director of nursing and the charge nurse about the allegation immediately after R1 reported it and they placed R1 and R2 on 15-minute checks. During an interview on 9/2/25 at 11:34 a.m., the administrator indicated she was notified of the incident on 8/21/25, however, did not know about R2 hitting R1. The administrator verified the FRI was submitted late to the SA on 8/22/25, when she became aware of the hitting.The Sheriff's Office Incident Report dated 8/21/25 at 7:21 p.m., R1's family member called to request a welfare check on R1 as R1 had reported R2 assaulted her. The sheriff's deputy responded at 7:34 p.m. and identified that R1 reported at 8 a.m. that morning, R2 pulled her hair, struck her in the back of the head, and pushed her wheelchair. The deputy informed staff of the situation and staff stated that they would keep R1 and R2 separated. Approximately 16 hours prior to the FRI was submitted to the SA.Review of facility policy titled The Abuse, Neglect, and Exploitation Policy last revised 4/25/25, indicated the facility was to report all alleged violations to the administrator, state agency, adult protective services, and all other required agencies (law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation was made for events that caused the allegation to involve abuse or result in serious bodily injury.