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	04/25/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49336 Based on observation, interview, and document review, the facility failed to ensure 1 of 24 residents (R3) appropriately disposed of cigarette butts after use. This had the potential to affect 23 other residents who also smoked. Findings include: Interview on 4/22/24 at 10:55 a.m., during initial interview with R3 stated after she smoked, she would store her used cigarette butts in her jacket pocket after use and discarded that cigarette butts in the trash bin in her room. R3 was aware of a receptacle outside to dispose of cigarette butts. Observation on 4/22/24 at 11:39 a.m., of facility entrance door to the designated smoking area had signs posted for residents to pick up their cigarette butts and place in proper receptacle when they were finished smoking. The designated smoking area had a smoking receptacle near the door for cigarette butt disposal. Observation and interview on 4/22/24 at 3:49 p.m., outside in the designated smoking area identified R3 walked away from the designated smoking area. R3 opened her jacket pocket and showed her used cigarette butts in her jacket pocket. She stated she planned to discard them in the trash rather than the ash tray outside. R3's 3/04/24, Smoking Review assessment identified R3 was a smoker and had visual deficit. R3 had understood the smoking policy, areas of designated smoking and storage of smoking materials. R3's, 3/07/24 quarterly Minimum Data Assessment (MDS) identified R3 had severe cognitive impairment, and a diagnosis of anxiety, depression, schizophrenia and was independent with mobility. The MDS failed to identify if R3 used tobacco products. R3's current, undated care plan identified R3 would not suffer injury from unsafe smoking practices and would be educated on smoking location, times, and concerns. Staff were to notify the charge nurse if R3 violated facility smoking policy. Interview on 4/23/24 at 9:04 a.m., with nursing assistant (NA)-B stated that facility had signs posted outside on the window to inform residents that cigarettes are to be discarded outside in the receptacle. The NA wasn't (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/23/24 at 10:25 a.m., with the director of nursing (DON) stated she was aware of R3's practices and had found cigarette buds in R3's room floor in her room and R3 had been educated on facility expectations of cigarette use in the past. The DON was unaware R3 was still continuing to practice of putting her used cigarettes in her pocket on her person. Review of 9/28/23, Smoking Policy-Residents identified the facility would have a designated smoking area outside the building and ashtrays would be placed in designated receptacle.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49336 Based on observation, interview, and document review, the facility failed to ensure 1 of 3 (R8) residents oxygen (O2) had been administered per physician orders. Findings include: R8's 3/15/24, quarterly Minimum Data Assessment (MDS) identified R8 had moderate cognitive impairment and had a diagnosis of pneumonia, anxiety, depression, and respiratory failure. R8 had partial/moderate assistance related to her activities of daily living and was independent with walking 10 to 50 feet. R8's Section O of the MDS identified R8 had oxygen. Review of R8's, current, undated, Order Summary Report identified R8 was to receive 2 liters of O2 at rest and 5 liters of O2 with activities. Observation on 4/22/24 at 11:51 a.m., with R8 asleep in bed. R8 had her nasal cannula on with her O2 set on 4 liters. Observation on 4/22/24 at 2:53 p.m., with R8 watching television with her O2 set at 4 liters. Observation on 4/22/24 at 4:39 p.m., with R8 eating a meal with her O2 set at 4 liters. Observation and interview on 4/22/24 at 4:55 p.m., with nursing assistant (NA)-C stated R8 should be on 2 liters of O2 when R8 when not active. NA-C confirmed the oxygen reading was at 4 liters of O2 and not at the correct setting. Interview and observation on 4/22/24 at 4:57 p.m., with licensed practical nurse (LPN)-B stated R8 should be on 2 liters of oxygen at rest and confirmed R8 was on 4 liters. LPN-B turned the O2 setting down to 2 liters. LPN-B stated staff would round on R8 to verify placement and setting of O2. LPN-B had no response for how staff would notify her of R8's O2 setting had been changed. Interview on 4/22/24 at 7:52 p.m., with director of nursing (DON) stated her expectations would be for staff to follow physician orders related to oxygen use and the facility should have interventions in place for oxygen tubing changes to prevent the risk of infection related to contamination of oxygen tubing when in use. There were no orders to titrate R8's oxygen between the baseline 2 L and the maximum 5L of oxygen. Review of 4/01/24 Oxygen Administration policy identified the facility would administer oxygen as prescribed by the physician. The facility would administer oxygen therapy for residents by following the professional standards of practice.

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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. 47497 Based on observation and interview, the facility failed to ensure an insulin pen was appropriately primed prior to administration for 1 of 1 resident (R7). Findings include: Observation and interview on 4/24/24 at 8:37 a.m., with licensed practical nurse (LPN)-A identified she completed a blood sugar check on R7 with blood sugar registering at 113. LPN-A identified that based on her blood sugar she would only receive her Lantus injection. LPN-A dialed the Lantus pen to 50 units, removed the cap and used an alcohol wipe to clean the pen hub, then attached a disposable needle tip. LPN-A then administered the insulin subcutaneously to R7. LPN-A did not prime the insulin pen with 2 units of insulin prior to dialing up the ordered dose. LPN-A identified she was surprised she had forgot to prime the pen. R7's April 2024, Medication Administration Record (MAR) identified R7 was administered Novolog (a rapid acting insulin) 5 units subcutaneously 2 times daily at 8:00 a.m., and 12:00 p.m., and 7 units one time daily at 4:30 p.m., R7 also received Lantus (long-acting insulin) 50 units subcutaneously two times daily at 8:00 a.m., and 8:00 p.m. for diabetes. Review of the current, Lantus How to use your Solostar pen instructions, located at https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf, identified: 1) Step 1: Remove the pen cap with clean hands. Check the reservoir to make sure the insulin is clear and colorless and has no particles-if not, use another pen. 2) Step 2: Attach the needle. Wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Do not make the needle too tight. If you have a push-on needle, keep it straight as you push it on. After you have attached the needle, take off the outer needle cap and save it (you will need it to remove the needle after your injection). Remove the inner needle cap and throw it away. 3) Step 3: Perform a safety test. Dial a test dose of 2 Units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. 4) Step 4: Administer the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's 3/17/24, quarterly Minimum Data Set (MDS) assessment identified her cognition was intact. R7 had diagnoses of diabetes mellitus, and had a daily insulin injection. Interview on 4/24/24, at 12:49 p.m., with director of nursing (DON) confirmed staff should be priming insulin pens with 2 units prior to dialing up ordered dose of insulin. She had not completed any insulin competencies with licensed nurses. She also identified that they did not have a drug book or manufacturer's directions available for nurses to reference at the nurses station, medication room, or medication cart but that she had requested the executive director of operations to order a new drug book for the nurses desk. Interview on 4/25/24 at 11:39 a.m., with the executive director of operations identified that she would expect the DON to have ensured licensed nurses were competent with insulin administration. There was no policy related insulin administration

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39988 Based on interview and document review the facility failed to have evidence of analysis and evaluation of the identified Performance Improvement Project (PIP) concerns for 1 of 1 Quality Assurance Performance Improvement (QAPI) program. Findings include: Review of the 5/25/23, QAPI meeting minutes identified the facility had a performance improvement project (PIP) for notifying the ombudsman of discharges, giving proper notice of discharge in an emergency, ensuring TeleMed MD visits were documented in point click care the facility electronic medical record, and ensure new residents were seen in-person by MD and were on a correct rounding schedule. These PIP projects were reviewed and discontinued at the meeting. Continued PIP project was to ensure new admission completed a Mantoux Skin Test and the process was followed correctly. Review of the 9/28/23, QAPI meeting minutes lacked identification of the Mantoux PIP project or analysis of the PIP project to ensure new admission completed a Mantoux Skin Test and the process was followed correctly and if the project would continue or not. There were no new high risk or problem-prone areas identified. Review of the 3/28/24, QAPI meeting minutes the facility had four PIP projects they were working on as follows: 1) A Call Light PIP project that was initiated 1/30/24, with a goal of staff response within 1 minute or less. The interventions included call light audits, discussion and brainstorming at IDT meetings, and educate staff. The plan identified to monitor and analyze the data with an expected close date of 4/25/24. Data identified average response rate in January 2024, was 2.2 minutes and in February 2024, was 1.3 minutes. 2) A Falls PIP project that was initiated 11/30/23, with a goal to decrease the number of falls per month and have a 6-month average below 10. The interventions included fall rounds, discussion and brainstorming at IDT, 100% fall risk assessment completion, and educate residents on their assistive devices with and expected close date of 4/25/24. The data identified number of falls for November 2023, was 5, December 2023, was 9, January 2024, was 3, February 2024, was 9, and March 2024, was 5. 3) a Relias PIP project that was initiated 1/30/24, with a goal to increase average completion rate of Relias training to above 75%. Interventions included educate staff, ensure that managers are monitoring completion, and review completion rates monthly with an expected close date of 4/25/24. The data identified average completion rate January 2024, was 32%, February 2024, was 2%, and March 2024, was 13%. 4) A Grievance PIP initiated 5/25/23, with a goal to reduce the number of grievances to 1 per calendar year. Interventions include educate residents upon admission about the facilities grievance system and educate staff on resident care via Relias with an expected close date of 4/25/24. The data identified the number of grievances in the month of: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a) May 2023 was 0, b) June 2023 was 5, c) July 2023 was 2, d) August 2023 was 0, e) September 2023 was 6, f) October 2023 was 0, g) November 2023 was 2, h) December 2023 was 0, i) January 2024 was 2, and j) February 2024 was 5. All four PIP projects lacked documentation on analysis of data reviewed, if the interventions should be modified or if the project needed to continue or not. Interview on 4/24/24 at 3:17 p.m., with executive director of operations identified she was not the administrator for the facility and the administrator was out and unavailable at the time. During review of the QAPI meeting minutes she identified she was unsure who was completing the fall rounds and requested the director of nursing (DON) to join. The DON reported all department heads were responsible to walk around each day. Following review of the fall data with the executive director identified she agreed that there had been no analysis of the fall data or modification to the interventions documented. She reported the Relias training project the staff were either going to do it or they were not, again she agreed that there had been no analysis of the data or modification to the interventions. She lastly stated she would have never picked grievances as a PIP project unless there was a system breakdown like grievances not being documented. She was unsure why the 9/28/23, QAPI meeting minutes lacked identification of the Mantoux PIP or the grievance PIP. Review of 1/1/24, Quality Assurance and Performance Improvement (QAPI) policy identified the committee would meet at least quarterly and evaluate activities under the QAPI program including identifying issues and PIP projects. The committee would develop and implement appropriate plans of action to correct identified issues and PIP projects. The committee would maintain documentation of its ongoing QAPI program and data collection with analysis at regular intervals.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47497 Based on observation and interview, the facility failed to ensure all 8 licensed nursing staff were appropriately trained and deemed competent to administer insulin. Findings include: Observation and interview on 4/24/24 at 8:37 a.m., with licensed practical nurse (LPN)-A identified she completed a blood sugar check on R7 with blood sugar registering at 113. LPN-A identified that based on her blood sugar she would only receive her Lantus injection. LPN-A dialed the Lantus pen to 50 units, removed the cap and used an alcohol wipe to clean the pen hub, then attached a disposable needle tip. LPN-A then administered the insulin subcutaneously to R7. LPN-A did not prime the insulin pen with 2 units of insulin prior to dialing up the ordered dose. LPN-A identified she was surprised she had forgot to prime the pen. R7's April 2024, Medication Administration Record (MAR) identified R7 was administered Novolog (a rapid acting insulin) 5 units subcutaneously 2 times daily at 8:00 a.m., and 12:00 p.m., and 7 units one time daily at 4:30 p.m., R7 also received Lantus (long-acting insulin) 50 units subcutaneously two times daily at 8:00 a.m., and 8:00 p.m. for diabetes. Review of the current, Lantus How to use your Solostar pen instructions, located at https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf, identified: 1) Step 1: Remove the pen cap with clean hands. Check the reservoir to make sure the insulin is clear and colorless and has no particles-if not, use another pen. 2) Step 2: Attach the needle. Wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Do not make the needle too tight. If you have a push-on needle, keep it straight as you push it on. After you have attached the needle, take off the outer needle cap and save it (you will need it to remove the needle after your injection). Remove the inner needle cap and throw it away. 3) Step 3: Perform a safety test. Dial a test dose of 2 Units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. 4) Step 4: Administer the medication. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/24/24, at 12:49 p.m., with director of nursing (DON) confirmed staff should be priming insulin pens with 2 units prior to dialing up ordered dose of insulin. She had not completed any insulin competencies with licensed nurses. She also identified that they did not have a drug book or manufacturer's directions available for nurses to reference at the nurses station, medication room, or medication cart but that she had requested the executive director of operations to order a new drug book for the nurses desk. Interview on 4/25/24 at 11:39 a.m., with the executive director of operations identified that she would expect the DON to have ensured licensed nurses were competent with insulin administration. There was no policy related insulin administration provided by the end of the survey.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 39988 Based on interview and document review, the facility failed to provide mandatory training on 1 of 1 facility's specific Quality Assurance Performance Improvement (QAPI) Program to all staff to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how staff was to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. Findings include: Interview on 4/24/24 at 7:39 a.m., with NA-B identified the QAPI committee was working on different things however, she was unsure of what specific QAPI items they were working on. She reported she did not believe there was training on Relias (online generalized QAPI training) about the facility's QAPI or QAPI in general . If the committee was training staff following their meetings, she was unaware of that and had never had training. Interview on 4/24/24 at 8:07 a.m., with maintenance supervisor identified he was part of the QAPI committee, and each department would bring up issues and they would discuss together a plan to correct the issue. He was unaware of anything specific the committee was working on. Interview on 4/24/24 at 8:41 a.m., with director of nursing (DON) identified staff completed QAPI training on Relias and by conversations. She posted information about what QAPI was, but it did not contain any specific details. At this time, she reported the QAPI committee was working on bed holds and making sure a discharge summary was completed. She identified the facility was completing audits for PASARR. She was unaware of any other audits being done at this time. The DON reported that she was unsure what the facility was exactly working on or if there were any performance improvement projects (PIP) at this time without reviewing the QAPI minutes. Interview on 4/24/24 at 8:52 a.m., with social service director identified she was completing audits on call lights and brought that information to the QAPI meeting to use it for a PIP project. She reported she had received a PASARR bulletin and found out residents that were long term were not grand-fathered in, so the committee planned how they were going to fix it. The QAPI members were to review items at QAPI to see their progress and if they had met a goal or not. Interview on 4/24/24 at 2:53 p.m., with trained medication aide (TMA)-A identified she was aware of what QAPI was, but could not describe specific goals or what the facility was monitoring overall. She could not remember anything specific the facility QAPI committee was working on. She stated the facility does try to reduce falls, but the meeting was about a specific resident who fell and what to do to prevent their future falls. Interview on 4/24/24 at 3:01 p.m., with dietary aide (DA)-A who identified she had not personally had any QAPI training or had to ever deal with QAPI. She reported we do need training, but the maintenance supervisor would tell the kitchen staff if there was anything going on in the facility. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/24/24 at 3:03 p.m., with the dietary manager (DM) identified yearly staff were to completed Relias QAPI training. She trained the kitchen staff on QAPI however, had no documentation of that training. She was unsure what the facility was working on for QAPI, but she monitored weight loss. She reported she had never attended a QAPI meeting at the facility. She stated the facility had a PIP on the refrigerator from a previous survey, but she was unsure why they were still monitoring that as it had been good. Review of Relias overall generalized QAPI training identified RN-B and the activity director had no QAPI training listed, RN-A last had Relias QAPI training on 12/24/22, NA-A last had Relias QAPI training on 12/15/22, NA-B last had Relias QAPI training on 6/28/21, and NA-C last had Relias QAPI training on 8/8/21. None of the above mentioned staff had facility specific QAPI training. Interview on 4/24/24 at 3:35 p.m., with the executive director of operations identified she felt staff were trained to elements of the facility's QAPI program, however she felt staff were quick to forget about what they had learned QAPI was working on. She agreed staff needed to be trained to the facility's specific QAPI program. Review of the August 2022, In-Service Training policy identified that staff would complete the required training that included elements and goals of the QAPI program.

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 39988 Based on interview and document review the facility failed to ensure 4 of 9 staff (director of nursing (DON), licensed practical nurse (LPN)-A, nursing assistant (NA)-A, and NA-C) received initial and annual training on Alzheimer's disease or related disorders, assistance with activities of daily living (ADL), problem solving with challenging behaviors, and communication skills. Findings include: Review of the DON's employee file identified the DON had a hire date of 10/16/23. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors. The DON training record lacked identification that she had completed training on Alzheimer's disease and related disorders upon hire. Review of LPN-A's employee file identified LPN-A had a hire date of 3/21/24. Review of LPN-A's Alzheimer's training records identified LPN-A had completed training on Alzheimer's disease and related disorders, ADLs, and behaviors. LPN-A's training record lacked identification she had completed training on communication needs upon hire. Review of NA-A's employee file identified NA-A had hire date of 5/8/19. Review of NA-A's Alzheimer's training records identified NA-A had completed training on Alzheimer's disease and related disorders, communication needs, and behaviors. NA-A's training record lacked identification NA-A had completed training on ADLs annually. Review of NA-C's employee file identified NA-C had a hire date of 10/20/20. Review of NA-C's training records identified NA-C had completed training on communication needs, ADLs, and behaviors. NA-C's training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the current, undated Resident Admission Packet identified the facility was to educate and ensure employees had training on understanding the Alzheimer's disease process, behaviors, assisting with ADLs, and communication skills. Review of August 2022, In-Service Training policy identified staff were to receive required training on dementia management. The policy lacked identification of required training on Alzheimer's disease or related disorder, assistance with ADL's, communication needs, and problem solving with challenging behaviors.