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	01/14/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and document review, the facility failed to appropriately identify, assess, and intervene for 1 of 3 residents (R2) with a change in condition. This caused actual harm when R2 experienced a delay in treatment after developing signs and symptoms of a worsening infection with the potential for sepsis (life-threatening infection) with a known history of infection, who was subsequently transferred to a higher level of care and was hospitalized . The non-compliance that began on 5/4/25 was corrected prior to the survey when the facility implemented corrective action on 8/5/25, to prevent recurrence; therefore, the tag was issued at PAST NON-COMPLIANCE. Findings include: Review of the National Library of Medicine article, SIS, qSOFA and New Sepsis Definition, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC5418298/, identified a patient had to meet 2 SIRS (Systemic Inflammatory Response Syndrome) criteria, and have a confirmed or suspected infection. The additional criteria listed was a heart rate greater than (>) 90 beats/minute, a respiratory rate >20 breaths/min, a temperature of (>) 100.4 F or less than (<) 96.8 F, a high white blood cell (cells that fight infection) count, or low white blood cell count and were used as early screening tools for potential sepsis. R2's 12/16/25, quarterly Minimum Data Set (MDS) assessment identified his cognition was intact and had a diagnosis of paraplegia (paralysis) and infection of a wound. R2 had a Stage 3 and a Stage 4 unhealed pressure ulcer that was present on admission. R2's 3/7/25, Nurse Admission-readmission assessment identified R2's primary reason for admission was wound care, history of sepsis, and the need for antibiotic therapy. R2's 5/12/25, hospital discharge summary identified R2 was admitted to the regional hospital intensive care unit (ICU) on 5/8/25 for evaluation of fever and feeling unwell, with purulent exudate (thick drainage indicating an infection) from their buttock wound. He was started on empiric (precautionary) antibiotic therapy and admitted to the ICU. He briefly required vasopressors (a medication often used in shock, heat failure, or sepsis, typically to critically ill patients to raise blood pressure) but was rapidly weaned off. Infectious disease (ID) was consulted, due to chronic osteomyelitis (bone infection) and chronic decubitus ulcer (bedsores caused by sustained pressure). The ID physicians recommended continuing 48 hours of empiric antibiotic therapy and subsequently discontinue them, if blood culture remained negative. R2 remained stable and his blood cultures remained negative for more than 48 hours. He was without fever but was at risk for having recurrent infection related to his infected decubitus ulcer. The physician recommended for R7 to follow-up with physicians in the outside setting, for definitive source (of infection) control if he was able to be clean (drug or alcohol free) from multiple substance abuse. Review of R2's progress notes identified the following: 4/30/25 at 11:01 p.m., R2 had been up in his chair and out to smoke. He was pleasant and cooperative. He was without fever and had no side effects noted from the antibiotic. R2's blood pressure (BP) was 111/59 millimeters of mercury (mm/hg) (normal is 120's/80) taken at 10:25 a.m. 5/3/25 at 10:28 p.m., R2 had a temperature of 102 degrees Fahrenheit (F) at the beginning of the shift. He was offered Tylenol and his fever dropped to within normal limits to 98.5 F and his blood pressure was 113/74 mm/hg. (There was no documentation to support R2's nurse practitioner had been contacted about increased signs and symptoms of potential worsening infection or that staff took a full set of vitals, to identify if R2 met SIRS criteria necessitating he be sent to the local ER for laboratory workup, and further medical (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	examination and/or specialist consultation.) 5/4/25 at 9:12 a.m., staff noted R2 had bloody drainage noted on the wound on his left buttock and had minimal discharge noted on the navel area. (There was no documentation to support R2's nurse practitioner had been contacted about increased signs and symptoms of potential further infection.) 5/4/25 at 5:35 p.m., R2 had a fever of 102.3 F and was given 650 milligrams (mg) of Tylenol. His BP was assessed at 10:35 p.m. and was 91/59 mm/hg. (There was no documentation to support R2's nurse practitioner had been contacted about increased signs and symptoms of potential further infection.) 5/5/25 at 11:35 p.m., R2 had a low-grade fever of 99. R2 had Tylenol for fever from the p.m. shift. R2 denied any pain or shortness of breath (SOB). His BP was assessed at 10:34 p.m. and was 93/48 mm/hg. (There was no documentation to support R2's nurse practitioner had been contacted about increased signs and symptoms of potential further infection.) 5/6/25 at 1:50 p.m., staff noted R2 was seen by the nurse practitioner this morning regarding continued elevated temperatures. His nurse practitioner ordered labs to be collected in 3 days on 5/9/25 and to ensure he received 20 grams of protein three times a day. (There was no indication staff had questioned R2's nurse practitioner of their decision for delayed diagnosis and treatment or consulted the medical director for assistance when R2 was showing signs and symptoms of worsening infection which may lead to potential sepsis). 5/7/25 at 5:50 a.m., R2 had a fever of 102.2 at the beginning of the shift, Tylenol was administered. His temperature came down to 98.7 F. (Staff noted no other signs or symptoms were noted, however, there was no documentation to support a full nursing assessment occurred.) 5/7/25 at 4:23 p.m., R2 has a temperature of 100.2. He complained of chills. Tylenol was administered for his elevated temperature. Resident was scheduled to be seen by the in-house nurse practitioner on 5/8/25. His BP was noted to be 91/59 mm/hg. 5/7/25 at 11:31 p.m., R2 was then sent to the local hospital emergency room (ER) for a fever of 104.0. Staff noted his fever started on the p.m. shift and they administered Tylenol. He was transported by ambulance at 8:20 p.m. 5/8/25 at 5:54 a.m., the ER updated the facility that R7 was transferred to the regional hospital Intensive Care Unit (ICU) for suspicion of sepsis. Interview on 1/14/26 at 1:00 p.m., with the registered nurse consultant (RN-E) identified she acknowledged R2's progress notes (identified above) and her expectation would have been that staff would notify the physician at the first change in his condition. After the nurse practitioner saw him on rounds and his symptoms continued into the next day, she would have expected the interdisciplinary team to identify the concerns through review of the nursing progress notes the following morning. In her opinion, R2 should have been sent to the hospital for evaluation sooner to prevent worsening of his infection and earlier medical treatment. Interview on 1/14/25 at 1:14 p.m., with licensed practical nurse (LPN)-A identified he was working during the time of R2's increasing symptoms on infection. He thought R2's fever could be caused by the existing infection and antibiotic medication he was being administered. LPN-A was unaware of SIRS criteria that is used by nurses and physicians to determine the need for further medical evaluation, or the need for full set of vitals (BP, heart rate, respiratory rate, oxygen saturation etc.) to assess the resident comprehensively. Attempts were made to contact 2 other staff who were working during the above dates with no success. An attempt was made to call the nurse practitioner on 1/14/25 during survey with no success. Interview on 1/14/25 at 6:00 p.m., with the medical director (MD) identified he would have expected when R2 started having elevated temperatures, nursing should have completed a full assessment of R2's wounds and vitals. When the nurse practitioner saw R2 for the continued elevated temperature and ordered labs, he would have expected those labs to be drawn that day rather than waiting 3 days. He identified, in his opinion, it can be hard to determine when R2 should have been sent to the ER. It would depend on if he was experiencing cardiovascular instability. The medical director did not elaborate on how cardiovascular instability would be identified. The current, undated facility provided Notification of Changes policy identified the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include a significant change in the resident's physical, mental or psychosocial (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	condition such as deterioration in health, mental or psychosocial status, life threatening conditions or clinical complications. and circumstances that require a need to alter treatment. This may include new treatment, discontinuation of treatment, acute conditions or exacerbation of chronic conditions. The deficient practice was corrected on 8/5/25, when it could be verified through observation, staff interviews, and document review, the facility had re-educated staff to identify a change of condition, identified steps to take when those changes occur, including appropriate notification, and performed competencies of staff on a change of condition.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure the kitchen and dining area was clean and sanitary to prevent cross contamination when preparing and serving food. In addition, the facility failed to ensure the garbage dumpster was securely closed to prevent attracting pests and rodents. This had the potential to affect all 41 residents residing in the facility. Findings include: Observation on 1/11/26 at 11:00 a.m., during the initial tour of the kitchen with the dietary manager (DM) present identified the following:The reach-in refrigerator the facility called the Milk Refrigerator, had an unknown substance that appeared wet and felt sticky. In addition, debris that appeared to be food crumb-like and was white and yellow in color, was scattered throughout the bottom shelf.The Veggie freezer had a sticky substance and residue smeared over the freezer doors and handles with visible fingerprints on and around the door handles. The bottom half of the freezer doors were covered in drip marks from spillage that started about half-way down the door and extended to the bottom edge of the door. Inside the freezer on the bottom shelf were white and orange food-like particles. A cardboard box was stuck to the bottom of the freezer, and a screw was observed laying on the bottom shelf.The cooking range had food crumbs and a grease-like residue on the burners and on the flat surface between the burners. The dials used to control the temperatures were covered in dirt and grease-like debris and the numbers on the dials were no longer readable because of it. The oven doors had a residue dripping down the front of the doors from the handles to the bottom edge, extending across the entire surface.A stainless-steel countertop with a can opener mounted on the edge had recently been used as evidenced by wet food on the can opener. There was also 3 large personal drink tumblers with straws belonging to staff.The steam table had a yellowish thick substance smeared across the lid of one of the wells, and on the flat surface between the wells. In addition, there were other unknown substances and food-like crumbs on the steam table between the wells. Cook-A was observed placing gravy into the dirty steam table for lunch service. Interview on 1/11/26 11:21 a.m., with cook-A identified she was preparing the steam table for lunch service. She identified the yellow smeared substance on the steam table was from eggs served earlier that morning for breakfast. She was not certain what the other debris on the steam table was from. Staff cleaned the steam table only once per week and not after each meal service. Observation on 1/11/26 at 11:21 a.m., identified the facilities dumpster located outside the building were overflowing, inhibiting the covers to be closed securely. The garbage was visible from the road. Observation on 1/11/26 at 2:24 p.m., the outside dumpster lids remained open, however, the dumpster had been emptied but since the covers were not ensured to be closed after staff put refuse in them, 3 bags of garbage were visible inside, open to pest and rodent contamination. Observation and interview on 1/12/26 at 11:57 p.m., with the dietary manager (DM) identified the outside dumpster lids were completely open, and the dumpster contained 3 large bags of garbage. The DM agreed with the above findings and identified it was her expectation that staff would ensure the dumpster lids would be securely closed at all times. In addition, she identified she had concerns with the cleanliness of the kitchen and it was her expectation that all surfaces would be wiped down as needed and the steam table would be cleaned after each meal. She had completed training and provided sign-off sheets that staff were to initial after completing tasks but noted she had not completed any documented audits to ensure staff were completing the tasks correctly. The facilities Food Safety Requirement policy identified staff would ensure all equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain floor covering in 2 of 2 resident-shared rooms (one room inhabited by R45 and R27 and the other room inhabited by R37 and R51). In addition, the facility failed to ensure the exterior wall in 1 of 1 dining room was maintained in good condition. This had the potential to affect all 41 residents. Findings include: RESIDENT ROOMS Observation on 1/11/26 at 2:55 p.m., of R45 and R27's room identified there were 10 broken tiles. Some had large missing pieces and others had smaller missing pieces. Neither resident residing in the room were aware of any facility plans to repair the tile and they had been that way a long time. Observation on 1/11/26 at 3:04 p.m., of R37 and R51's room identified there was a hole in the carpet in the doorway with some fraying strings observed. The area was at the seam of the hall carpet and the room carpet in the doorway that was approximately 3 inches wide by 12 inches long. One resident residing in the room used a walker and the other resident walked independently. Neither resident was aware of any plans to repair the carpet. Interview on 1/12/26 at 2:25 p.m., with maintenance director identified that he was aware of the broken tiles in room [ROOM NUMBER]. He reported that the tiles were 9 x 9 and he was unable to get replacements, so he needed to replace all the tiles in the entire room with a new style. He was unable to do this until a room opened so that room [ROOM NUMBER] could be empty while he repaired it. He was also aware of room [ROOM NUMBER] with the hole in the carpet as he had trimmed up the loose frayed strings from the carpet once already. He had been busy working on the new shower in the facility and had not had time to repair it yet. He stated he would get a piece of trim ordered to cover the hole in carpet in the doorway for room [ROOM NUMBER] today. Interview on 1/13/26 at 2:26 p.m., with administrator identified the tiles in R45 and R27's room had been broken since he started 3 months ago. The issue was that the room needed to be empty so that the facility could replace the entire floor in that room as they could not get tiles the same size. He had been made aware of the hole in the carpet in the doorway of R37 and R51's room by maintenance yesterday and reported the maintenance director did get a trim piece ordered to install in the doorway to cover the hole in the carpet. His expectation was that items would be repaired as issues were identified to maintain the facility in good repair. DINING AND REFUSE Observation on 1/11/26 at 12:07 p.m. in the dining room identified just above floor level on the west wall (per the facility map) in the dining room, was a quarter-sized hole leading to the exterior of the building and open to the outside. Below the hole was a square piece of unfinished wood nailed to the wall panel that covered another hole. Above that piece of wood and to the right was another hole approximately silver dollar-sized in diameter, with what appeared to be a washcloth stuffed into it. Interview on 1/12/26 at 11:39 a.m., with the dietary manager identified the facility used to have an air conditioning unit mounted through there. They put it in the dining room in the summertime. I know it's been in here the last couple of summers. I guess the washcloth is a temporary fix. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on 1/12/26 at 2:17 p.m., with the maintenance director regarding the dining room walls identified agreed there were 3 holes in the exterior wall that were used for an air conditioning unit in the summertime. He covered the largest hole with a board, the 2nd hole is for the air conditioners drainpipe, and the 3rd hole is just a hole. He stated, I didn't know it was a problem. He agreed this could cause a problem with pest control and identified they have a pest control company that visits the facility monthly. There was no policy related to the maintenance and upkeep/repair of the facility provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to monitor for expired items and appropriately store items in a sanitary manor for 1 of 1 medication room.Findings include: Observation and interview on [DATE] at 9:57 a.m., of the medication room with registered nurse (RN)-D and RN-E identified RN-D opened the refrigerator located inside the medication room. Inside, there were 3 pre-filled elastomeric pumps (also known as balloon pumps for controlled delivery of medication over a specified period) of Vancomycin (antibiotic to treat serious bacterial infections) for R50 who RN-D reported had discharged back in [DATE]. There were 9 boxes of barrier wipes that all had expired [DATE] boxes of a 4 pack of COVID tests that had expired [DATE], and 6 boxes of bacitracin (antibacterial ointment) packets that expired [DATE]. RN-E confirmed the expiration of items and reported they should have been removed once expired. There were also 4 boxes of Ensure (nutritional supplement) sitting on the floor next to the refrigerator and 3 boxes of Ensure sitting inside a plastic box on the floor next to the refrigerator. RN-E stated no items should be stored on the floor. RN-E was the consulting nurse for the facility and was unaware of what the protocol was for monitoring for expired items and storage in the medication room. Review of the February 2023, Medication Storage policy identified that the consultant pharmacist routinely inspected the medication room for outdated, discontinued, defective, or deteriorated medications with missing labels, or illegible labels. There was no mention of monitoring for storing items in a sanitary manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview the facility failed to follow appropriate infection control practices when obtaining a blood sugar (BS) level for 1 of 1 resident (R19) while in the dining room. The facility also failed to disinfect 1 of 1 sampled multiple-resident use glucometer. This had the potential to affect all 3 residents seated at the dining table with R19 and 2 other residents who used the multi-resident use glucometer. Findings include: R19's 11/27/25, accepted comprehensive Minimum Data Set (MDS) assessment identified R19's cognition was moderately impaired. R19 required substantial assistance from staff for cares. He had diagnoses of hypertension, GERD, diabetes and depression. R19's Order Summary Report identified an order for blood glucose monitoring before meals and at bedtime related to diabetes management. R19's 12/10/25, care plan identified R19 had diabetes. Staff were to administer medication as ordered. Observation and interview on 1/11/26 at 12:31 p.m., of registered nurse (RN)-D identified she entered the dining room with several residents already seated at tables. RN-D walked over to a table of 3 residents and proceeded to put on gloves, set up the glucometer and used a lancet to prick R19's finger and obtain a blood sample while R19 was seated at the table in front of other residents. Once RN-D finished, R19 was observed to have a small amount of blood on tip of his finger. R19 placed his hand on the table and touched his bloody finger on the top of the table. RN-D reported that she normally did not check residents' BS in the dining room; however, R19's BS needed to be done prior to eating and he was already in the dining room. Observation on 1/11/26 at 12:36 p.m. of RN-D identified she returned to the medication cart located by the nurse's station. RN-D placed the contaminated glucometer back into the medication cart drawer without disinfecting it. Continuous observation and interview on 1/11/26 from 12:26 p.m. until 1:06 p.m. of RN-D identified RN-D removed the contaminated glucometer she had placed in the drawer. RN-D removed the glucometer and took a Sani-Cloth wipe and wiped the glucometer off without ensuring surface remained wet for the correct amount of time per the manufacturer to ensure disinfection had occurred. RN-D then gathered the rest of her supplies and proceeded to enter R3's room. RN-D checked R3's BS and returned to the medication cart. When asked, RN-D reported she felt she had appropriately disinfected the glucometer by using the Sani-Cloth wipe per facility protocol but was unaware Sani-Wipes required a 2-minute wet-contact time to ensure disinfection occurred. Interview on 1/11/26 at 3:51 p.m., with the infection preventionist (IP) identified the Assure glucometer should be wiped off first to clean it and then disinfected with the wet time of 2 minutes and air-dry per the instructions on the Sani-Cloth disinfectant wipe manufacturer. That machine was used by 3 residents. Interview on 1/14/26 at 11:19 with RN-C identified BS should be done prior to meals, and no BS should be done in common areas including the dining room. Review of the 2023, Blood Glucose Monitoring policy identified that the nurse would perform BS testing per the glucometer manufacture's instruction. The nurse would abide by the facility infection control protocols for cleaning and disinfecting the glucometers. The nurse would gather supplies, provide privacy, and perform the BS testing. Review of the 2024, Glucometer Disinfection policy identified glucometers would be cleaned and disinfected after each use and according to manufacturer's instructions. Glucometer would be disinfected with a wipe pre-saturated with an EPA registered health care disinfectant that was effective against HIV, Hepatitis C and Hepatitis B virus. Following use of the glucometer, staff would retrieve 2 disinfectant wipes from the container. The first wipe was to remove heavy soil, blood or other contaminants from the surface of the glucometer. The second wipe was to disinfect the glucometer thoroughly following the manufacture's instruction and allow the glucometer to air-dry. Sani-Cloth direction to disinfect, use wipe to remove visible soil prior to disinfecting. Use the wipe to thoroughly wet surface and allow the surface to remain wet for 2 minutes and let air-dry.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 2 of 5 (R16 and R21) sampled residents were offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings include: Review of the current, 10/26/24, Centers for Disease Control (CDC) Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV21) at any age and a PPSV23 at or after the age of [AGE] years old. R16 R16's face sheet identified they were admitted to the facility in October 2025. R16's accepted 10/29/25 at 4:02 a.m., comprehensive Minimum Data Set (MDS) identified R16 was [AGE] years old and had a diagnoses spinal fusion, multidrug resistance organism (MDRO) (bacteria or fungi developed resistance to multiple antibiotics), substance abuse and pressure ulcer of the sacral (lower back) region. Section O, of the MDS Identified R16's PCV vaccine status was not up to date. R16 received the PPSV-23 on 12/19/11. There was no indication that R16 was offered or decline the vaccine. R21R21's face sheet identified they were admitted to the facility in October 2025. R21's accepted 10/21/25 at 7:37 p.m., comprehensive MDS identified R21 was [AGE] years old and had diagnoses of depression, alcohol dependence, post-traumatic stress disorder (PTSD) and clostridium difficile (C-diff) (causes severe diarrhea of the colon). Section O, of the MDS identified R21 PCV vaccine status was not up to date. There was no indication that R21 was offered or declined the vaccine. Callback interview on 1/14/2026 at 11:13 a.m., with the infection preventionist (IP) identified she voiced agreement residents were to be assessed of their vaccine status upon admit to the facility and/or provided risk to benefits and a declination form for PCV vaccines according to Centers of Disease Control (CDC) guidelines. Review of October 2024, Pneumococcal Vaccine policy identified the facility was to follow State or local guidance for PCV vaccines and to assess resident status upon admission. The PCV vaccine was to be offered, and a consent was to be signed, unless it was medically contraindicated. Resident or resident representative had the right to refuse the vaccine and was to be recorded in the resident's medical record. Overall, the PCV vaccine offered was to depend on the recipients age, risk factors, and previous vaccine history, in accordance with Centers of Disease Control (CDC) recommendations.

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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 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 investigate a potential crime involving illegal drugs involving 1 of 1 resident (R41). Findings include: Interview on 1/11/26 at 1:00 p.m. with the administrator identified on 1/4/26, there was a concern with alcohol and illegal drugs brought into the facility by R41. Law enforcement were involved. Police were referring the case to the county attorney for review of charges. R41 was not arrested at the time of the incident. R41 has since been discharged and would not be returning to the facility. Review of the 1/4/26 at 1:06 p.m., Redwood County Sheriff's Office Incident Report identified officers arrived at the facility at 1:19 p.m., to investigate the report of a resident possibly under the influence. During interview, R41 admitted to having possession of the crystal-like substance, which was field tested and tested presumptive positive by the sheriff's office as methamphetamine. R41 reported the substance had been given to him by another resident, [R17]. During interview with the officer, R41 displayed quick, fidgety movements with his hand and had dilated pupils. A second bag that was confiscated by police, contained a blue, glass pipe and two lighters, which staff identified had been thrown over the fence surrounding the outdoor smoking area. Charges for drug possession were to be sent to the District Attorney's (DA) office for review. The resident council meeting on 1/13/26 at 10:30 a.m., held with surveyors identified it was reported by members the social worker had been made aware of their concerns of drugs and alcohol being brought into the facility, but there had been no action or investigation into their concerns. Residents stated the facility had found alcohol bottles and contraband. The police had been at the facility about 5 times in the last month. There are residents who are visibly intoxicated. Review of the January 2026 resident council meeting minutes identified there was no recorded mention of resident council members' concerns for drug and alcohol use in the facility. Interview on 1/13/26 at 12:05 p.m., with the ombudsman (O) identified she attends resident council meetings at the facility. Residents did discuss concerns at the 1/8/26 meeting about drug and alcohol use in the facility at that meeting. R41's 1/8/26 submitted, admission Minimum Data Set (MDS) assessment identified he was admitted in December of 2025, following hospitalization. His cognition was intact, he was independent with activities of daily living, (ADLS), and had diagnosis including alcohol-induced chronic pancreatitis (inflammation of the pancreas, causing severe upper abdominal pain, nausea, and vomiting, often triggered by gallstones or alcohol), anxiety disorder, alcohol use, and alcoholic hepatitis, (liver inflammation from heavy alcohol use). Review of the 1/4/26 at 12:15 p.m. fall incident report listed R41 was heard calling for help, registered nurse (RN)-B responded and discovered R41 had fallen and gotten himself up and denied any injuries. There was no mention of the suspicion R41 was possibly under the influence of drugs or alcohol, but it was documented he was very unsteady. Staff had reported he seemed off. No additional information was documented in the report. R41's undated, current care plan listed a problem of substance abuse/dependence with a goal to refrain from use while in the facility, identify triggers through the review date, meet with LADC (licensed alcohol and drug counselor), for assessment within 30 days of admission, (identified as overdue). Interview on 1/13/26 at 11:13 a.m. with nursing assistant (NA)-A confirmed she had been working on 1/4/26 and had initially observed R41 in his room at 12:45 p.m., and then at 1:00 p.m. she was informed R41 had fallen and was very unsteady. NA-A assisted by NA-B went to clean up the spilled items from the floor and noted R41 was focused on a Walmart bag on his bed. Both NAs reported R41, seemed off, but were not aware of what the problem was. R41 was taken from the room to have his weight and vital signs checked, but prior to leaving, quickly shoved the Walmart bag into the drawer on his nightstand. When he was out of the room, NA-B reported she felt there was something going on and they needed to check what R41 had put in the drawer. Upon opening the drawer, the bag was open and a small zip-lock bag was visible which contained a crystal-like substance. NA-A took the bag to registered nurse (RN)-B, who secured it in the (continued on next page)

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	245400	A. Building B. Wing	01/14/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication room and contacted the non-emergent 911 sheriff's office, the administrator, interim director of nursing (IDON), and social service designee (SSD). No facility management came to the facility following the report. Emergency medical services (EMS) responded and assessed R41 who refused to be transferred to the emergency department (ER) for further evaluation. When law enforcement ([NAME]) arrived, they tested the crystalline substance and confirmed it was methamphetamine. [NAME] then confiscated the illegal drugs. Interviews were obtained by [NAME] personnel of NA-A & B, in addition to R41 and R17. An addition officer (accompanied by a K-9 drug dog) searched both R41's and R17's rooms, and the outdoor smoking area. Additional drugs and/or paraphernalia were discovered on the outside of the fence surrounding the smoking area. [NAME] reported R41 was being charged but not arrested, and the information was being referred to the DA for determination. R41 discharged on 1/6/26 with his family member to return to his home setting. Interview on 1/13/26 at 2:25 p.m. with RN-C identified when a resident was admitted , a log was made of any personal items brought with them. The signed admission agreement listed drugs and alcohol were not permitted, unless prescribed by their physician (MD). There had been incidents within the past month when residents were thought to be under the influence of drugs or alcohol, and the procedure was to contact the physician for further directions, to monitor vital signs, and send to the ER for further evaluation if indicated. Interview on 1/13/26 at 3:01 p.m. with RN-B reported on 1/4/26, R41 had fallen and gotten himself back up without injury. She telephoned the non-emergency sheriff's office line, the administrator, the IDON, and the SSD but neither came to the facility after being notified. RN-B completed an incident report for R41's fall but had not completed an incident report for the illegal drug incident. Interview on 1/13/26 at 3:11 p.m. with the administrator reported he had been telephoned by the sheriff with an update on what had occurred but noted he did not come to the facility. He voiced agreement that an incident report should have been completed. No further investigation into the incident was completed by the facility. Iif a resident consumed alcohol or a prohibited substance, the facility was to contact the physician for their recommendation, and if indicated, would do 1:1 monitoring but facility response was made on the individual case situation. Interview on 1/14/26 at 4:25 p.m. with the RN-E, who was the facility nursing consultant, identified if a resident was discovered to have illegal substances, the facility was to contact law enforcement to search for and seize any illegal substance. She confirmed an incident report should have been completed with investigation and documentation completed. Her expectation for staff was to be aware of the procedure to be followed and complete appropriate documentation of an investigation. Interview on 1/14/26 at 5:51 p.m. with the medical director (MD)- A identified his expectation for the facility to have a protocol for monitoring residents for signs and symptoms od substance use, and facility management or designee to assess the situation and/or resident and take charge of the situation. He would expect an investigation be completed. Review of the October 2025 Resident Possession and Use of Illegal Substances policy identified the residents' right to have and use personal possessions unless it interfered or affected health or safety for other residents. Illegal substance use was not allowed in the facility. Staff were to be knowledgeable of signs or symptoms for residents using illegal substances such as changes in behavior, increased, unexplained drowsiness, lack of coordination, slurred speech, mood changes, and loss of consciousness. If the facility determined a resident may have access to illegal substances, the facility was to notify [NAME]. The facility was to provide additional monitoring and supervision. There was no mention of conducting an investigation to determine if other residents were at risk or how the substances were brought into the facility to potentially prevent further incidents.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and document review the facility failed to notify the responsible party of a hospital transfer for 1 of 4 sampled residents (R7) reviewed for hospitalizations. Findings include: R7's 12/19/25, quarterly accepted Minimum Data Set (MDS) assessment identified she had moderate cognitive impairment. She required moderate staff assistance with activities of daily living (ADLS), impairment on one side upper extremity, uses a wheelchair for mobility, and required extensive staff assistance for toileting, dressing and grooming. R7 received both scheduled and as needed (PRN) pain medication for frequent pain which interfered with her day-to-day activities and was described as severe. She had diagnoses of generalized weakness, psychoactive substance abuse, acute respiratory failure with hypoxia, adult failure to thrive, bipolar and anxiety disorder, and Buerger's disease (inflammatory condition that affects circulation and clotting in small to medium blood vessels of the extremities). R7's 10/31/25, accepted end of stay with return anticipated MDS assessment identified R7 had been discharged to the hospital. The 11/3/25, accepted readmission to facility MDS identified R7 returned on 10/31/25. Review of R7's progress notes on 10/26/25 identified she was transferred to the hospital. The progress note lacked identification that the family member had been notified of the transfer to the hospital. R7's hospital notes identified dates of stay as 10/26/25 through 10/31/25. R7 was hospitalized with shortness of breath, cough, and hypoxia, with a diagnosis of pneumonia and kidney injury. There was no documentation that notification had been made to the resident's representative of R7's transfer to the hospital with an admission. Interview and document review on 1/12/26 at 2:11 p.m., with registered nurse (RN)- C of R7's medical record confirmed there was no documentation of notification to R7's family/emergency representative of her transfer and subsequent admission to the hospital. The facility policy was to notify the provider, ombudsman, and family/emergency representative when a resident was transferred from the facility. Interview on 1/14/26 at 3:30 p.m. with the interim director of nursing (IDON) identified her expectation was for the policy to be followed for appropriate notifications with documentation when a resident was transferred from the facility. A policy was requested but not provided by time of survey exit.

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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. Based on observation, interview, and document review, the facility failed to revise 1 of 12 sampled resident's (R4) care plan for behaviors.Findings include: R4's 10/31/25, accepted comprehensive Minimum Data Set (MDS) assessment identified R4's cognition was intact but had verbal behavioral symptoms directed towards others 1 to 3 days during the assessment period. R4 required substantial assistance from staff for cares and transfers. He took pain medication as needed and reported he had occasional moderate pain. R4 was noted to have had 2 or more falls with minor injury. He took an antipsychotic, antidepressant, antibiotic, and anticonvulsant during the assessment period. R4 had been seen by speech therapy and occupational therapy. R4's goal was to return to the community. R4's 1/14/26, Diagnosis Report identified diagnoses of paranoid schizophrenia, spinal stenosis (narrowing of the spine), cognitive communication deficit, dysphagia (difficulty swallowing), abnormal posture, borderline personality disorder, cannabis dependence, difficulty walking, high blood pressure, and generalized anxiety disorder. He also had a history of falling, insomnia, major depressive disorder that was severe with psychotic symptoms, stimulant dependence, muscle spasms, muscle weakness, Post-Traumatic Stress Disorder (PTSD), and schizoaffective disorder. Observation and interview on 1/11/26 at 4:31 p.m., with R4 identified was seated in his wheelchair. He was hunched over reportedly due to neck pain and his hair was disheveled from rubbing his hands through his hair. R4 reported he would fall out of his wheelchair and bed and did it on purpose because he did not like his wheelchair and would also do it when he wanted to get out of bed. He stated it did not hurt as he does it right. R4 also noted he did not like where he was seated in the dining room, but was told he needed to sit at a certain spot for staff to be able to assist him. R4 stated staff were dirty, rotten scoundrels.they should be aides here and [nurse] is their crew leader. R4 identified he felt staff had not liked to help him, and felt they avoided his room, even when he would put the call light on. Observation on 1/12/26 at 9:50 a.m., of R2 identified staff were wheeling him in his wheelchair to the day room. R4 was swearing stating he did not give a [expletive] about this place.this place is a [expletive]. Further observation at 2:02 p.m., identified R4 was wheeling himself down the hall towards the smoking area. R4 was exhibiting behaviors by swearing at staff other residents as he saw them when he proceeded down the hall. There were no observations obtained during the survey of R4 placing himself onto the floor. R4's progress notes identified on:12/3/25, R4 moved around in his wheelchair. He had a habit of lowering himself to the floor from his wheelchair. His mood during the shift was aggressive and abusive when he didn't get his will.12/5/25, R4 reported he placed himself onto the floor. When R4 was asked why he placed himself onto the floor, he replied to get staff attention. When asked what attention he needed from staff, and he replied nothing.and noted he just wanted their attention. Staff discussed safety and other [more productive] ways to get staff attention.12/7/25, R4 was yelling and swearing throughout the shift at staff members. He was agitated that he could not be taken out to smoke. R4 continuously laid himself on the floor from his wheelchair. Multiple attempts were made by staff to redirect R4.12/8/25, R4 was yelling and swearing throughout the shift at staff members. R4 attempted a self-transfer from his wheelchair in order to walk outside and had fallen.12/20/25, R4 was yelling, cursing, screaming, and putting himself on the floor.12/23/25, R4 voluntarily got out of his wheelchair and laid himself on the floor.12/24/25, R4 had behaviors and threw himself on the floor.12/24/25, R4 voluntarily slipped onto the floor from his wheelchair.12/25/25, R4 stated to staff he will put himself on the floor.12/28/25, R4 put himself onto the floor as a behavior.12/28/25, R4 was on behavior monitoring as he voluntarily slipped twice from his wheelchair to the floor by the nurse's station.12/29/25, R4 was noted to be having behaviors during the shift. R4 would lower himself to the floor as a bid to get attention. Staff noted he did this three times during the shift.12/29/25, R4 was using inappropriate words, had lowered himself to the ground on several occasions in order to get attention from staff, with the goal of getting help to go (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside to the smoking area.12/30/25, R4 laid himself on the floor multiple times throughout the shift.12/31/25, R4 was yelling, using inappropriate words and lowered himself to ground on several occasion, to get staff attention with goal of getting help to the smoking area.1/8/26, R4 lowered himself to floor from wheelchair stating he needed help getting into bed. R4's 10/17/25, care plan identified a potential for ineffective coping skills related to his PTSD. Staff were to allow him to express his feelings, communicate that he was safe and situations were not his fault, and they were sorry that had happened to him. Staff were to remain with R4 and offer support at times of high anxiety and offer music. R4 had the potential to be verbally aggressive, use profanity related to ineffective coping skills, and mental and emotional illness. Staff were to administer medication and monitor for side effects as ordered and were to assess and anticipate R4's needs, such as food, thirst, toileting, comfort, body positioning and pain. Staff were to intervene before agitation escalated. If R4's response was aggressive, staff were to walk calmly away and approach later. Staff were to also give many choices and offer snacks or small pieces of candy when he becomes upset. R4's target behaviors were poor self-esteem, potential to be withdrawn, lack of social skills, and irrational thought process. R4 was high risk for falls related to impaired cognition and mobility. R4 had been moved closer to the nurse's station and in a high traffic area. Staff were to assist him when he went out to smoke. R4 had anti-roll back breaks on his wheelchair. Staff assisted R4 with toileting, and offer him his urinal at 2 a.m R4 had a sign placed to call don't fall in his room, and staff were to ensure his bed was at appropriate height when sitting bedside and encourage R4 to ask for assistance. There was no mention that R4 would intentionally place himself on the floor from his wheelchair or his bed. Interview and care plan review on 1/14/26 at 11:19 a.m., with registered nurse (RN)-C identified R4's target behaviors would be hollering out, threatening to put himself on the floor, swearing, being withdrawn, lack of social skills, and having irrational thoughts. RN-C reviewed the care plan listed target behaviors as noted above and agreed, there was no mention of R4 placing himself on the floor as a behavior. Interview on 1/13/26 at 2:45 p.m., with NA-B identified R4's target behaviors as yelling out, swearing, and he will put himself on the floor. NA-B reported R4's behaviors had improved since he had some medications adjusted and he started a pain patch. R4 would put himself on the floor when staff did not get to him immediately when he wanted something. For instance, R4 will ask to lay down in his bed and then want to get back up in 10 minutes and if staff did not get there right away, he would put himself on the floor. NA-B reported staff have to run to his light when it goes on, or he will put himself on the floor. Review of 2023, Comprehensive Care Plans policy identified that the care plan would be developed using the MDS assessment and other factors identified by the interdisciplinary team, and with the resident's preferences. The care plan would include individualized interventions and be developed by the interdisciplinary team. The care plan will be reviewed and revised after each MDS assessment. The care plan will include measurable goals and time frames and be monitored for progress. The care plan was to be revised after each comprehensive and quarterly MDS assessment. There was no mention of ensuring the care plans were updated more often if necessary for behaviors identified.