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	02/25/2026

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 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 neglect to the State Agency immediately (2 hours) for 1 of 1 resident (R1) who spilled hot liquid on her upper thigh which result in a significant injury.Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency on 2/19/26, identified R1 was transferred to the emergency room (ER) related to fever and lethargy. R1 was noted to have a severe burn that was covering a large portion of the thigh with peeling skin. The burn was reported by R1 to be caused by spilling hot water on her thigh on 2/9/26. R1's admission Minimum Data Set, dated [DATE], identified R1 had intact cognition, walked independently with use of a walker and was independent with eating. Diagnoses included diabetes, peripheral neuropathy (damage to peripheral nerves that result in numbness, pain, and weakened in the hands and feet), malnutrition, and anxiety. R1's Progress Notes indicated the following:2/9/26 at 3:03 p.m., R1 spilled hot water on her right upper thigh. R1 had a visible red upper right thigh. R1 was educated to be careful with hot liquids and ask for help when she needs it. The physician [unknown] ordered to apply Vaseline to the affected area and pain medication was administered [to R1].2/10/26 at 11:38 a.m., R1 has reddened area to her right thigh with blister approximately five (5) inches by three (3) inches. Provider at the facility and gave orders for Xeroform to cover area with abd (pad) and secure with kerlix and to changed daily and as needed. Provider added her to wound rounds. R1's progress notes lacked evidence the facility reported R1's burn to the state agency on 2/10/26 when it resulted in a serious injury. R1's hospital Wound Care Initial Consult dated 2/17/26, identified R1's right thigh burn wound was chemically and mechanically debrided (a procedure that thoroughly cleans the wound and removes all dead tissue, foreign debris, and residual material from dressings). Wound measurements were 15 x 26 x 0.1 centimeters (cm). The burn wound was described as a partial thickness burn (involving the epidermis and part of the dermis layer of the skin) that was blistered, fragile, bleeding, and erythematous (abnormal redness of the skin). During an interview on 2/25/26 at 1:25 p.m., the director of nursing (DON) indicated she was notified of R1's burn on 2/9/26 and was in the facility. The DON identified she did not consider the burn significant until 2/12/26. The DON verified the facility did not assess the residents for mitigation of hazards related to hot liquids prior to R1's burn and did not report R1's burn to thigh to the State Agency. During an interview on 2/25/26 at 2:55 p.m., the administrator indicated staff texted or called him immediately after R1's burn incident but verified the incident had not been reported to the State Agency. Review of facility policy titled The Abuse, Neglect, and Exploitation Policy last reviewed 6/16/25, identified neglect as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further defined serious bodily injury as an injury involving extreme physical pain, involving substantial risk of death, involving protracted loss or impairment of the bodily member, (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	organ, or mental faculty, requiring medical interventions such as surgery, hospitalization, or physical rehabilitation, or an injury resulting from criminal sexual abuse. The policy further 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.

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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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure 1 of 3 residents were free from avoidable accidents from hot liquids. This resulted in actual harm to R1 who spilled hot coffee on her lap and sustained a third-degree burn. In addition, the facility failed to implement a system to assess residents for safety with hot liquids. The facility implemented appropriate corrective action prior to the onsite investigation; therefore, the deficiency is being cited at past non-compliance.Findings include:A Vulnerable Adult Maltreatment Report submitted to the State Agency on 2/19/26, identified R1 was transferred to the emergency room (ER) related to fever and lethargy. R1 was noted to have a severe burn that was covering a large portion of the thigh with peeling skin. The burn was reported by R1 to be caused by spilling hot water on her thigh on 2/9/26. R1's admission Minimum Data Set, dated [DATE], identified R1 had intact cognition, walked independently with use of a walker and was independent with eating. Diagnoses included diabetes, peripheral neuropathy (damage to peripheral nerves that result in numbness, pain, and weakened in the hands and feet), malnutrition, and anxiety. R1's care plan dated 1/7/26, identified R1 was able to eat independently, a care plan revision was made on 2/12/26 to add staff were to ensure lid was on and secure for resident with hot liquids. R1's Risk Management Report dated 2/9/26, indicated R1 was having lunch and spilled hot water on her upper right thigh. The report did not include a description or measurements of the burn wound. R1's Progress Notes indicated the following:2/9/26 at 3:03 p.m., R1 spilled hot water on her right upper thigh. R1's upper thigh was visibly red. R1 was educated to be careful with hot liquids and ask for help when she needs it. The physician ordered application of Vaseline to the affected area and pain medication was administered.2/10/26 at 11:38 a.m., R1 has reddened area to her right thigh with blister approximately five inches by three inches. Provider gave orders for Xeroform, cover area with ABD (dressing) and secure with kerlix (gauze wrap), to be changed daily and as needed. R1 was also added to wound rounds on 2/12/26.2/12/26 at 11:38 a.m., partial thickness burn acquired in house, length 0.35 cm; 0.6 cm depth; 0.17 cm area; moderate dressing saturation (verified by later interviews that measurements were incorrect). 2/13/26 at 12:59 p.m., notified R1's primary care provider (PCP) that wound is not healing and asked for Silvadene (cream used for burns).2/14/26 at 10:44 a.m., R1 complaining of not feeling well and transferred to ER for further evaluation.2/16/26 at 15:28 a.m. update from ER; R1 was in surgery having fractured left ankle repaired, R1 had recurrent urinary tract infection (UTI), R1 would be seeing wound care to address burn to upper right thigh region once out of surgery. R1's PCP Nursing Home Visit note dated 2/10/26, identified PCP saw R1 in facility and was evaluated for Vitamin D deficiency; no other issues or concerns voiced from nursing staff at this time. Physical examination of skin: warm and dry. No rashes or lesions on exposed skin. The note did not include any documentation regarding R1's thigh burn. R1's telephone order on 2/10/26 at 11:45 a.m. indicates dressing to right thigh; xeroform to area, cover with ABD (dressing) and secure with kerlix, change daily and as needed. R1's Nursing Home Visit note dated 2/12/26, indicated R1 was seen by PCP for routine wound evaluation of her right thigh stage 2 (two) burn site. Photo taken of wound and debridement of wound completed. Multiple comorbidities affecting would healing and wound progression, as well as risk for wound including reduced mobility, muscle weakness, DMII (Type two diabetes), risk of malnutrition. Orders for daily wound care provided. R1's hospital Wound Care Initial Consult dated 2/17/26, identified R1's right thigh burn wound was chemically and mechanically debrided (a procedure that thoroughly cleans the wound and removes all dead tissue, foreign debris, and residual material from dressings). Wound measurements were 15 x 26 x 0.1 centimeters (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(cm). The burn wound was described as a partial thickness burn (involving the epidermis and part of the dermis layer of the skin) that was blistered, fragile, bleeding, and erythematous (abnormal redness of the skin).During observation and interview on 2/23/26 at 3:05 p.m., R1 was sitting on her bed fully clothed and stated she had fractured her ankle and had surgery recently and then a few days later (could not remember the exact date) the cover was not sitting correctly on top of her plastic thermal mug and it popped off causing the hot water to splash out onto her hand; it startled her and she instinctively jerked and the remainder of the hot water spilled on her right thigh. R1 further indicated that she had horrible pain, and it continued to burn through her sweatpants while the nursing assistant brought her back to her room and found the nurse. R1 indicated she had burnt most of the top of her right thigh and the hot water continued to soak into the incontinent brief which caused a burn on the right groin fold. R1 stated it took 20-30 minutes for a nurse to come, and she had attempted to independently remove the clothing but struggled. R1 stated the nurses put Vaseline on it. R1 further identified she had neuropathy in her fingers, feet, and legs so she doesn't feel pain like other people do. R1 indicated nurses change the dressing on her right thigh every day and it still caused her some pain but not as bad as it was. R1 said she was now receiving wound care from outside the facility. During a follow up observation and interview on 2/25/26 at 2:15 p.m., licensed practical nurse (LPN)-A performed right thigh wound care and dressing change. Observation of the wound extends throughout a majority of her upper thigh and into the right groin folds (panty line) and displayed a red, bubbly appearance with eschar (layer of dead skin tissue). R1 stated it still hurts a little. During observation and interview on 2/25/26 at 8:55 a.m., the dining specialist (DS) said all hot water and coffee were served out of the kitchen and the water was too hot, so it was being turned down today 2/25). DS further identified she was working at the time R1 was burnt by the hot water but did not give her the hot water and was not sure who did. DS stated, I am assuming as bad as her [R1] burn was, it [the water] was way too hot. DS indicated after R1's burn, the dietary department has a new policy now that says all hot water and coffee should have the temperature taken before it leaves the kitchen and if the temperature is greater than 140 degrees Fahrenheit (f), they would add a couple ice cubes to it. DS clarified they did not have a policy on hot water prior to the incident. During interview on 2/25/26 at 11:24 a.m., nursing assistant (NA)-A identified she was notified by dietary staff that R1 had spilled hot water on herself and took R1 back to her room immediately and left to find the charge nurse. NA-A said R1 had attempted to remove her pants by the time the nurse responded and described R1's leg as a large really red area on her right thigh with a blister forming. NA-A stated, I could tell it was significant and reported R1 expressed a lot of pain and frustration with the situation.During an interview on 2/25/26 at 11:41 a.m., RN-B indicated she was working the day of R1's incident, had not seen the wound but by the documentation considered the burn to be significant. RN-B stated the facility had not previously done hot water assessments on residents but after the incident, on 2/10/26, hot water assessments were done on all residents, and care plans were updated. During an interview on 2/25/26 at 1:43 p.m., registered nurse (RN)-A stated she was called to R1's room for a burn and found R1's right thigh with angry red skin, she called the PCP and received an order to put Vaseline on the burn and was told by the night nurse the following day that a blister had formed. RN-A stated she did not feel the burn wound was significant right away but did consider it a significant burn the next day because of the blister. RN-A identified that she assessed the wound but did not measure the burn wounds as part of that assessment. During an interview on 2/25/26 at 1:25 p.m., the director of nursing (DON) indicated she was notified of R1's burn on 2/9/26 and was in the facility. The DON identified she did not consider the burn significant until (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2/12/26. The DON stated immediately upon notification of the incident, she called an emergency response meeting, and a hot water assessment was completed for all residents, care plans were updated, auditing of food and water temperatures before it is served to the residents, and a policy and education was given to all staff related to hot water temperatures. During an interview on 2/25/26 at 1:40 p.m., the certified dietary manager (CDM) indicated she was aware of R1's burn by hot water. The CDM further explained DS-B reheated the water in the microwave and was told during the investigation that the water was temped, and it was 138 degrees F. The dietary staff are supposed to log the temperatures on a temperature log and that the hot water policy was not new. The facility's Hot Liquid Safety policy implemented 11/25, identified all residents are assessed for their ability to handle containers and consume hot liquids. Residents with difficulties will receive appropriate supervision and use of assistive devices in order to consume hot liquids. Interventions will be individualized and noted on the resident's plan of care. The policy also identified time and temperature relationship to serious burns and at 133 degrees F it would the time required for a 3rd degree burn to occur would be 15 seconds and at 140 degrees F, the time would be 5 seconds (The reported water temperature of the hot water given to R1 was 138 degrees F). Burns can occur even at water temperature below those identified in the table, depending on an individual's condition and length of exposure. The facility's undated policy titled, Accidents and Supervision identified the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: identifying hazards and risks; evaluating and analyzing hazards and risks; implementing interventions to reduce hazards and risks; and monitoring for effectiveness and modifying interventions when necessary. Supervision is an intervention and a means of mitigating risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency and based on the individual resident's assessed needs and identified hazards in the resident environment. The following facility's corrective actions dated 2/10/26 were verified as implemented prior to the survey: -All residents were assessed for hot liquid safety-All resident care plans were updated to include risk assessment.-Education on temperature logs in the kitchen and in the breakroom-Education on hot water policy, all food/liquids need to be temped and logged before giving to the resident, and what to do in case of a hot liquid burn.