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	05/20/2026

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 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 alcohol sanitizing clothes were stored safely out of reach for 1 of 1 resident (R1). The facility's failures resulted in harm for R1 after she obtained alcohol sanitizing/germicidal wipes, placed them in a glass with water, ingested the solution, and required hospitalization with a resulting diagnosis that included acute kidney injury.ˆ Findings include: R1's face sheet dated 5/20/26, identified diagnoses of alcohol abuse, attention deficit hyperactivity disorder, major depressive disorder, and seizures.ˆ R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, had no behaviors or rejection of care, was independent with transfers and mobility with the use of a walker. R1's care plan dated 6/9/25, identified R1 had a substance abuse/dependence of alcohol abuse as evidenced by current triggers, isolation, and emotions. Interventions as follows: -Assure resident does not have access to alcohol-based products. Dated 11/6/25. -If resident goes out and brings bags, ask resident to look to assure no alcohol-based products in bags. Notify director of nursing if found. Dated 1/19/26. ˆ R1's hospital emergency department (ED) notes dated 1/14/26, identified R1 was seen in the emergency department (ED) after drinking a half a bottle of hand sanitizer attempting to get drunk.ˆ ˆ During an interview on 5/20/26 at 12:40 p.m., licensed practical nurse (LPN)-A stated she was working on 5/17/26 at around 3:00 p.m., R1 was observed running into things as she was walking, staff had entered R1's room to search for alcohol and found a drinking mug full of sanitizing wipes called Super Sani-Cloth Germicidal Wipes.ˆ R1 had admitted placing the wipes in a cup and adding some water and drinking the liquid.ˆ LPN-A stated staff found an almost empty container of the wipes in a drawer and removed them and made sure all of the wipes were all locked up in the facility.ˆ ˆ During an interview on 5/20/26 at 1:14 p.m., nursing assistant (NA)-A stated she worked the day shift on 5/17/26 and found a cup on R1's nightstand full of sanitizing wipes with some water in the bottom.ˆ NA-A informed the nurse right away and then performed an inspection of R1's room and found an almost empty container or sanitizing wipes in the drawer in her nightstand.ˆ R1 wound not tell her where she had obtained the wipes. NA-A stated R1 had a history of drinking hand sanitizer and staff were supposed to make sure R1 did not have any access to any alcohol containing products. When NA-A did a quick visual check of R1's room, she did not see any alcohol containing products in her room. NA-A stated R1 was independent with her walker and ambulate in the facility and was unsure how she would have obtained them, because all of the alcohol-based sanitizing wipes were all kept under lock and key in the nursing department.ˆ ˆAccording to the manufacture label on the container of Super Sani-Cloth Germicidal Disposable Wipe (trademark name), it contained 55 percent of Isopropyl alcohol. According to the Safety Data Sheet for Super Sani-Cloth Disposable Wipes dated 3/16/26, toxicology information for ingestion as ingestion unlikely due to product form. No adverse effects.ˆ According to the National Institutes of Health (NIH) indicated isopropanol ingestion is characterized by ketosis without significant metabolic acidosis and is generally managed with supportive therapy. Approximately 80% of ingested isopropanol is absorbed within 30 minutes, with peak blood concentrations occurring between 30 minutes and 3 hours after ingestion. About 80% of absorbed (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 - Actual harm Residents Affected - Few	unsupervised and allow a resident to enter the room and grab the container. OT further explained she had not had any formal education on the process for keeping chemicals locked up at all times when not in use. During an interview on 5/20/26 at 2:44 p.m., director of nursing (DON) stated she had been contacted on 5/17/26 that R1 had placed a bunch of sanitizing wipes in a cup and added water to it and had been drinking the liquid.ˆ DON stated she was unsure how R1 had obtained the sanitizing clothes since nursing keeps all the sanitizing clothes under lock and key but was unaware that the therapy department had a bottle in their room that was not currently locked up.ˆ DON explained she had not checked in that department and assumed each department was responsible for ensuring the chemicals were locked up.ˆ ˆˆ During an interview on 5/20/26 at 2:57 p.m., social services director (SSD) stated she had provided education on 5/20/26 to the occupational therapist that all of the sanitizing clothes need to be locked up and out of resident reach at all times when staff are not using them. These types of clothes should have not been left out so a resident could easily get a hold of them and possibly ingest them.ˆThe facility would be placing them in a cabinet when not in use now and should have not been left out so a resident could easily get a hold of them and possibly ingest them. Review of an email dated 5/18/26 at 12:24 p.m., identified a performance improvement project was discussed to develop a solid plan to ensure the corrective process is implemented successfully: -Each department will have a designated locked storage area for supplies; Maintenance (boiler room); Laundry (laundry room); Nursing (white closet near therapy); Therapy (therapy room). During an interview on 5/20/26 at 4:25 p.m., administrator stated the therapy director had been included in a meeting to discuss how the facility was going make sure toxic chemicals were kept in a locked area to prevent the possibility of resident(s) ingestion. The staff member who did not follow the facility protocol for securing chemicals was given corrective action. During an interview on 5/20/26 at 3:42 p.m., medical director (MD) stated by R1 getting access to the Super Sani-Cloths that contained isopropyl alcohol then proceeding to create a kind of tea to drink, this caused her to have the acute kidney injury, however, it quickly resolved with fluids while in the hospital.ˆ MD stated the wipes should have been all kept in a locked cabinet to prevent any residents obtaining them.ˆ ˆ The facility's education with staff began on 5/19/26 included any product with high alcohol content should always be locked in a locked location. This included but is not limited to Sani-Cloths, hand sanitizers, and alcohol prep pads.ˆ Residents were not allowed to keep or have access to any products with high alcohol content.ˆ The facility also created a supply inventory checklist for each item, and a supply sign out sheet to document if and when an employee removed the product from the locked unit to ensure it would be returned.ˆ Review of the facility's Alcohol Based Hand Rub Policy dated 3/31/25, identified a new chemical management and accountability process (that was undated when added) for staff use within the building: -Each department will have a designated locked storage area containing the chemical and supplies required for that department's daily operations. Specific amounts will be maintained for each item to help ensure supplies do not run out during shifts.ˆ -Effective immediately, all staff members who remove chemicals from storage for use must sign out before use and sign them back in immediately upon return. Staff are responsible for maintaining direct supervision of any chemical brought onto the floor at all times.ˆ Chemicals must remain in the possession of the staff members using them and may not be left unattended under any circumstances. -In accordance with facility policy, no chemicals are permitted to be left in resident rooms. This includes, but is not limited to, alcohol wipes, bleach spray, urine remover, or any other cleaning or disinfecting products.ˆ Residents are not permitted access to these chemicals.ˆ -Access to the garage storage area will be limited to managers, nursing assistants, and designated staff members responsible for restocking supplies. -At the end of each shift, the staff member assigned to chemical accountability will review the sign-out sheets to verify all items have been returned and properly accounted for. Any low stock items will be restocked before the end of the shift. -If, during the review process, an item is found to be missing without proper documentation, the staff member responsible for oversight must immediately follow up with all staff members who had access to (continued on next page)

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