DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 2, 2026

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

RE: CCN: 245400
Cycle Start Date: January 14, 2026

Dear Administrator:

On February 10, 2025, we notified you a remedy was imposed. On March 30, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 29, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 14, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 11, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 14, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 29, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 11, 2026

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

RE: CCN: 245400
Cycle Start Date: January 14, 2026

Dear Administrator:

On February 10, 2026, we informed you of imposed enforcement remedies.

On February 25, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 14, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 14, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 14, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries

enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of February 10, 2026, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 14, 2026.

**ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

**DEPARTMENT CONTACT**

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an"E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or
Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

**FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 14, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

**APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

**INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

**INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 11, 2026

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

Re: Event ID: 1F16F0-H1

Dear Administrator:

The above facility survey was completed on February 25, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

**Minnesota Department of Health**

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/25/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WABASSO RESTORATIVE CARE CENTER | 660 MAPLE STREET , WABASSO, Minnesota, 56293 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>On 2/23/26 and 2/25/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint(s) was/were reviewed: H54006472C (2746245) and a deficiency was issued at F689 at HARM PAST NON-COMPLIANCE.<br><br>However, as a result of the investigation, a deficiency was cited at F609.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F0000 | | 03/20/2026 |
| F0609<br>SS = D | Reporting of Alleged Violations<br><br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the | F0609 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>Education on the rapid response process and abuse, neglect, and misappropriation policy provided to the NHA and DON by Regional Clinical Consultant on 3/2/2026<br><br>How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: | 03/29/2026 |

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 reverse for further 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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/25/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WABASSO RESTORATIVE CARE CENTER | 660 MAPLE STREET , WABASSO, Minnesota, 56293 |

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| F0609 SS = D | Continued from page 1<br>allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>Findings include:<br><br>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.<br><br>R1's admission Minimum Data Set dated 1/25/26, 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.<br><br>R1's Progress Notes indicated the following:<br><br>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 | F0609 | Continued from page 1<br>All incident reports and grievances for the past 30 days were reviewed by the DON on 3/16/2026 to determine if any met the standard for reporting under the abuse, neglect, misappropriation policy definition. There were no incidents found that met the standard.<br><br>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and:<br><br>Education on the Abuse, Neglect reporting policy was initiated by the DON on 3/12/2026 with all staff being educated by 3/24/2026. Any staff not receiving education by end of business day on 3/24/2026 will not be allowed to work until receiving education.<br><br>All grievances, incidents reports, and progress notes will be reviewed Monday-Friday as part of the daily clinical stand up process with any incidents, grievances, and notes from the weekend being reviewed on Monday to ensure that any incidents or events that meet the standard of reporting are reported timely.<br><br>Describe the Quality Assurance and Process Improvement Program that will be put into place.<br><br>QAPI was held on 3/16/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained<br><br>Facility alleges substantial compliance on 3/29/2026 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/25/2026 |
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| WABASSO RESTORATIVE CARE CENTER | 660 MAPLE STREET , WABASSO, Minnesota, 56293 |

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| F0609 SS = D | Continued from page 2<br>to apply Vaseline to the affected area and pain medication was administered [to R1].<br><br>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.<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>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, | F0609 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/25/2026 |
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| F0609 SS = D | Continued from page 3<br>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. | F0609 | | |
| F0689 SS = G | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>Findings include:<br><br>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.<br><br>R1's admission Minimum Data Set dated 1/25/26, identified R1 had intact cognition, walked independently with use of a walker and was independent | F0689 | "Past Noncompliance - no plan of correction required" | 02/10/2026 |

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| F0689 SS = G | Continued from page 4<br>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.<br><br>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.<br><br>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.<br><br>R1's Progress Notes indicated the following:<br><br>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.<br><br>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.<br><br>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).<br><br>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).<br><br>2/14/26 at 10:44 a.m., R1 complaining of not feeling well and transferred to ER for further evaluation.<br><br>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.<br><br>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 | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/25/2026 |
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| F0689 SS = G | Continued from page 5<br>on exposed skin. The note did not include any documentation regarding R1's thigh burn.<br><br>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.<br><br>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.<br><br>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).<br><br>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. | F0689 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WABASSO RESTORATIVE CARE CENTER | 660 MAPLE STREET , WABASSO, Minnesota, 56293 |

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| F0689 SS = G | Continued from page 6<br><br>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”.<br><br>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.<br><br>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”.<br><br>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.<br><br>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 | F0689 | | |

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| F0689 SS = G | Continued from page 7<br>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.<br><br>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 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.<br><br>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.<br><br>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.<br><br>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 | F0689 | | |

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| F0689 SS = G | Continued from page 8<br>and frequency and based on the individual resident's assessed needs and identified hazards in the resident environment.<br><br>The following facility's corrective actions dated 2/10/26 were verified as implemented prior to the survey:<br><br>-All residents were assessed for hot liquid safety<br><br>-All resident care plans were updated to include risk assessment.<br><br>-Education on temperature logs in the kitchen and in the breakroom<br><br>-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. | F0689 | | |

Minnesota State Department of Health

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| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br><br>On 2/23/26 and 2/25/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure.<br><br>The following complaints were reviewed during the survey. H54006472C (2746245). | 20000 | | 03/20/2026 |

Office of Primary Care and Health Systems Management

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Minnesota State Department of Health

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| 20000 | Continued from page 1<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 20000 | | |

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| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br><br>On 2/23/26 and 2/25/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure.<br><br>The following complaints were reviewed during the survey. H54006472C (2746245). | 20000 | | |



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Minnesota State Department of Health

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| 20000 | Continued from page 1<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 20000 | | |

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| F0000 | INITIAL COMMENTS<br><br>On 2/23/26 and 2/25/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint(s) was/were reviewed: H54006472C (2746245) and a deficiency was issued at F689 at HARM PAST NON-COMPLIANCE.<br><br>However, as a result of the investigation, a deficiency was cited at F609.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F0000 | | |
| F0609<br>SS = D | Reporting of Alleged Violations<br><br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the | F0609 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>Education on the rapid response process and abuse, neglect, and misappropriation policy provided to the NHA and DON by Regional Clinical Consultant on 3/2/2026<br><br>How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: | 03/29/2026 |

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 reverse for further 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.

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| F0609 SS = D | Continued from page 1<br>allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>Findings include:<br><br>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.<br><br>R1's admission Minimum Data Set dated 1/25/26, 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.<br><br>R1's Progress Notes indicated the following:<br><br>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 | F0609 | Continued from page 1<br>All incident reports and grievances for the past 30 days were reviewed by the DON on 3/16/2026 to determine if any met the standard for reporting under the abuse, neglect, misappropriation policy definition. There were no incidents found that met the standard.<br><br>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and:<br><br>Education on the Abuse, Neglect reporting policy was initiated by the DON on 3/12/2026 with all staff being educated by 3/24/2026. Any staff not receiving education by end of business day on 3/24/2026 will not be allowed to work until receiving education.<br><br>All grievances, incidents reports, and progress notes will be reviewed Monday-Friday as part of the daily clinical stand up process with any incidents, grievances, and notes from the weekend being reviewed on Monday to ensure that any incidents or events that meet the standard of reporting are reported timely.<br><br>Describe the Quality Assurance and Process Improvement Program that will be put into place.<br><br>QAPI was held on 3/16/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained<br><br>Facility alleges substantial compliance on 3/29/2026 | |

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| F0609 SS = D | Continued from page 2<br>to apply Vaseline to the affected area and pain medication was administered [to R1].<br><br>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.<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>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, | F0609 | | |

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| F0609 SS = D | Continued from page 3<br>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. | F0609 | | |
| F0689 SS = G | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>Findings include:<br><br>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.<br><br>R1's admission Minimum Data Set dated 1/25/26, identified R1 had intact cognition, walked independently with use of a walker and was independent | F0689 | "Past Noncompliance - no plan of correction required" | 02/10/2026 |

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| F0689 SS = G | Continued from page 4<br>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.<br><br>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.<br><br>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.<br><br>R1's Progress Notes indicated the following:<br><br>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.<br><br>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.<br><br>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).<br><br>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).<br><br>2/14/26 at 10:44 a.m., R1 complaining of not feeling well and transferred to ER for further evaluation.<br><br>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.<br><br>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 | F0689 | | |

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| F0689 SS = G | Continued from page 5<br>on exposed skin. The note did not include any documentation regarding R1's thigh burn.<br><br>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.<br><br>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.<br><br>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).<br><br>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. | F0689 | | |

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| F0689 SS = G | Continued from page 6<br><br>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”.<br><br>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.<br><br>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”.<br><br>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.<br><br>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 | F0689 | | |

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| F0689 SS = G | Continued from page 7<br>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.<br><br>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 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.<br><br>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.<br><br>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.<br><br>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 | F0689 | | |

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| F0689 SS = G | Continued from page 8<br>and frequency and based on the individual resident's assessed needs and identified hazards in the resident environment.<br><br>The following facility's corrective actions dated 2/10/26 were verified as implemented prior to the survey:<br><br>-All residents were assessed for hot liquid safety<br><br>-All resident care plans were updated to include risk assessment.<br><br>-Education on temperature logs in the kitchen and in the breakroom<br><br>-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. | F0689 | | |