Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 6, 2026

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN: 245283
Cycle Start Date: November 21, 2025

Dear Administrator:

On December 11, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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January 6, 2026

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: Reinspection Results
Event ID: 1D9336-H1

Dear Administrator:

On December 11, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 21, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Saint Paul, MN 55164-0900
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An equal opportunity employer.

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November 21, 2025

Administrator
The Waterview Pines LLC

1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN:245283
Cycle Start Date: November 21, 2025

Dear Administrator:

On November 21, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor RR
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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 21, 2026, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 21, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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Administrator
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1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: State Nursing Home Licensing Orders
Event ID: 1D9336-H1

Dear Administrator:

The above facility survey was completed on November 21, 2025, 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Regional Operations Supervisor RR
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

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.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/21/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	**1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792**

(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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 10/1/25 through 10/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		11/21/2025

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/21/2025**

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20000	Continued from page 1 The following complaints were reviewed: H52835268C (2629601) with no licensing orders issued. Additionally, as a result of the investigation, a licensing order was issued at 1805. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE	20000		
21805	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 5 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805	Corrected	11/26/2025

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21805	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review the facility failed to promote dignity and respect for 1 of 3 residents (R1) who required assistance with activities of daily living (ADLs) and reported rough and disrespectful care by staff. Findings include: R1's Entry Minimum Data Set (MDS) dated 9/30/25, identified admission to facility on 9/25/25, from an acute care hospital. R1's care plan (CP) dated 9/26/25, identified he was vulnerable to abuse and instructed staff to monitor for signs of emotional distress, mood or behavior changes and continue to follow the facility's Vulnerable Abuse Reporting policy and directed R1 was independent with activity choices and staff were to respect his choices of preferred room leisure time. CP also indicated R1 had an alteration in mobility related to colon cancer, edema (fluid retention), pain, and malnutrition with a goal he would move safely within his environment; staff were directed to assist with movement in bed and in/out of bed assist of one with front wheeled walker/wheelchair. R1 also had an alteration in mood, behaviors, and psychosocial well-being related to adjustment to facility and current health condition and staff were directed to reapproach R1 when he refused (cares, medications, linen changes to bed) with a soft tone and give him time and options, monitor and document mood state/behaviors upon occurrence, and provide emotional support, validation and comfort measures as needed (PRN). R1's progress notes from 9/26/25, identified: -at 10:32 a.m. R1 refused to allow nursing assistant (NA) and registered nurse (RN) on shift to complete cares and all scheduled medications. Writer went into resident room and spoke with him. He stated, "can't you guys just let me sleep for a few more hours and come back". Writer said yes and asked if he had any pain or needed pain medication. He denied pain at that time. -at 7:36 a.m. On Hospice, laid in bed. Not willing to have a full body check due to pain. -at 3:15 p.m. Hydro morphine Hydrocholoride (HCL) 2 milligrams (mg) administered by mouth (po) every 1 hour as needed for low back pain and cancer.	21805		

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21805	Continued from page 3 -at 6:14 p.m. Follow-up pain scale was 5 out of 10. PRN administration of Hydro morphine was ineffective. Review of the nursing assistant (NA) tasks documentation dated 9/26/25, identified: no behavior charting. During an observation on 10/2/25 at 8:50 a.m., NA-A offered to change his bed; he refused until later and exited the room. During an observation/interview on 10/2/25 at 8:55 a.m. R1 laid in a dark room on bed fully dressed covered with a blanket. R1 stated he was admitted to the facility on 9/25/25, and the stay had been ok, but the staff would not listen to him, and he was feeling upset about that. R1 had told staff when he was sleeping, he did not want to be bothered. R1 stated one afternoon, right after he was admitted to the facility, a staff NA was ruff with him while she assisted him. The NA moved his legs too fast and almost ripped out his drainage tube. He explained they "did not get along or see eye to eye, and she lacked respect for his wishes." R1 stated there was also another female NA in the room when the incident occurred, adding the day it happened NA-A was told he did not want her in his room or taking care of him anymore, then today, she had been assigned to him. This was upsetting for him, and he did not want her in his room or caring for him. There was lack of respect and she refused to listen to what his needs were. He wanted to get back to sleep, not be bothered and would let staff know when he wanted his bed changed. During an interview on 10/2/25 at 9:44 a.m., director of nursing (DON) stated she had gone into R1's room along with NA-A and asked if he wanted to be washed up and dressed for the day and he requested to be left alone and allowed to sleep. She left early that day and was unaware of any concerns R1 may have had or that he did not want NA-A to care for him. During a follow-up interview on 10/3/25 at 11:15 a.m., DON stated she went back yesterday (10/2/25) and realized she had received an email from the floor manager RN-A on 9/26/25 at 3:44 p.m. which indicated MD stopped to see R1, heard him crying due to pain while cares were provided by two staff NAs. MD requested NA-A not be allowed to care for R1. DON stated if she would have been contacted that day she would have removed NA-A from the floor immediately, began an investigation, interviewed all residents she had taken care of, completed skin checks on all cognitively impaired residents, and if signs and symptoms of abuse	21805		

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21805	Continued from page 4 or neglect were found, reported it within two hours to the state. She would have expected to be contacted by the floor manager RN-A right away. DON added, after she talked with R1 and learned the reason behind the pain was NA-A had moved to his legs too fast, he felt safe, not malicious attempt in any way, it was more of a care concern. DON stated she was unaware NA-A had previous history of discipline action taken with inappropriate behaviors (yelling in hallways, bulling other peers, HIPPA) that could be projected onto residents and mistreated them. Facility untitled document on 10/2/25, identified administrator and director of nursing (DON) were notified of possible “rough cares” with R1. Writer attempted to speak with R1 around 12:15 p.m. on 10/2/25, he appeared agitated, did not want to speak, was unable to breath and was in pain. R1 was assisted up into wheelchair, brought outside, and communicated he felt better. Interviews with intact cognition residents and skin checks were initiated on all residents. Administrator was notified by Minnesota Department of Health (MDH) surveyor R1 did not want NA-A, who the allegation was against, to care for him. NA-A was immediately given a new assignment and was not removed from the schedule. DON visited with R1, and he did not express any care concerns. Administrator received statements from the two NAs at time of allegation, there were no care concerns noted. During an interview on 10/2/25 at 10:08 a.m. NA-A stated on 9/26/25, around 2:30 p.m. she had entered R1’s room along with NA-B and transferred him out of bed. NA-A cleaned up his bed and NA-B assisted R1 with cares and placed clean clothing on him. Together both NAs assisted him back into bed, he complained of pain, indicated the drainage tube had gotten pulled on and hurt. R1 stated out loud, you hurt me and my tube, we did not see anything happen to his tube. R1 repeated my tube hurts now. We were careful and the drainage tube may have rubbed up against something when in bed. No bleeding was noted and no complaints about how he was transferred. MD entered the room as she exited, unsure as to who he was. NA-A’s shift was over and did not inform the nurse prior to leaving work that day. Things were going ok since that day; she had worked the following two days (Saturday and Sunday) alone with him, without any other staff in the room with her. She had apologized to R1 on Saturday morning and he did not seem angry, upset, or ask her to leave. The administrator just informed her they would have someone else to take care of R1 the rest of the day, she was not to go in his room and not told why. She was allowed to stay and work with other residents on the floor.	21805		

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21805	Continued from page 5 During an interview on 10/2/25 at 11:00 a.m. medical doctor (MD) stated on 9/26/25 in the afternoon he had walked into the middle of a situation with R1 and a staff NA-A. R1 stated NA-A pulled on his catheter drain and almost ripped it off. The NA-A stated she was sorry that happened and would report it to the supervisor, R1 appeared teary eyed, visibly upset, obviously something happed that should have not, and needed to be investigated. NA-B interacted great with R1 and informed him she planned on reporting this to the supervisor. Prior to leaving the building he stopped at the front desk office off to the right of the front door and informed a staff that sat behind the desk NA-A was rough with R1 and she informed him she would investigate it. He was a mandated reporter and felt this was a situation that should have had follow up regarding rough handling. During an interview on 10/2/25 at 11:50 a.m. registered nurse (RN)-B stated she was loud at times while in R1's room and he had told her to get out frequently, refused cares and medications. She reapproached him and sometimes it had worked. On 9/26/25, NA-B informed her R1 had been man handled and needed something for pain. R1 was visually upset and teary eyed, stated his drainage tube had been pulled, tube was assessed and intact. While she was in R1's room he stated he did not ever want that lady in there again and pointed to NA-A, was rough handled and his tube hurt. The incident occurred at the end of the day shift, NA-A went home, returned the following day and cared for R1 and other residents. RN-B stated she did not ask R1 if he felt safe or was ok with NA-A caring for him but was aware he had requested no further care by her. During an interview on 10/3/25 at 11:52 a.m., administrator stated they were not aware of the incident with R1 and NA-A until 10/2/25. Administrated indicated both NA-A and NA-B (witness) provided statements, they reviewed NA-A's personnel file and education was provided. We did not suspect abuse. NA-A lifted R1's legs too fast, possibly bumping his drainage tube and increased his pain. Education on professional boundaries and safe handling had been completed with NA-A on 10/2/25. During an interview on 10/2/25 at 2:40 p.m. NA-B stated she cared for R1 frequently and he required total assist of two person with cares. He had cancer and was terminally ill. He did not use his call light, they checked on him at least every two hours, and it was important to be quiet and calm when she entered his room. NA-B stated she arrived at work at 2:30 p.m. on	21805		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	**1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792**

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21805	Continued from page 6 9/26/25, and received report from NA-A. R1 had not been touched all day and refused cares. NA-A requested assistance to try again. We entered R1's together and room smelled of bowel movement (BM) and urine (noted to be on the bed linens). She sent NA-A out of the room to gather linens. NA-B assisted R1 to stand up while she cleansed his front, back, bottom and placed clean clothing on him. NA-B re-entered the room and changed the linens on his bed. NA-A stood on R1's right side and NA-B stood on his left side, he grabbed under their arms, stood up, pivoted, and sat down on edge of bed. She took ahold of his shoulders and NA-A grabbed his feet. She counted three, two and before she could say one NA-A quickly swung his feet/legs up onto the bed, and was not gentle, adding she "gave it all it was worth, not sure what [NA-A] was thinking." (he was a thin person, and legs were light). R1 started to scream and cry and stated his drainage tube got pull and was in pain. She informed NA-A she would finish. NA-A started to pick up dirty lines and was told to leave the room. NA-B reassured R1 and looked at the tube, no bleeding noted. MD was outside R1's door waiting to see him, walked into the room. She informed MD NA-A was a little rough with R1 while she placed his feet/legs onto the bed. MD informed her he did not want NA-A back in the room, the incident reported, and pain medication given now. R1 cried in pain. She walked down to the desk and talked with the nurse on duty requested pain medication to be given per MD. NA-B went down to the office located by the front of the building around 2:45 p.m. where two-unit managers were located. She informed them MD was in R1's room, upset and requested NA-A stay out of his room due to being rough with him and this incident needed to be reported. They responded ok and went back to work. MD came down the hallway and asked NA-B if she had informed the unit managers of the incident and she stated yes, and he thanked her. NA-B stated NA-A was rough with R1 but did not seem to be maliciously done. She had worked with NA-A for 15 years and not seen her treat any other resident that way, felt she was in a hurry and wanted to go home for the day. When R1's legs were grabbed and thrown onto the bed the drainage tube must have been located underneath, was hooked on something, and pulled. During an interview on 10/2/25 at 3:36 p.m., floor manager RN-A stated she had worked on 9/26/25 and heard R1 refused cares throughout the day and at shift change NA-A and NA-B completed R1's cares together. MD came to the office and informed her and another floor manager he did not want NA-A working with R1 anymore without explanation and walked out of the office. NA-B stopped in the office informed her MD did not want NA-A working with R1. RN-A stated she emailed the director of	21805		

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21805	Continued from page 7 nursing (DON) later that afternoon with the information she had but now sees it would have been beneficial to have asked NA-B more questions. She was made aware he was in pain and resistive to care earlier in the day. Facility policy Combined Federal and State Bill of Rights dated 6/18/19, identified the resident has a right to a dignified existence, self-determination, and communication, and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Facility policy Safe Resident Handling dated 3/2020, identified safe patient handling is a key component to reducing hazards of injury to our employees and our residents so that when residents receiving care require assistance from facility employees to move, assistance is provided in a manner that is safe to both the resident and employee. The facility is committed to provide high quality resident care. Facility document undated Professional Boundaries identified the employee-resident relationship was designed to meet the needs of the resident and protects the resident's dignity, autonomy, and privacy and allows for the development of trust. Professional boundaries are the spaces between the employee's power and the resident's vulnerability. Employees should make every effort to respect the power imbalance and ensure resident-centered relationships. SUGGESTED METHOD OF CORRECTION: The facility could review their education and training in providing dignified care of vulnerable adults and review/implement policies and procedures for ensuring dignified care. The facility could assure all staff are trained on providing care and services to promote dignity during activities of daily living (ADLs). Audits can be conducted to ensure ongoing compliance as well as resident satisfaction surveys. The facility could provide ongoing education and training and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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F0000	INITIAL COMMENTS On 10/1/25 through 10/3/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H52835268C (2629601) with no deficiencies issued. Deficient practice was identified related to incidental findings at F550 and F610. 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. 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		11/21/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550	F0550 Resident Rights/Exercise of Rights Immediate Corrective Action: Resident expired. Corrective Action as it applies to others: Resident Rights Policy reviewed. All cognitive residents were interviewed to report any residents' right concerns. All non-cognitive residents' responsible representatives contacted to report any resident right concerns.	11/26/2025

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

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F0550 SS = D	Continued from page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review the facility failed to promote dignity and respect for 1 of 3 residents (R1) who required assistance with activities of daily living (ADLs) and reported rough and disrespectful care by staff. Findings include: R1's Entry Minimum Data Set (MDS) dated 9/30/25, identified admission to facility on 9/25/25, from an acute care hospital. R1's care plan (CP) dated 9/26/25, identified he was vulnerable to abuse and instructed staff to monitor for signs of emotional distress, mood or behavior changes and continue to follow the facility's Vulnerable Abuse Reporting policy and directed R1 was independent with activity choices and staff were to respect his choices of preferred room leisure time. CP also indicated R1 had an alteration in mobility related to colon cancer, edema (fluid retention), pain, and malnutrition with a goal he would move safely within his environment; staff were directed to assist with movement in bed and in/out	F0550	Continued from page 1 All resident right concerns will be filed, investigated, and followed up on per policy. All staff will be educated on resident rights. Date of Compliance: 11/26/25 Recurrence will be prevented by: 5 residents or responsible representatives will be interviewed to report any resident rights concerns weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee	

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F0550 SS = D	Continued from page 2 of bed assist of one with front wheeled walker/wheelchair. R1 also had an alteration in mood, behaviors, and psychosocial well-being related to adjustment to facility and current health condition and staff were directed to reapproach R1 when he refused (cares, medications, linen changes to bed) with a soft tone and give him time and options, monitor and document mood state/behaviors upon occurrence, and provide emotional support, validation and comfort measures as needed (PRN). R1's progress notes from 9/26/25, identified: -at 10:32 a.m. R1 refused to allow nursing assistant (NA) and registered nurse (RN) on shift to complete cares and all scheduled medications. Writer went into resident room and spoke with him. He stated, "can't you guys just let me sleep for a few more hours and come back". Writer said yes and asked if he had any pain or needed pain medication. He denied pain at that time. -at 7:36 a.m. On Hospice, laid in bed. Not willing to have a full body check due to pain. -at 3:15 p.m. Hydro morphine Hydrocholoride (HCL) 2 milligrams (mg) administered by mouth (po) every 1 hour as needed for low back pain and cancer. -at 6:14 p.m. Follow-up pain scale was 5 out of 10. PRN administration of Hydro morphine was ineffective. Review of the nursing assistant (NA) tasks documentation dated 9/26/25, identified: no behavior charting. During an observation on 10/2/25 at 8:50 a.m., NA-A offered to change his bed; he refused until later and exited the room. During an observation/interview on 10/2/25 at 8:55 a.m. R1 laid in a dark room on bed fully dressed covered with a blanket. R1 stated he was admitted to the facility on 9/25/25, and the stay had been ok, but the staff would not listen to him, and he was feeling upset about that. R1 had told staff when he was sleeping, he did not want to be bothered. R1 stated one afternoon, right after he was admitted to the facility, a staff NA was ruff with him while she assisted him. The NA moved his legs too fast and almost ripped out his drainage tube. He explained they "did not get along or see eye to eye, and she lacked respect for his wishes." R1 stated there was also another female NA in the room when the incident occurred, adding the day it happened NA-A was told he did not want her in his room or taking	F0550		

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F0550 SS = D	Continued from page 3 care of him anymore, then today, she had been assigned to him. This was upsetting for him, and he did not want her in his room or caring for him. There was lack of respect and she refused to listen to what his needs were. He wanted to get back to sleep, not be bothered and would let staff know when he wanted his bed changed. During an interview on 10/2/25 at 9:44 a.m., director of nursing (DON) stated she had gone into R1's room along with NA-A and asked if he wanted to be washed up and dressed for the day and he requested to be left alone and allowed to sleep. She left early that day and was unaware of any concerns R1 may have had or that he did not want NA-A to care for him. During a follow-up interview on 10/3/25 at 11:15 a.m., DON stated she went back yesterday (10/2/25) and realized she had received an email from the floor manager RN-A on 9/26/25 at 3:44 p.m. which indicated MD stopped to see R1, heard him crying due to pain while cares were provided by two staff NAs. MD requested NA-A not be allowed to care for R1. DON stated if she would have been contacted that day she would have removed NA-A from the floor immediately, began an investigation, interviewed all residents she had taken care of, completed skin checks on all cognitively impaired residents, and if signs and symptoms of abuse or neglect were found, reported it within two hours to the state. She would have expected to be contacted by the floor manager RN-A right away. DON added, after she talked with R1 and learned the reason behind the pain was NA-A had moved to his legs too fast, he felt safe, not malicious attempt in any way, it was more of a care concern. DON stated she was unaware NA-A had previous history of discipline action taken with inappropriate behaviors (yelling in hallways, bulling other peers, HIPPA) that could be projected onto residents and mistreated them. Facility untitled document on 10/2/25, identified administrator and director of nursing (DON) were notified of possible "rough cares" with R1. Writer attempted to speak with R1 around 12:15 p.m. on 10/2/25, he appeared agitated, did not want to speak, was unable to breath and was in pain. R1 was assisted up into wheelchair, brought outside, and communicated he felt better. Interviews with intact cognition residents and skin checks were initiated on all residents. Administrator was notified by Minnesota Department of Health (MDH) surveyor R1 did not want NA-A, who the allegation was against, to care for him. NA-A was immediately given a new assignment and was not removed from the schedule. DON visited with R1, and he	F0550		

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F0550 SS = D	Continued from page 4 did not express any care concerns. Administrator received statements from the two NAs at time of allegation, there were no care concerns noted. During an interview on 10/2/25 at 10:08 a.m. NA-A stated on 9/26/25, around 2:30 p.m. she had entered R1's room along with NA-B and transferred him out of bed. NA-A cleaned up his bed and NA-B assisted R1 with cares and placed clean clothing on him. Together both NAs assisted him back into bed, he complained of pain, indicated the drainage tube had gotten pulled on and hurt. R1 stated out loud, you hurt me and my tube, we did not see anything happen to his tube. R1 repeated my tube hurts now. We were careful and the drainage tube may have rubbed up against something when in bed. No bleeding was noted and no complaints about how he was transferred. MD entered the room as she exited, unsure as to who he was. NA-A's shift was over and did not inform the nurse prior to leaving work that day. Things were going ok since that day; she had worked the following two days (Saturday and Sunday) alone with him, without any other staff in the room with her. She had apologized to R1 on Saturday morning and he did not seem angry, upset, or ask her to leave. The administrator just informed her they would have someone else to take care of R1 the rest of the day, she was not to go in his room and not told why. She was allowed to stay and work with other residents on the floor. During an interview on 10/2/25 at 11:00 a.m. medical doctor (MD) stated on 9/26/25 in the afternoon he had walked into the middle of a situation with R1 and a staff NA-A. R1 stated NA-A pulled on his catheter drain and almost ripped it off. The NA-A stated she was sorry that happened and would report it to the supervisor, R1 appeared teary eyed, visibly upset, obviously something happed that should have not, and needed to be investigated. NA-B interacted great with R1 and informed him she planned on reporting this to the supervisor. Prior to leaving the building he stopped at the front desk office off to the right of the front door and informed a staff that sat behind the desk NA-A was rough with R1 and she informed him she would investigate it. He was a mandated reporter and felt this was a situation that should have had follow up regarding rough handling. During an interview on 10/2/25 at 11:50 a.m. registered nurse (RN)-B stated she was loud at times while in R1's room and he had told her to get out frequently, refused cares and medications. She reapproached him and sometimes it had worked. On 9/26/25, NA-B informed her R1 had been man handled and needed something for pain. R1 was visually upset and teary eyed, stated his	F0550		

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F0550 SS = D	Continued from page 6 given now. R1 cried in pain. She walked down to the desk and talked with the nurse on duty requested pain medication to be given per MD. NA-B went down to the office located by the front of the building around 2:45 p.m. where two-unit managers were located. She informed them MD was in R1's room, upset and requested NA-A stay out of his room due to being rough with him and this incident needed to be reported. They responded ok and went back to work. MD came down the hallway and asked NA-B if she had informed the unit managers of the incident and she stated yes, and he thanked her. NA-B stated NA-A was rough with R1 but did not seem to be maliciously done. She had worked with NA-A for 15 years and not seen her treat any other resident that way, felt she was in a hurry and wanted to go home for the day. When R1's legs were grabbed and thrown onto the bed the drainage tube must have been located underneath, was hooked on something, and pulled. During an interview on 10/2/25 at 3:36 p.m., floor manager RN-A stated she had worked on 9/26/25 and heard R1 refused cares throughout the day and at shift change NA-A and NA-B completed R1's cares together. MD came to the office and informed her and another floor manager he did not want NA-A working with R1 anymore without explanation and walked out of the office. NA-B stopped in the office informed her MD did not want NA-A working with R1. RN-A stated she emailed the director of nursing (DON) later that afternoon with the information she had but now sees it would have been beneficial to have asked NA-B more questions. She was made aware he was in pain and resistive to care earlier in the day. Facility policy Combined Federal and State Bill of Rights dated 6/18/19, identified the resident has a right to a dignified existence, self-determination, and communication, and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Facility policy Safe Resident Handling dated 3/2020, identified safe patient handling is a key component to reducing hazards of injury to our employees and our residents so that when residents receiving care require assistance from facility employees to move, assistance is provided in a manner that is safe to both the resident and employee. The facility is committed to provide high quality resident care.	F0550		

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F0550 SS = D	Continued from page 7 Facility document undated Professional Boundaries identified the employee-resident relationship was designed to meet the needs of the resident and protects the resident's dignity, autonomy, and privacy and allows for the development of trust. Professional boundaries are the spaces between the employee's power and the resident's vulnerability. Employees should make every effort to respect the power imbalance and ensure resident-centered relationships.	F0550		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to thoroughly investigate an allegation of staff to resident abuse and protect residents during the investigation for 1 of 3 residents (R1) who reported a staff handled their care roughly, causing them pain. Findings include: R1's entry Minimum Data Set (MDS) dated 9/30/25, identified he was admitted to the facility on 9/25/25, from an acute care hospital. R1's care plan (CP) dated 9/26/25, identified he was vulnerable to abuse and instructed staff to monitor for signs of emotional distress, mood or behavior changes and continue to follow the facility's Vulnerable Abuse	F0610	F0610 Investigate/Prevent/Corrected Alleged Violation Immediate Corrective Action: Grievances filed per Complaint and Grievance Policy. Corrective Action as it applies to others: Complaint and Grievance Policy reviewed. All cognitive residents were interviewed to report any complaints involving allegations of abuse, neglect, exploitation, or mistreatment. All non-cognitive residents had a skin check completed. All residents' complaints will be filed, investigated and followed up on per policy. All staff will be educated on complaints involving allegations of abuse, neglect, exploitation, or mistreatment. All clinical leaders will be educated on the need to complete skin checks on non-interviewable residents with any complaints involving abuse, neglect, exploitation or mistreatment. Date of Compliance: 12/10/2025 Recurrence will be prevented by: 5 residents will be interviewed to report any complaints and grievances involving allegations of abuse, neglect, exploitation or mistreatment weekly x4 weeks, then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease or discontinue audits.	12/10/2025

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F0610 SS = D	Continued from page 8 Reporting policy and directed R1 was independent with activity choices and staff were to respect his choices of preferred room leisure time. CP also indicated R1 had an alteration in mobility related to colon cancer, edema (fluid retention), pain, and malnutrition with a goal he would move safely within his environment; staff were directed to assist with movement in bed and in/out of bed assist of one with front wheeled walker/wheelchair. R1 also had an alteration in mood, behaviors, and psychosocial well-being related to adjustment to facility and current health condition and staff were directed to reapproach R1 when he refused (cares, medications, linen changes to bed) with a soft tone and give him time and options, monitor and document mood state/behaviors upon occurrence, and provide emotional support, validation and comfort measures as needed (PRN). During an observation on 10/2/25 at 8:50 a.m., NA-A offered to change his bed; he refused until later and exited the room. During an observation/interview on 10/2/25 at 8:55 a.m., R1 laid in a dark room on bed fully dressed covered with a blanket. R1 stated he was admitted to the facility on 9/25/25, and the stay had been ok, but the staff would not listen to him, and he was feeling upset about that. R1 had told staff when he was sleeping, he did not want to be bothered. R1 stated one afternoon, right after he was admitted to the facility, a staff NA was ruff with him while she assisted him. The NA moved his legs too fast and almost ripped out his drainage tube. He explained they "did not get along or see eye to eye, and she lacked respect for his wishes." R1 stated there was also another female NA in the room when the incident occurred, adding the day it happened NA-A was told he did not want her in his room or taking care of him anymore, then today, she had been assigned to him. This was upsetting for him, and he did not want her in his room or caring for him. There was lack of respect and she refused to listen to what his needs were. He wanted to get back to sleep, not be bothered and would let staff know when he wanted his bed changed. During an interview on 10/2/25 at 9:44 a.m., director of nursing (DON) stated she had gone into R1's room along with NA-A and asked if he wanted to be washed up and dressed for the day and he requested to be left alone and allowed to sleep. She left early that day and was unaware of any concerns R1 may have had or that he did not want NA-A to care for him. During a follow-up interview on 10/3/25 at 11:15 a.m.,	F0610	Continued from page 8 Corrections will be monitored by: Administrator or designee	

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F0610 SS = D	Continued from page 9 DON stated she went back yesterday (10/2/25) and realized she had received an email from the floor manager RN-A on 9/26/25 at 3:44 p.m. which indicated MD stopped to see R1, heard him crying due to pain while cares were provided by two staff NAs. MD requested NA-A not be allowed to care for R1. DON stated if she would have been contacted that day she would have removed NA-A from the floor immediately, began an investigation, interviewed all residents she had taken care of, completed skin checks on all cognitively impaired residents, and if signs and symptoms of abuse or neglect were found, reported it within two hours to the state. She would have expected to be contacted by the floor manager RN-A right away. DON added, after she talked with R1 and learned the reason behind the pain was NA-A had moved to his legs too fast, he felt safe, not malicious attempt in any way, it was more of a care concern. DON stated she was unaware NA-A had previous history of discipline action taken with inappropriate behaviors (yelling in hallways, bulling other peers, HIPPA) that could be projected onto residents and mistreated them. During an interview on 10/2/25 at 10:08 a.m., NA-A stated on 9/26/25, around 2:30 p.m. she had entered R1's room along with NA-B and transferred him out of bed. NA-A cleaned up his bed and NA-B assisted R1 with cares and placed clean clothing on him. Together both NAs assisted him back into bed, he complained of pain, indicated the drainage tube had gotten pulled on and hurt. R1 stated out loud, you hurt me and my tube, we did not see anything happen to his tube. R1 repeated my tube hurts now. We were careful and the drainage tube may have rubbed up against something when in bed. No bleeding was noted and no complaints about how he was transferred. MD entered the room as she exited, unsure as to who he was. NA-A's shift was over and did not inform the nurse prior to leaving work that day. Things were going ok since that day; she had worked the following two days (Saturday and Sunday) alone with him, without any other staff in the room with her. She had apologized to R1 on Saturday morning and he did not seem angry, upset, or ask her to leave. The administrator just informed her they would have someone else to take care of R1 the rest of the day, she was not to go in his room and not told why. She was allowed to stay and work with other residents on the floor. During an interview on 10/2/25 at 11:00 a.m., medical doctor (MD) stated on 9/26/25 in the afternoon he had walked into the middle of a situation with R1 and a staff NA-A. R1 stated NA-A pulled on his catheter drain and almost ripped it off. The NA-A stated she was sorry that happened and would report it to the supervisor, R1	F0610		

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F0610 SS = D	Continued from page 10 appeared teary eyed, visibly upset, obviously something happed that should have not, and needed to be investigated. NA-B interacted great with R1 and informed him she planned on reporting this to the supervisor. Prior to leaving the building he stopped at the front desk office off to the right of the front door and informed a staff that sat behind the desk NA-A was rough with R1 and she informed him she would investigate it. He was a mandated reporter and felt this was a situation that should have had follow up regarding rough handling. During an interview on 10/2/25 at 11:50 a.m., registered nurse (RN)-B stated NA-B informed her R1 had been "man handled" and needed something for pain. R1 was visually upset and teary eyed, stated his drainage tube had been pulled, tube was assessed and intact. While she was in R1's room he stated he did not ever want that lady in there again and pointed to NA-A, was rough handled and his tube hurt. Whoever came across the situation would have been expected to report it to the DON. MD requested it be reported to upper management and should have adding, if he had gotten hurt or not, it cannot just be dismissed as an incident, whether valid or not and had to be investigated. She would have been expected to report the incident to the DON and administrator right away; she was busy, slipped her mind, and dropped the ball. She had brought this incident up during the employee meeting on 9/29/25, DON and administrator were there. The incident occurred at the end of the day shift, NA-A went home, returned the following day and cared for R1 and other residents. RN-B stated she did not ask R1 if he felt safe or was ok with NA-A caring for him but was aware he had requested no further care by her. During an interview on 10/2/25 at 1:00 p.m., administrator stated RN-B had just informed surveyor she had not reported the incident with R1 (9/26/25) until Monday 9/29/25, did not feel it would have been important due to NA-A would have not rough handled R1. She expected RN-B to have reported this incident immediately. All staff education on safe handling and reporting, resident and staff interviews, skin checks on cognitively impaired residents will be completed today. NA-A was interviewed today, moved to a different wing and allowed to care for other residents as an NA. DON had interviewed R1. During an interview on 10/3/25 at 11:52 a.m., administrator stated they were not aware of the incident with R1 and NA-A until 10/2/25. Administrated indicated both NA-A and NA-B (witness) provided	F0610		

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F0610 SS = D	Continued from page 11 statements, they reviewed NA-A's personnel file and education was provided. We did not suspect abuse. NA-A lifted R1's legs too fast, possibly bumping his drainage tube and increased his pain. Education on professional boundaries and safe handling had been completed with NA-A on 10/2/25. During an interview on 10/2/25 at 2:40 p.m., NA-B stated she cared for R1 frequently and he required total assist of two person with cares. He had cancer and was terminally ill. He did not use his call light, they checked on him at least every two hours, and it was important to be quiet and calm when she entered his room. NA-B stated she arrived at work at 2:30 p.m. on 9/26/25, and received report from NA-A. R1 had not been touched all day and refused cares. NA-A requested assistance to try again. We entered R1's together and room smelled of bowel movement (BM) and urine (noted to be on the bed linens). She sent NA-A out of the room to gather linens. NA-B assisted R1 to stand up while she cleansed his front, back, bottom and placed clean clothing on him. NA-B re-entered the room and changed the linens on his bed. NA-A stood on R1's right side and NA-B stood on his left side, he grabbed under their arms, stood up, pivoted, and sat down on edge of bed. She took ahold of his shoulders and NA-A grabbed his feet. She counted three, two and before she could say one NA-A quickly swung his feet/legs up onto the bed, and was not gentle, adding she "gave it all it was worth, not sure what [NA-A] was thinking." (he was a thin person, and legs were light). R1 started to scream and cry and stated his drainage tube got pull and was in pain. She informed NA-A she would finish. NA-A started to pick up dirty lines and was told to leave the room. NA-B reassured R1 and looked at the tube, no bleeding noted. MD was outside R1's door waiting to see him, walked into the room. She informed MD NA-A was a little rough with R1 while she placed his feet/legs onto the bed. MD informed her he did not want NA-A back in the room, the incident reported, and pain medication given now. R1 cried in pain. She walked down to the desk and talked with the nurse on duty requested pain medication to be given per MD. NA-B went down to the office located by the front of the building around 2:45 p.m. where two-unit managers were located. She informed them MD was in R1's room, upset and requested NA-A stay out of his room due to being rough with him and this incident needed to be reported. They responded ok and went back to work. MD came down the hallway and asked NA-B if she had informed the unit managers of the incident and she stated yes, and he thanked her. NA-B stated NA-A was rough with R1 but did not seem to be maliciously done. She had worked with NA-A for 15 years and not seen her treat any other resident that way,	F0610		

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F0610 SS = D	Continued from page 12 felt she was in a hurry and wanted to go home for the day. When R1's legs were grabbed and thrown onto the bed the drainage tube must have been located underneath, was hooked on something, and pulled. During an interview on 10/2/25 at 3:36 p.m., floor manager RN-A stated she had worked on 9/26/25 and heard R1 refused cares throughout the day and at shift change NA-A and NA-B completed R1's cares together. MD came to the office and informed her and another floor manager he did not want NA-A working with R1 anymore without explanation and walked out of the office. NA-B stopped in the office informed her MD did not want NA-A working with R1. RN-A stated she emailed the director of nursing (DON) later that afternoon with the information she had but now sees it would have been beneficial to have asked NA-B more questions. She was made aware he was in pain and resistive to care earlier in the day. She was made aware he was in pain, should have laid eyes on R1, completed a skin assessment and interview with him prior to leaving that day to make sure he was safe. She knew R1 was resistive to care earlier in the day and did not think it was anything that needed to be reported. Facility policy Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, identified investigation will begin immediately in accordance with Federal Law. Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress. The investigation may include interviewing staff, residents, or other witnesses to the incident. Corrective action based on the investigation will be completed (e.g. change of procedure, training, discipline or discharge staff). The facility will provide proper follow up communication related to the incident across all shifts and to practitioners and resident representatives as applicable.	F0610		