Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 24, 2026

Administrator
Bethany On The Lake LLC
1020 LARK STREET
ALEXANDRIA, MN 56308

RE: CCN: 245434

Cycle Start Date: March 26, 2026

Dear Administrator:

On April 8, 2026, we notified you a remedy was imposed. On April 20, 2026, the Minnesota Departments of Health 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 April 15, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 23, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 8, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 26, 2026. 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,

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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April 8, 2026

Administrator
Bethany On The Lake LLC
1020 LARK STREET
ALEXANDRIA, MN 56308

RE: CCN: 245434

Cycle Start Date: March 26, 2026

Dear Administrator:

On March 26, 2026, 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 widespread deficiencies that constituted actual harm that was not immediate jeopardy (Level I), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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),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)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- 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 June 26, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 26, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 26, 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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany on the Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 26, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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.

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 September 26, 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.

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.

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

Email: sarah.lane@state.mn.us

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April 8, 2026

Administrator
Bethany On The Lake LLC
1020 LARK STREET
ALEXANDRIA, MN 56308

Re: Event ID: 22BCFB-H1

Dear Administrator:

The above facility survey was completed on March 26, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany On The Lake LLC	**1020 LARK STREET , ALEXANDRIA, Minnesota, 56308**

(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 On 3/24/26, through 3/26/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H54348641C (2803722) with a deficiency issued at F600 PAST NON-COMPLIANCE. Additionally, deficient practice was identified related to incidental findings at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in e POC, 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		03/13/2026
F0600 SS = SQC-I	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F0600	"Past Noncompliance - no plan of correction required"	03/13/2026

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: 245434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0600 SS = SQC-I	Continued from page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to protect 1 of 3 residents (R1) reviewed for abuse, from mental abuse when nursing assistant (NA)-A ridiculed, yelled with intent to intimidate, and threatened R1 with physical abuse, to be sent to a locked unit, and for staff to be unwilling to provide cares to R1 in the future. R1’s actual response and the use of the reasonable person concept identified serious psychosocial harm to R1 when she exhibited crying and combative behavior above baseline, fear/anxiety manifested as combativeness, resistance to care and social interaction, and self-isolation. The IJ began on 3/11/26 at 8:30 p.m., when NA-A was witnessed to make derogatory aggressive toned statements in the presence of R1 and two other staff. NA-A was not removed from shift and continued to work with R1 and other vulnerable residents despite an internal report being made. The administrator and director of nursing (DON) were notified of the IJ on 3/26/26 at 2:45 p.m. The facility implemented corrective action by 3/13/26 prior to the start of the survey and therefore is issued as past non-compliance. Findings Include: R1’s admission Minimum Data Set (MDS) dated 3/11/26, identified admission to facility on 2/26/26, from home/community. R1 had severely impaired cognition, feeling down, depressed, or hopeless (two-to-six days out of seven), and no behaviors noted. R1 required partial/moderate assistance with oral/personal hygiene, shower/bathe, substantial/maximal assistance with upper body dressing, roll left and right in bed, sitting to lying position, lying to sitting on side of bed, was dependent with toileting hygiene, lower body dressing, sit to stand, all transfers, was unable to walk, and used a manual wheelchair for mobility. R1 was frequently incontinent of bowel and bladder. R1’s diagnoses included non-traumatic brain dysfunction, arthritis, muscle weakness, Alzheimer’s disease, dementia, anxiety, depression, and psychotic disorder. R1's medications include antipsychotic, antianxiety, and antidepressant. R1’s Saint Louis University Mental Status (SLUMS) (an assessment designed to evaluate various cognitive functions, including memory, attention, and	F0600		

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F0600 SS = SQC-I	Continued from page 2 problem-solving skills) dated 3/3/26, identified a score of 4 out of 31 [sic] – dementia (25-30 normal cognition, 20-24 mild neurocognitive disorder, and 1-19 points dementia). R1's care plan dated 3/16/26, identified the following areas of concerns and interventions to address each area:Alteration in behavior as evidenced by (AEB) wandering, yelling in room for help, yelling in hallway, combative with staff, throwing belongings, calling staff names related to psychotic disorder, anxiety, Alzheimer's disease, dementia and chronic pain. Interventions included to call family or granddaughter to assist with compliance of medications and calming R1 down, be alert to mood and behavior changes, approach in a calm voice making eye contact and using therapeutic touch. Behaviors were to be documented. Additional interventions included to validate feelings/provide emotional support, administer medications as ordered, re-direct by offering food/fluids/toileting/repositioning, Alteration in cognition and psychosocial wellbeing. Interventions included to allow her time to communicate her needs/wants, provide and maintain consistent environment, provide cues, reorientation/supervision as needed, monitor and respond to unmet needs, and monitor mood state.Alteration in mood and behavior related to psychotic disorder with delusions. Interventions included to monitor and document mood state/behaviors upon occurrence.R1 was a vulnerable adult while she resided in facility. Interventions included to monitor for signs of emotional distress or mood and behavior changes, continue to follow the facility vulnerable adult and abuse reporting policy. In addition, the local Ombudsman, Adult Protection, Police and/or state/financial agencies were to be notified of any suspected abuse or financial exploitation as needed.Facility investigation 5-day report dated 3/16/26 at 3:10 p.m., indicated on 3/11/26 at 8:30 p.m., NA-A and NA-B assisted R1 with evening cares. R1 was crying, and had ended a phone call with her son when NA-A stated, you need to stop crying, you are acting like a two-year-old. NA-B reported NA-A seemed frustrated and sounded stern. NA-A placed R1's arms on the EZ stand (mechanical device used to lift and lower a resident), R1 swatted out at NA-A. NA-A stated if you hit me again, I am going to hit you back. This statement confirmed by NA-A, who stated she made the comment not thinking but would never hit a resident. Staff assistance was requested over the walkies. NA-C entered R1's room and heard NA-A yell at R1 in a loud toned voice, stop crying, they are going to put you in a locked unit. NA-C felt NA-A was not joking. NA-A left R1's room briefly to assist another resident and	F0600		

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F0600 SS = SQC-I	Continued from page 3 returned approximately five minutes later. R1 continued to cry and was distraught. NA-A stated to R1, nobody will want to keep working with you, nobody wants to work with a crybaby. R1's physician orders included: -Monitor for signs and symptoms of emotional distress and place a note in chart three times a day until 3/26/26 at 11:59 p.m. Order date: 3/12/26. Start date: 3/12/26. -Monitor for bruising on upper body every shift. Order date: 3/12/26. Start date: 3/12/26. -Target behavior monitoring: 1. Restlessness, 2. Increase in complaints, 3. Refusing care, 4. Self-isolation, 5. Crying, 6. Not sleeping at night, 7. Wandering into other resident rooms. Non-pharmacological, Document number of those interventions used: 0: N/A, 1. redirection, 2. Ambulate, 3. offer activity, 4. Ambulate, 5. Reposition, 6. Toileting, 7. Provide 1:1, 8. Offer food/fluids, 9. Offer pain relief two times a day. If target behavior observed. Select chart other and enter findings including effectiveness of interventions in the nursing progress notes. Order date: 3/12/26. Start date: 3/12/26. -Sending to ER for evaluation of symptoms of combativeness and emotional distress. Order date: 3/14/26. -Risperidone (used to treat agitation, aggression, and psychosis during dementia) oral tablet 0.25 milligrams (mg) give 0.25 mg by mouth (po) at bedtime for dementia with aggressive behavior. Start date: 3/14/26. Discontinue date: 3/16/26. - Risperidone oral tablet 0.25 mg give po at bedtime related to psychotic disorder with delusions due to known physiological condition. Start date: 3/16/26. Hold date: 3/18/26, through 3/24/26. Discontinue date: 3/24/26. -Alprazolam (anti-anxiety) oral tablet 0.25 milligram (mg) po as needed (PRN) for anxiety related to anxiety disorder for 14 days, three times a day (t.i.d.), morning, noon and evening. Order date: 2/26/26. Start date 2/26/26, and renewed order on 3/14/26. Start date: 3/14/26. End date: 3/28/26. - Quetiapine (Seroquel) Fumarate (antipsychotic) oral tablet give 50 mg po three times a day (8:00 a.m., 2:00	F0600		

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F0600 SS = SQC-I	Continued from page 4 p.m., 8:00 p.m.) related to dementia with other behavioral disturbance disorder with delusions due to psychological condition. Start date: 2/26/26. R1’s electronic medication administration record (EMAR) dated March 2026, from 3/11/26 through 3/21/26, identified: -Risperidone oral tablet 0.25 milligrams (mg) give 0.25 mg po. Administered on 3/14/26, 3/15/26, 3/16/26, and 3/17/26. -Quetiapine Fumarate give 50 mg po three times a day. Administered as ordered 3/11/26 through 3/16/26, except on 3/14/26, 8:00 a.m. dose refused. -Alprazolam (anti-anxiety) oral tablet 0.25 mg. Give 0.25 mg po as needed for anxiety three times a day (morning, noon, and evening). Administered one time a day on 3/3/26, 3/4/26, 3/6/26, 3/7/26, 3/8/26, two times a day 3/9/26, 3/10/26, 3/11/26, one time a day on 3/15/26, 3/18/26, 3/19/26, 3/20/26, and two times a day on 3/21/26. R1’s nursing target behavior monitoring two times a day (2:00 p.m. and 9:00 p.m.). If target behavior was observed from 3/4/26 through 3/17/26, identified: 1. Restlessness, 2. Increase in complaints, 3 Refusing care. 4. Self-isolation. Document number of those interventions using the code provided. Start date 2/26/26.At 2:00 p.m. on 3/4/26, 3/5/26, 3/9/26, and 3/10/26, no documentation. At 2:00 p.m. on 3/6/26, 3/7/26, 3/8/26, 3/11/26, 3/15/26, 3/16/26, and 3/17/26, no behaviors noted.At 9:00 p.m. on 3/4/36, 3/5/26, 3/6/26, 3/7/26, 3/9/26, 3/11/26, 3/15/26, 3/16/26, and 3/17/26, no behaviors noted.At 9:00 p.m. on 3/8/26, refused care. Intervention: provide 1:1.At 9:00 p.m. on 3/10/26, restlessness. Intervention: redirection, offer activity, reposition, and provided 1:1.At 9:00 p.m. on 3/12/26, restlessness and refusing care. Intervention: redirection, offer activity, reposition, and toileting.At 2:00 p.m. on 3/13/26, restlessness, increase in complaints, refusing care, and wandering into other resident rooms. Interventions: redirection, offer activity, provide 1:1, and offer food/fluids. At 9:00 p.m. self-isolation. Intervention: redirection.At 2:00 p.m. on 3/14/26, no documentation. At 9:00 p.m. X entered each box.R1’s NA behavior charting every shift (night, day, evening) from 3/4/26, through 3/16/26, identified: Responses:3/4/36 - Not applicable: all three shifts3/5/36 – Not applicable: all three shifts3/6/26 –	F0600		

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F0600 SS = SQC-I	Continued from page 5 Not applicable: nights/days. Crying/expressions of sadness: evening.3/7/26- Not applicable: all three shifts3/8/26 – Not applicable: nights. Crying/expressions of sadness day and evening.3/9/26- Not applicable/none noted: nights and days. Crying/expressions of sadness: evening.3/10/26 – Not applicable: nights and days. Crying/expressions of sadness: evening.3/11/26- Not applicable: nights and days. Calling out/yelling: evening.3/12/26 -Not applicable/none noted: all three shifts3/13/26- Calling out/yelling, hitting or kicking, pinching scratching: nights. Resisting or refusing care: days. Not applicable: evening.3/14/26- Not applicable/none noted: nights and days. Resident not available: evening.3/15/26 – Not applicable/none noted: nights and days. Resisting or refusing care: evening.3/16/26 – Not applicable/none noted: all three shifts.R1's NA meal intake/amount eaten and fluid intake documentation from 3/4/26, through 3/17/26, identified: 3/4/26, 51 to 100% of all three meals. Fluids consumed 1200 milliliters (ml). 3/5/26, 51 to 100% of all three meals. Fluids consumed 780 ml. 3/6/26, 51 to 75% of all three meals. Fluids consumed 840 ml. 3/7/26, 51 to 100% of all three meals. Fluids consumed 1060 ml. 3/8/26, 76 to 100% of all three meals. Fluids consumed 720 ml. 3/9/26, refused breakfast and 51 to 75% of lunch and supper. Fluids consumed 490 ml. 3/10/26, 26 to 50% of breakfast, 75 to 100% of lunch and supper. Fluids consumed 840 ml. 3/11/26, 26 to 50 % of breakfast, 75 to 100% of lunch and supper. Fluids consumed 840 ml. 3/12/26, 0 to 25% of breakfast, 26 to 50% of lunch, and refused supper. Fluids consumed 360 ml. 3/13/26, refused breakfast and lunch, 76 to 100% of supper. Fluids consumed 450 ml. 3/14/26, refused breakfast and not available for lunch and supper. Fluids consumed 0. 3/15/26, 76 to 100% breakfast and supper, refused	F0600		

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F0600 SS = SQC-I	Continued from page 6 lunch. Fluids consumed 490 ml. 3/16/26, breakfast not available, 51 to 75% of lunch and supper. Fluids consumed 690 ml. 3/17/26, 76 to 100% of all meals. Fluids consumed 1210 ml. R1's psychiatric care notes identified:On 2/26/26 at 12:07 p.m., the virtual visit with this writer was cancelled due to her moving from assisted living to a different assisted living facility. R1 will receive ongoing psychiatric medication management by rounding providers at her new home.On 3/16/26 at 3:00 p.m., writer spoke to nursing home facility nurses (2) and was updated R1 had been in ER over the weekend for increased behaviors, anxiety, and agitation. The nursing team was looking for guidance on how to best address R1's psychiatric care going forward. This writer was under the impression she had been moved to a locked memory care unit from AL though her current living situation was not that. Additionally, there had been some hesitancy from the rounding provider at her current place of resident in managing psychiatric conditions and heightened behaviors. Would be best for R1's wellbeing and care to be in an inpatient psychiatric unit, transition to a locked memory care unit and most likely be the best option so aggressive medication adjustments can be made under constant surveillance and supervision and was discussed with her son. R1's progress notes from 3/9/26, through 3/14/26, identified:On 3/9/26 at 8:24 p.m., R1 behaviors this shift very emotional and whiny. Crying at supper and stating she wants to get out of here. Took half of her supper and dumped it on the floor. Sat at nurse's station whining and crying. Called son. Put to bed around 8:00 p.m. and was calm.On 3/10/26 at 5:07 a.m., Tried to slide out of recliner at 4:15 a.m., wanted to get up and look outside. Toileted and transferred back into recliner. Hollered out and tried sliding out again. Unplugged her oxygen (02) concentrator and refused to leave O2 on. Redirected and TV turned on to distract her.On 3/10/26 at 10:55 a.m., Received a call from Mental Health Provider and able to see resident by tele-health but not in person. Will discuss rounding provider.On 3/10/26 at 2:05 p.m., Wandering around the unit redirected back to room. Attempted to get on elevator. Crying episode and anxious behaviors noted. Hollering for ride to go home for over four hours repeated cycle from 10:00 a.m. to 2:00 p.m. Less crying and hollering after Seroquel and alprazolam given earlier.On 3/10.26 at 8:32 p.m., Very emotional this	F0600		

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F0600 SS = SQC-I	Continued from page 7 shift. Constantly crying, wanted to go to another facility. Redirected many times and activities offered. Wandered halls did not attempt to exit building.On 3/11/26 at 6:49 a.m., Resident did not calm down after PRN. Continued to cry out and screaming she wanted to leave. Tried to soothe her, offer activities to distract her, 1:1 bathroom multiple times, reason with her, and reposition.On 3/12/26 at 3:18 p.m., Resident cried most of the morning. Very restless and difficult to redirect. Writer attempted to give morning pills at 9:00 a.m., gave her cup of water to drink and she almost threw the cup at the writer. Writer unable to get morning medications in at this time. R1 name-calling staff, hitting staff when trying to redirect or toilet. Staff offered county music, coffee snacks, and repositioning. Resident seen wandering into other resident rooms this shift. Writer was able to administer morning medications at 1:00 p.m., with no behavioral issues at this time.On 3/12/26 at 3:30 p.m., received notification of verbal allegations. OHFC filed per policy. Investigation pending. Resident stated she felt safe in facility.On 3/12/26 at 6:48 p.m., R1 wandering halls this shift going into other resident rooms. Unable to redirect. Yelling at staff “you’re giving into the shit”. Refused blood sugar check and medications, will reapproach later. Crying in the halls stating she wants to go home. Offered activity, toileting both ineffective. Hollering out in the halls she needs help. When writer approached resident, she was unable to express what she needed help with. Wants to go home. Wander guard (device placed on a resident to alert staff when resident is too close to an exit or other unsafe area) and video monitoring in place. On 3/12/26 at 9:26 p.m., R1 continued to have behaviors after supper. Hitting out at staff, refused medications, went into resident rooms and was unable to be redirected. Resident yelling out and crying. DON (director of nursing) updated and stated to call family and see if they would be able to provide 1:1 with resident to help with behaviors or call on-call provider and send to ER (emergency room) if behaviors are unable to be managed. Called daughter who tried talking to resident on phone but was not calm enough and unable to talk. Daughter agreed to call on-call and send in if appropriate. Granddaughter called the desk stating she can usually calm resident down and resident did talk to her on the phone. Resident calmed down and took oral medications plus PRN Tylenol. R1 laughed and joked with staff, ate some ice cream, and placed in recliner. On 3/12/26 at 10:36 p.m., R1 also yelling swear words loudly.On 3/13/26 at 12:38 a.m., R1 in her room screaming get out of here and leave me alone at this time loud enough to hear her at the nurse’s station. Staff had attempted to reposition, toilet, and	F0600		

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F0600 SS = SQC-I	Continued from page 8 offered snacks. R1 screamed at staff, swings, pinches at staff with redirection. Staff will monitor.On 3/13/26 at 5:54 a.m., R1 had been waking periodically throughout the night and yelling then fell back to sleep. Writer approached resident to attempt to get her up for the day. Resident yelled “no” and began getting agitated. Did not get up on the night shift.On 3/13/26 at 12:33 p.m., Resident yelled out at staff this a.m. so slept until 11:30 a.m. Staff got resident up and dressed. No injuries, bruising noted, or complaints of pain. R1 loudly refused to have blood sugar checked, insulin, and medications given. Yelled at writer and stated, “your only out for the money!” R1 made her way down the hallway and refused food when offered. Went into another resident’s room and loudly protested when wheeled out of room. Door shut per request by another resident. Resident protested stated “stop slamming doors”.On 3/13/26 at 2:26 p.m., R1 refused all food and drink today. Had been wandering halls in wheelchair and made multiple attempts to go into other residents’ rooms. Administered Seroquel with a sip of water. Made frequent statements that people want to take her money.On 3/13/26 at 3:12 p.m., primary provider here and ordered resident monitored for emotional distress. Noted OHFC was filed for allegations of verbal abuse. Recommended consult with psych.On 3/14/26 at 10:34 a.m., Usual Mental Status/Cognition Function before the Acute Change in Condition: Alert, disoriented, but cannot follow simple instructions. Behavioral concerns: combativeness, emotional distress, and inconsolable physical and verbal behaviors. Sent to ER for evaluation for the behavioral concerns.On 3/14/26 at 1:35 p.m., R1 slept in this afternoon. She repeated statements “what am I doing here” and “tell me what is going on”. Reassurance given. Assisted to wheelchair, started crying and hollering out “someone please tell me”. Attempted to comfort with non-pharmalogical interventions. R1 swung arms at writer when attempted medication administration, food and fluids. Called son, attempted to talk to her. R1 threw phone when son tried to talk resident into taking scheduled medications. R1 cried and screamed on the phone, “I said no I don’t want to!” Son attempted for five minutes to talk and R1 continued to throw phone. Son gave okay for R1 to be sent to hospital. R1 would not allow staff to have the phone, swung arms, kicked out at staff whenever they attempted to come near her. Contacted provider and called 911 for transport, sent two officers and ambulance crew. R1 continued to be aggressive towards officers and ambulance crew, swore and swung at them while they attempted to transfer her onto the stretcher. Ambulance crew administered an IM medication with assistance from the officers. No further outbursts were noted.On 3/14/26 at 2:42 p.m., R1 returned via EMS	F0600		

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F0600 SS = SQC-I	Continued from page 9 (emergency medical services) to facility. She was assisted into recliner by staff and EMS. R1 was sleeping upon arrival to facility. New orders for Xanax and Risperidone. Son called and updated.On 3/14/26 at 6:26 p.m., Resident slept in recliner for three hours after return from ER. At 5:00 p.m., R1 was getting out of recliner and yelled out “help me”. Staff walked into room and resident yelled, “get out of here I don’t want you, I need help”. Staff attempted to give Risperidone prescribed by ER and R1 hit out and yelled at staff “shit and assholes”. Staff boosted her due to sliding out of chair and she hollered out and hit at staff. R1’s behaviors increased as time went on. On call provider notified. R1 was hallucinating things in her room and told EMS she did not feel good. She was unable to express where she did not feel good. Physician Referral Form dated 3/13/26, identified issues to be addressed: R1 will be monitored 14 days for emotional distress. Office of Health Facility Complaints (OHFC) filed for allegation of verbal abuse. Recommend appointment with psychology. Provider verbal order document dated 3/14/26 at 10:31 a.m., Sending to emergency room (ER) for evaluation of symptoms of combativeness and emotional distress. Emergency Department (ED) provider notes dated 3/14/26 at 11:59 a.m., identified R1 presented to ED today via emergency medical system with concerns about behavioral agitation from her dementia. Agitation/behavior currently managed with Seroquel. Per report from staff in the last couple of days she has had poor oral intake, refused oral medications, and increased agitation. Today she was aggressive with staff so 911 was activated for transport to ED for emergency evaluation. She was given intramuscular (IM) injection 50 mg of Benadryl (relieves allergy symptoms and makes you sleepy), Versed (used for sedation) 5 mg and Haldol (antipsychotic used to treat psychotic disorders) 5 mg by EMS was quite sedated and very drowsy on arrival, and did not appear to be in any acute distress. Blood sugar was 65 (normal range 60 to 100 milligrams/deciliter (mg/dl) on arrival and dextrose 10% in water 200 milliliter (ml) was administered via intravenous (IV). Final diagnoses: dementia with aggressive behavior, hypoglycemia (low blood sugar most likely due to not eating/drinking), and elevated blood pressure. Discharged back to nursing home on 3/14/26 at 1:11 p.m. ED provider note dated 3/14/26, arrived at 6:26 p.m., and discharged at 9:19 p.m. identified presented to ED	F0600		

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F0600 SS = SQC-I	Continued from page 10 via EMS from a local dementia care unit with concerns about dementia, history of dementia with worsening aggression/behaviors. She was seen earlier today in ED given large doses of Benadryl/Versed/Haldol by EMS and quite sedated, then sent back to nursing home. During the afternoon/evening, since the medications wore off, she had became vocally aggressive and refused to take her morning medications. She does not appear to be in any acute distress. Olanzapine (Zyprexa) (antipsychotic) 5 mg in sterile water 1 ml solution was administered intramuscular (IM) on 3/14/26 at 6:56 p.m. Course: reached out to nursing home to see if there was anything specific, they needed us to do so that they would not send the comfort care dementia patient back to the ED. They had no specific recommendations. Diagnosis: dementia and discharged in stable condition back to nursing home facility with encouraged close follow up with primary care provider. A written interview completed by DON with NA-A on 3/13/26 at 2:00 p.m., identified on 3/11/26 at 8:30 p.m., NA-A walked into R1's room. R1 was on the phone with her son crying. NA-A hung up phone and assured R1 everything would be ok. NA-A stated while she undressed R1, R1 became combative, hitting, hollering, and crying. NA-A told her everything would be ok, please do not hit me, I don't want to hit you back, and called for backup. Three staff assisted R1 to transfer with up/down lift to toilet and then to chair. NA-A stated her voice maybe seemed elevated because R1 was sobbing and hollering the entire time and NA-A tried to get R1's attention. NA-A felt another NA was mad at her because she told her she needed to hurry up with her residents that she assisted to bed. NA-A stated she had been ablet to calm R1 down when crying and did not feel her conversation made her anymore upset. At 8:50 p.m., R1's cares were completed, had stopped crying, placed in her chair, and appeared to be sleeping. At 9:30 p.m., NA-A completed rounds by herself, checked on R1 and was still in her chair sleeping. Additionally, NA-A had assisted five other residents: hearing aids, provided blanket, repositioned and checked brief, assisted to bed, assisted with tootsie rolls, and another checked and changed. NA-A left the facility at 10:30 p.m., end of shift. During an interview on 3/24/26 at 2:00 p.m., trained medication assistant (TMA) stated on 3/11/26, at approximately 9:15 p.m., NA-C and NA-B told her NA-A had been mean to R1. NA-A called R1 names, hollered at R1, and was verbally abusive. Licensed practical nurse (LPN)-A was informed prior to when she left the facility at 9:00 p.m., and nothing was done. TMA stated she encouraged the NAs to call the DON and report it as	F0600		

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F0600 SS = SQC-I	Continued from page 11 soon as possible but was unsure if they did. TMA stated both NAs informed her they would report it the next morning, TMA did not report it, left it up to LPN-A to report it as soon as possible and was aware the DON had to be called within two hours so incident could be reported to SA. NA-A continued to work, TMA was unsure if she should have made NA-A leave if abuse was suspected. TMA stated the staff nurse should have taken care of that prior to leaving the shift to protect the residents. TMA monitored NA-A during the remainder of her shift, but was not aware if NA-A had interactions with other residents after the incident with R1. TMA stated NA-A's actions she was aware of included: taking out the garbage and sitting at the nurse's station. TMA-A checked on R1 twice to see if she was ok, R1 was sleepy and didn't really want to talk, no questions were asked. During an interview on 3/24/26 at 3:02 p.m. NA-B stated on 3/11/26, she entered R1's room with the stand lift while she talked on the telephone with her son, persistent she wanted to leave the facility, and cried. Once R1 hung up the phone, NA-A was not being very nice to R1 and repeated loudly, "STOP CRYING, STOP CRYING YOU ARE ACITNG LIKE A TWO-YEAR-OLD." NA-A attempted to place sling around R1, was aggressive and could have been gentler, and R1 was in distress and swatted NA-A with her hand. NA-A stated, "If you hit me, I'll hit you back," and requested assistance over the walkie. NA-A told R1 she was, "in trouble now." NA-B was unsure of what NA-A meant by that. Per NA-B, NA-A stated to R1, "they," were going to send her to the locked area so she couldn't get out and she should be, "grateful," we were helping her. R1 continued to cry and called NA-A an, "asshole." NA-C entered R1's room. A resident call light went on and NA-C instructed NA-A to go answer the call light. NA-A exited R1's room willingly, R1 continued to cry, NA-A returned five minutes later and assisted R1 to the recliner. NA-B along with NA-C informed LPN-A of the allegation of abuse to R1 by NA-A. Licensed practical nurse (LPN)-A informed us to call the floor manager/supervisor registered nurse (RN)-A but did not tell them when they were required to call her. NA-A continued to work the remainder of her shift. NA-B called RN-A the following day at approximately 1:00 p.m. During an interview on 3/25/26 at 11:32 a.m., NA-C stated R1 had behaviors that varied from one day to the next. R1 swore, screamed, cried, wandered, and yelled. NA-C stated on 3/11/26, at approximately 9:00 p.m., NA-C heard a call for assistance with R1 come over the walkie. NA-C entered R1's room. NA-A and NA-B hooked R1 up to the EZ stand and instructed R1 to hold onto the	F0600		

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F0600 SS = SQC-I	Continued from page 12 bars. NA-A stated loudly and yelled at R1, "HOLD ON!" NA-C calmly placed R1's hands on the bars and encouraged her to hold on. NA-A yelled at R1, "Stop crying! Where would you be if you were not here? Probably lying on the floor." "Stop crying! Who is going to want to take care of you when you cry like a baby?" NA-C felt NA-A was obviously upset and overwhelmed dealing with R1. Another resident call light came on and NA-A left room to answer it. Once NA-A left room, R1 was transferred to the toilet and calmed down. NA-B told NA-C about NA-A's comment to R1, "If you hit me, I'll hit you back." NA-C stated she told NA-B she needed to report it and NA-B seemed uncomfortable with that suggested. NA-A re-entered R1's room five minutes later and assisted NA-C with the EZ Stand to transfer R1 back into her recliner. NA-C stated she exited R1's room with NA-B and they immediately went to the nurse's station and informed LPN-A what they heard NA-A say to R1, the tone of her voice was loud and stern. NA-C and NA-B told LPN-A, they had never witnessed any staff treat a resident like that before. We made it very clear to LPN-A, NA-A yelled at R1 and threatened to hit her. NA-C stated she felt this was verbal abuse, threatening to hit a resident and yelled at them to stop crying. LPN-A did not appear to take the allegation seriously, was told it needed to be reported to someone, LPN-A stated she would talk to RN-A the next day and planned on coming into facility in the morning and would talk to the DON. TMA told NA-C, the DON should be called right away. NA-C trusted LPN-A would take care of it. At 9:30 p.m., NA-A continued to work on the floor. At 10:30 p.m., both NA-C and NA-A clocked out for the night and walked out of the facility together. NA-A stated to NA-C, "I will most likely be fired." Prior to this incident, NA-C stated she had witnessed N-A snap at another resident and thought she was just having a bad day. NA-C stated she told NA-A she should not snap at residents, and did not report the incident. NA-A seemed grumpy as time went on. NA-C recalled another occurrence when a resident requested help and NA-A was short with her, tone of her voice stern and loud as NA-A told resident, "We'll be right there." During interview on 3/25/26 at 12:41 p.m., LPN-A stated R1 had episodes of behaviors such as resistive to cares, refusals, occasionally cried, verbal with staff telling them to stop talking and to go away. LPN-A was unsure what made them worse, but R1 was not easily redirected. LPN-A stated it was brought to her attention on 3/11/26, between 8:00 p.m. to 8:30 p.m., by NA-B and NA-C concerns of inappropriate interactions between NA-A and R1. NA-A threatened R1, if she hit	F0600		

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F0600 SS = SQC-I	Continued from page 13 NA-A, NA-A would hit her back. LPN-A informed both NA's she would talk to nurse manager, RN-A, the next day. LPN-A felt like it was verbal abuse. LPN-A stated according to facility policy, an allegation of abuse was to be reported within two hours, and she thought it was 24 hours due to no injury. The facility policy was not followed. DON called her the next day on 3/12/26 at 2:20 p.m., and informed her NA-A should have been removed from the floor to prevent any further danger to any other residents. After LPN-A found out about the incident, she observed R1 in her room and made sure she was safe in her recliner, eyes were open. R1 acknowledged LPN-A by replying, "hi," but did not say anything else. LPN-A did not ask R1 any questions. NA-A remained working on the floor after the allegation of abuse was made until 10:30 p.m. LPN-A left the facility at 9:00 p.m. that day, her shift had ended. LPN- A stated she had previously worked with NA-A and only concern she had was NA-A seemed stressed out at times and frazzled, not enough time to do things, and issues with her home life. During an interview on 3/25/26 at 1:40 p.m., NA-D stated R1 had behaviors but not every day. R1 wandered all over the building in her wheelchair and occasionally cried. NA-D stated R1's behaviors increased when she was rushed, approached in a demanding tone of voice such as "get up now", and did not like to be hurried. NA-D stated on 3/12/26, she arrived at work for the day shift and R1 was already up for the day. R1 sat at the nurse's station. This was not typical for R1. After breakfast R1 had increased behaviors: pinching, hitting, crying. NA-D stated R1 had not displayed those types of behaviors when she worked with her prior to this day. She was informed by RN-A about the incident that happened one day ago. NA-D felt this made sense, why R1 was acting out, it was obvious something was bothering her. NA-D charted no behaviors early that morning around 9:18 a.m., noted the change in behaviors after that, and reported the concerns to LPN-B. During an interview on 3/25/26 at 2:04 p.m., LPN-B stated R1 lacked short term memory and had dementia. LPN-B stated approximately two weeks ago she noticed R1's behaviors had increased. On 3/12/26, LPN-B tried to administer R1's medications. R1 refused medications and water. LPN-B stated it appeared R1 was going to through the cup of water at LPN-B. This was an off day for R1, usually happy. R1 seemed irritated. R1 entered another resident's room with family visiting, this was unusual behavior for her. R1 called staff assholes and said they were mean directly to their face. LPN-B had heard R1 say such things under her breath but never out	F0600		

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F0600 SS = SQC-I	Continued from page 14	F0600		

Continued from page 14
loud to their face. LPN-B was unsure if the incident on 3/11/26, had anything to do with her increased behaviors but LPN-B was aware when R1 was upset, her behaviors increased. Staff were expected to contact the DON right away and report any suspicion of abuse and not try to figure it out by themselves. Allegations of abuse must be submitted to the SA within two hours. Residents with dementia lack short term memory and the ability to speak for themselves, should be free from all types of abuse and relied on staff to advocate and keep them safe.

During an interview on 3/25/26 at 3:36 p.m., family member (FM) stated RN-A had contacted her on 3/13/26 at approximately 1:00 p.m., regarding an internal report. She requested a copy of the report and was by told by RN-A, the facility unable to provide FM with a copy of the report. RN-A informed FM, the staff member identified in the report was no longer employed by the facility. R1's behaviors increased to the point she had to be sent to ER twice on 3/14/26. FM thought the events on 3/11/26, explained why R1 was anxious about interactions with people. The ER doctor had told R1's son, the nursing home staff informed him R1 was fine until staff walked in the room and then her behaviors increased. R1 was the type of person who would not make a scene about what happened, and would not tell FM, didn't want to worry her. FM stated if R1 was treated poorly by a staff member, R1 would not like it and most likely feel bad.

During an interview on 3/26/26 at 8:33 a.m., medical doctor (MD) stated she was notified of R1's incident on 3/13/26. MD stated she would have expected staff to contact her immediately on 3/11/26, or at least the next day if there were allegations regarding maltreatment or abuse. It would have been important to monitor R1 for behavioral changes and any indications to change medications especially when R1 had experienced behavioral disturbances related to dementia in the ER following the events on 3/11/26. MD stated R1 had been at the facility for a short time. When MD had seen R1, it was during the morning hours, and no behaviors were noted. MD had not seen R1 cry (staff had told MD about R1's crying), and her general pattern was pretty redirectable most of the time in the evenings when R1's behaviors tended to escalate. If R1 had a pattern change, for example, an indication of decreased appetite, MD would consider this a change in behavior. Emotional distress would not have been new for R1 and R1 had just established care with psychology. Due to R1's vulnerability, her ability to cope with abusive words would be affected. R1 was unable to advocate for herself. As far as to what degree R1 would be affected

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F0600 SS = SQC-I	Continued from page 15 by raised voices towards her, threatening and abusive words, this was subjective and MD could not speak to that. MD stated severe Alzheimer's creates a delicate brain, and R1 was most certainly identified as vulnerable. During an interview on 3/26/26 at 10:00 a.m., RN-A stated R1's memory was, "in left field," was not good and R1 was unable to remember what she had for breakfast. R1's pattern of behavior was inconsistent, depending on the time and day. Behaviors included: roaming around in wheelchair, throwing things, hitting, pinching, climbing out of recliner, cried, and disrupting other residents. Redirection did not seem to work. RN-A stated she was notified on 3/12/26, in the early afternoon by an NA via phone, on 3/11/26, NA-A told R1 while assisting her with cares, "if you do not stop crying," NA-A would give her something to cry about and, if R1 hit NA-A again she would, "hit her back." This would have made R1 feel belittled, humiliated, and unable to express herself verbally. R1 could not put it into words how she felt in general, other than to cry. The changes in R1's behaviors, over the following weekend, resulted in R1 being sent to ER two times. The increase in behaviors and the change in behaviors earlier in the day, could have been her reaction to what happened during the allegation of abuse. A general change in R1's behavior baseline, such as increased outbursts and more combative, could have indicated emotional distress. Yesterday, R1's daughter mentioned R1 had got upset when a staff member entered her room. R1's daughter was unsure of who the staff was but if a fear of a specific staff or gender was noted, this could have indicated an emotional response to the incident on 3/11/26. RN-A stated the staff who witnessed the allegation of abuse immediately informed LPN-A. LPN-A should have called the manager on call. On 3/11/26, the manager on call was the DON. RN-A thought direction would have been provided to LPN-A to remove NA-A from the facility to protect other residents. RN-A stated there was a lack of immediate action, placing other residents at risk. NA-A was allowed to remain working that evening until her shift ended at 10:30 p.m. RN-A was unsure if NA-A was allowed unsupervised contact with R1 or other residents. During an interview on 3/26/26 at 1:00 p.m., DON stated on 3/11/26, the NAs did a great job of recognizing the alleged verbal abuse and reported it to the staff nurse. The staff nurse should have called her immediately. DON was not notified until 3/12/26, approximately 1:30 p.m. We had only two hours to report, the facility policy was not followed and therefore reported late to the State agency (SA). LPN-A	F0600		

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F0600 SS = SQC-I	Continued from page 16 should have intervened immediately, removed NA-A from the situation and contacted her. DON stated she would have initiated the suspension of NA-A, to protect other residents and reported the allegation of abuse to the SA. DON stated, she was told by LPN-A, she thought only physical abuse had to be reported within two hours and was unsure if verbal abuse had to be reported within two hours or 24 hours. DON stated, NA-A remained working independently after the incident. NA-A had unsupervised contact with five residents that evening until 10:30 p.m., when NA-A's shift ended. DON stated she called NA-A on 3/12/26 at 1:45 p.m., to get her story. NA-A told DON, she spoke before she thought and said to R1, "if you hit me, I don't want to have to hit you back." DON stated she suspended NA-A on 3/12/26 at 1:45 p.m. via phone. DON stated LPN-A informed DON, as the allegation was verbal abuse, there was no need to reassess R1 or immediately report the allegation to the manager on call. LPN-A did not think there was anything wrong at the time and planned to inform floor manager, RN-A the following day. LPN-A left the facility at 9:00 p.m., when her shift ended. NA-A went back into R1's room at 9:00 p.m., R1 was sleeping and was not woken up. On 3/12/26, R1 had an increase in behaviors, refused morning medications, refused cares and food and sat in the hallway crying. DON stated it was hard to know if the incident the evening prior had affected R1. On 3/14/26, R1's behaviors escalated. R1 was resistive, refused medications and food, was aggressive towards staff and distraught. Staff informed DON, this was unusual for R1 when compared to previously seen behaviors. R1 was sent to the ER, received an injection that made her calm, but it wore off towards evening. R1's behaviors escalated again and R1 was sent back to the ER. DON stated she was unable to rule out R1's emotional distress which she may have experienced as result of the verbal abuse on 3/11/26. R1 had dementia, was not able to effectively communicate with staff so was not able to tell us if the events on 3/11/26 were causing her added distress. DON stated the incident and allegation of verbal abuse could have made R1 afraid of the alleged perpetrator and afraid of other staff who entered her room. This could have also caused R1 to refuse eating/drinking/taking medications. During an interview on 3/26/26 at 1:51 p.m., administrator stated he was on vacation on 3/11/26. The administrator would have expected staff to notify either the DON or himself immediately on 3/11/26. Staff were expected to always protect the residents. The allegation was verbal abuse, the policy was not followed, there was a short delay in reporting the incident to the SA. Administrator stated, staff had been educated if they hear, see or know of abuse to	F0600		

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F0600 SS = SQC-I	Continued from page 17 immediately protect all residents. The alleged perpetrator should have been immediately removed, and either call DON or himself if needed for direction or assistance. Administrator stated he felt the residents were always safe, a staff made a mistake of words they used, resident safety was not in jeopardy at that time. Unable to interview NA-A on 3/25/26 at 9:59 a.m. and 3/26/26 at 10:30 a.m., messages left, no return call received. Facility policy Abuse Prohibition/Vulnerable Adult dated 11/2025, identified guidelines for prevention of maltreatment of vulnerable adults in healthcare centers. Purpose: protect residents against abuse by anyone, to promptly report, document, and investigate all incidents of alleged or suspected abuse/neglect and determine probable cause of unknown injuries and identify and remedy any potentially abusive situations. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries). A supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. The nurse will take the following actions to mitigate any potential for further abuse: a. If this is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed and human resources (HR) will be notified. Notification to the facility administrator will occur immediately for any incidents of resident abuse, alleged or suspected abuse, injury of unknown origin, neglect, financial exploitation, or involuntary seclusion. If the administrator is absent or unavailable, staff will follow the chain of command for notification. Abuse is defined as the willful (as used in definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm) infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition can cause physical harm, pain or mental anguish and include verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Suspected abuse shall be reported to OHFC online reporting process not later than 2 hours after forming the suspicion of abuse.	F0600		

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F0600 SS = SQC-I	Continued from page 18 The immediate jeopardy began on 3/11/26 when R1 was mentally abused by NA-A. The immediate jeopardy was removed and the deficient practice corrected on 3/13/26, prior to survey entrance, after the facility implemented a systemic plan that included the following actions and is therefore issued at past noncompliance: Investigated the circumstances around the allegation of verbal abuse and implemented immediate resident protectionRe-educated the staff on verbal abuse, reporting, prevention The nurse manager team completed this by huddles, phone calls and 1:1 conversations and tracked by an excel document to ensure all staff were educated.The education on abuse, reporting and resident was posted to the Point Click Care (PCC) home page for staff review.Flyers were made which defined verbal abuse, gave examples, listed staff responsibility including reporting, and gave warning signs to monitor. These were posted around the building.Re-education pf staff was verified through interview and training records.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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 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. §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	F0609	F609 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure allegations of abuse are reported to the State agency no later than 2 hours. - All residents residing in the facility have the potential to be affected if this requirement is not met. - The plan of care for R1 was reviewed and revised as needed to ensure there was no harm or lasting effects. - The incident was investigated, to include, but is not limited to, other like resident interviews completed to ensure there was no harm. - The investigation concluded there was no threat to residents. - All staff have received training utilizing Monarch Healthcare Management abuse prohibition policy, with an emphasis on reporting requirements according to the guidance by the Minnesota Department of Health (MDH), and to report suspected abuse within 2 hours regardless of if it's substantiated or unsubstantiated. -All previous State Agency Reports for the previous 6 months were reviewed to ensure timely reporting. No concerns were identified or noted from any previous reports.	04/15/2026

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F0609 SS = D	Continued from page 19 action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and documents review, the facility failed to report an allegation of abuse to the State Agency (SA) within two hours for 1 of 1 resident (R1) who was witnessed being verbally abused by a staff member. Findings Include: Facility Vulnerable Adult Maltreatment Report filed with State Agency (SA) dated 3/12/26 at 5:15 p.m., identified estimated date and time of most recent occurrence: 3/11/26 at 8:30 p.m., in resident [R1's] room. Description of incident: It was reported by nursing assistant (NA) she witnessed verbal aggressive tone and language towards resident by alleged perpetrator (AP) when NA and AP were getting resident ready for bed last evening. NA stated there were no changes with the resident behavior, no signs of injury mentally or physically resulting from the incident. Resident feels safe in facility. Allegations: abuse emotional or mental. Facility investigation 5-day report dated 3/16/26 at 3:10 p.m., indicated on 3/11/26 at 8:30 p.m., NA-A and NA-B assisted R1 with evening cares at 8:30 p.m. R1 was crying, and had ended a phone call with her son when NA-A stated, you need to stop crying, you are acting like a two-year-old. NA-B reported NA-A seemed frustrated and sounded stern. NA-A placed R1's arms on the EZ stand (mechanical device used to lift and lower resident), R1 swatted out at NA-A. NA-A stated if you hit me again, I am going to hit you back. This statement confirmed by NA-A who stated she made the comment not thinking but would never hit a resident. Staff assistance was requested over the walkies. NA-C entered R1's room and heard NA-A yell at R1 in a loud toned voice stop crying, they are going to put you in a locked unit. NA-C felt NA-A was not joking. NA-A left R1's room briefly to assist another resident and returned approximately five minutes later. R1 continued to cry and was distraught. NA-A stated to R1 nobody will want to keep working with you, nobody wants to work with a crybaby. R1's admission Minimum Data Set (MDS) dated 3/11/26, identified admission to the facility on 2/26/26, from home/community. R1 had severely impaired cognition, feeling down, depressed, or hopeless (2 to 6 days out of 7), and no behaviors noted. She was dependent with	F0609	Continued from page 19 - Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. - Administrator or designee is responsible party. - Corrective action will be completed on or before 4/15/26	

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F0609 SS = D	Continued from page 20 toileting hygiene, lower body dressing, sit to stand, all transfers, unable to walk, and used a manual wheelchair for mobility. R1's diagnoses included non-traumatic brain dysfunction, arthritis, muscle weakness, Alzheimer's disease, dementia, anxiety, depression, and psychotic disorder. She takes antipsychotic, antianxiety, and antidepressant medications. R1's care plan dated 3/16/26, identified the following areas of concern and interventions to address each area:An alteration in cognition and psychosocial wellbeing. Staff were directed to allow her time to communicate her needs/wants, provide and maintain consistent environment, provide cues, reorientation/supervision as needed (PRN), monitor and respond to unmet needs, and monitor mood state and refer PRN. AAlteration in mood and behavior related to psychotic disorder with delusions. Staff were directed to monitor and document mood state/behaviors upon occurrence.R1 was a vulnerable adult while she resided in facility. Staff were directed to monitor for signs of emotional distress or mood and behavior changes, continue to follow the facility vulnerable adult and abuse reporting policy, and the local Ombudsman, Adult Protection, Police and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed.A written interview completed by DON with NA-A on 3/13/26 at 2:00 p.m., identified on 3/11/26 at 8:30 p.m., NA-A walked into R1's room. R1 was on the phone with her son crying. NA-A hung up phone and assured R1 everything would be ok. NA-A stated while she undressed R1, R1 became combative, hitting, hollering, and crying. NA-A told her everything would be ok, please do not hit me, I don't want to hit you back, and called for backup. Three staff assisted R1 to transfer with up/down lift to toilet and then to chair. NA-A stated her voice maybe seemed elevated because R1 was sobbing and hollering the entire time and NA-A tried to get R1's attention. NA-A felt another NA was mad at her because she told her she needed to hurry up with her residents that she assisted to bed. NA-A stated she had been ablet (able)to calm R1 down when crying and did not feel her conversation made her anymore upset. At 8:50 p.m., R1's cares were completed, had stopped crying, placed in her chair, and appeared to be sleeping. At 9:30 p.m., NA-A completed rounds by herself, checked on R1 and was still in her chair sleeping. Additionally, NA-A had assisted five other residents: hearing aids, provided blanket, repositioned and checked brief, assisted to bed, assisted with tootsie rolls, and another checked and changed. NA-A left the facility at 10:30 p.m., end of shift.	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany On The Lake LLC	**1020 LARK STREET , ALEXANDRIA, Minnesota, 56308**

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F0609 SS = D	Continued from page 21 During an interview on 3/24/26 at 2:00 p.m., trained medication assistant (TMA) stated on 3/11/26, at approximately 9:15 p.m., NA-C and NA-B told her NA-A had been mean to R1. NA-A called R1 names, hollered at R1, and was verbally abusive. Licensed practical nurse (LPN)-A was informed prior to when she left the facility at 9:00 p.m., and nothing was done. TMA stated she encouraged the NAs to call the DON and report it as soon as possible but was unsure if they did. TMA stated both NAs informed her they would report it the next morning, TMA did not report it, left it up to LPN-A to report it as soon as possible and was aware the DON had to be called within two hours so incident could be reported to SA. NA-A continued to work, TMA was unsure if she should have made NA-A leave if abuse was suspected. TMA stated the staff nurse should have taken care of that prior to leaving the shift to protect the residents. TMA monitored NA-A during the remainder of her shift, but was not aware if NA-A had interactions with other residents after the incident with R1. TMA stated NA-A's actions she was aware of included: taking out the garbage and sitting at the nurse's station. TMA-A checked on R1 twice to see if she was ok, R1 was sleepy and didn't really want to talk, no questions were asked. During an interview on 3/24/26 at 3:02 p.m. NA-B stated on 3/11/26, she entered R1's room with the stand lift while she talked on the telephone with her son, persistent she wanted to leave the facility, and cried. Once R1 hung up the phone, NA-A was not being very nice to R1 and repeated loudly, "STOP CRYING, STOP CRYING YOU ARE ACITNG LIKE A TWO-YEAR-OLD." NA-A attempted to place sling around R1, was aggressive and could have been gentler, and R1 was in distress and swatted NA-A with her hand. NA-A stated, "If you hit me, I'll hit you back," and requested assistance over the walkie. NA-A told R1 she was, "in trouble now." NA-B was unsure of what NA-A meant by that. Per NA-B, NA-A stated to R1, "they," were going to send her to the locked area so she couldn't get out and she should be, "grateful," we were helping her. R1 continued to cry and called NA-A an, "asshole." NA-C entered R1's room. A resident call light went on and NA-C instructed NA-A to go answer the call light. NA-A exited R1's room willingly, R1 continued to cry, NA-A returned five minutes later and assisted R1 to the recliner. NA-B along with NA-C informed LPN-A of the allegation of abuse to R1 by NA-A. Licensed practical nurse (LPN)-A informed us to call the floor manager/supervisor registered nurse (RN)-A but did not tell them when they were required to call her. NA-A continued to work the remainder of her shift. NA-B called RN-A the following day at	F0609		

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F0609 SS = D	Continued from page 22 approximately 1:00 p.m. During an interview on 3/25/26 at 11:32 a.m., NA-C stated R1 had behaviors that varied from one day to the next. R1 swore, screamed, cried, wandered, and yelled. NA-C stated on 3/11/26, at approximately 9:00 p.m., NA-C heard a call for assistance with R1 come over the walkie. NA-C entered R1's room. NA-A and NA-B hooked R1 up to the EZ stand and instructed R1 to hold onto the bars. NA-A stated loudly and yelled at R1, "HOLD ON!" NA-C calmly placed R1's hands on the bars and encouraged her to hold on. NA-A yelled at R1, "Stop crying! Where would you be if you were not here? Probably lying on the floor." "Stop crying! Who is going to want to take care of you when you cry like a baby?" NA-C felt NA-A was obviously upset and overwhelmed dealing with R1. Another resident call light came on and NA-A left room to answer it. Once NA-A left room, R1 was transferred to the toilet and calmed down. NA-B told NA-C about NA-A's comment to R1, "If you hit me, I'll hit you back." NA-C stated she told NA-B she needed to report it and NA-B seemed uncomfortable with that suggested. NA-A re-entered R1's room five minutes later and assisted NA-C with the EZ Stand to transfer R1 back into her recliner. NA-C stated she exited R1's room with NA-B and they immediately went to the nurse's station and informed LPN-A what they heard NA-A say to R1, the tone of her voice was loud and stern. NA-C and NA-B told LPN-A, they had never witnessed any staff treat a resident like that before. We made it very clear to LPN-A, NA-A yelled at R1 and threatened to hit her. NA-C stated she felt this was verbal abuse, threatening to hit a resident and yelled at them to stop crying. LPN-A did not appear to take the allegation seriously, was told it needed to be reported to someone, LPN-A stated she would talk to RN-A the next day and planned on coming into facility in the morning and would talk to the DON. TMA told NA-C, the DON should be called right away. NA-C trusted LPN-A would take care of it. At 9:30 p.m., NA-A continued to work on the floor. At 10:30 p.m., both NA-C and NA-A clocked out for the night and walked out of the facility together. NA-A stated to NA-C, "I will most likely be fired." Prior to this incident, NA-C stated she had witnessed N-A snap at another resident and thought she was just having a bad day. NA-C stated she told NA-A she should not snap at residents, and did not report the incident. NA-A seemed grumpy as time went on. NA-C recalled another occurrence when a resident requested help and NA-A was short with her, tone of her voice stern and loud as NA-A told resident, "We'll be right there." During interview on 3/25/26 at 12:41 p.m., LPN-A stated	F0609		

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F0609 SS = D	Continued from page 23 R1 had episodes of behaviors such as resistive to cares, refusals, occasionally cried, verbal with staff telling them to stop talking and to go away. LPN-A was unsure what made them worse, but R1 was not easily redirected. LPN-A stated it was brought to her attention on 3/11/26, between 8:00 p.m. to 8:30 p.m., by NA-B and NA-C concerns of inappropriate interactions between NA-A and R1. NA-A threatened R1, if she hit NA-A, NA-A would hit her back. LPN-A informed both NA's she would talk to nurse manager, RN-A, the next day. LPN-A felt like it was verbal abuse. LPN-A stated according to facility policy, an allegation of abuse was to be reported within two hours, and she thought it was 24 hours due to no injury. The facility policy was not followed. DON called her the next day on 3/12/26 at 2:20 p.m., and informed her NA-A should have been removed from the floor to prevent any further danger to any other residents. After LPN-A found out about the incident, she observed R1 in her room and made sure she was safe in her recliner, eyes were open. R1 acknowledged LPN-A by replying, "hi," but did not say anything else. LPN-A did not ask R1 any questions. NA-A remained working on the floor after the allegation of abuse was made until 10:30 p.m. LPN-A left the facility at 9:00 p.m. that day, her shift had ended. LPN- A stated she had previously worked with NA-A and only concern she had was NA-A seemed stressed out at times and frazzled, not enough time to do things, and issues with her home life. During an interview on 3/26/26 at 10:00 a.m., RN-A stated she was notified on 3/12/26, in the early afternoon by an NA via phone, on 3/11/26, NA-A told R1 while assisting her with cares, "if you do not stop crying," NA-A would give her something to cry about and, if R1 hit NA-A again she would, "hit her back." This would have made R1 feel belittled, humiliated, unable to express herself verbally, could not put it into words with what was going on, and how she felt in general other than crying. The staff that witnessed the allegation of abuse immediately informed LPN-A, the nurse on duty. LPN-A should have called the manager on call. RN-A thought direction would have been provided to LPN-A to remove NA-A from the facility to protect other residents. RN-A stated there was a lack of immediate, placing other residents at risk. NA-A was allowed to remain working that evening until her shift ended at 10:30 p.m. RN-A was unsure if NA-A was allowed unsupervised contact with R1 or other residents. During an interview on 3/26/26 at 1:00 p.m., DON stated on 3/11/26, the NAs did a great job of recognizing the alleged verbal abuse and reported it to the staff nurse. The staff nurse should have called her	F0609		

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F0609 SS = D	Continued from page 24	F0609		

immediately. DON was not notified until 3/12/26, approximately 1:30 p.m. We had only two hours to report, the facility policy was not followed and therefore reported late to the SA. LPN-A should have intervened immediately, removed NA-A from the situation and contacted her. DON stated she would have initiated the suspension of NA-A, to protect other residents and reported the allegation of abuse to the SA. DON stated, she was told by LPN-A, she thought only physical abuse had to be reported within two hours and was unsure if verbal abuse had to be reported within two hours or 24 hours. DON stated, NA-A remained working independently after the incident. NA-A had unsupervised contact with five residents that evening until 10:30 p.m., when NA-A's shift ended. DON stated she called NA-A on 3/12/26 at 1:45 p.m., to get her story. NA-A told DON, she spoke before she thought and said to R1, "if you hit me, I don’t want to have to hit you back." DON stated she suspended NA-A on 3/12/26 at 1:45 p.m. via phone. DON stated LPN-A informed DON, as the allegation was verbal abuse, there was no need to reassess R1 or immediately report the allegation to the manager on call. LPN-A did not think there was anything wrong at the time and planned to inform floor manager, RN-A the following day. LPN-A left the facility at 9:00 p.m., when her shift ended.

During an interview on 3/26/26 at 1:51 p.m., administrator stated he was on vacation on 3/11/26. The administrator would have expected staff to notify either the DON or himself immediately on 3/11/26. Staff were expected to always protect the residents. The allegation was verbal abuse, policy was not followed, there was a small delay, reported to the SA the next day. Administrator stated staff had been educated if they hear, see or know of abuse to immediately protect all residents. The alleged perpetrator should have been immediately removed, and either call DON or himself if needed for direction or assistance. Administrator stated he felt the residents were always safe, a staff made a mistake of words they used, resident safety was not in jeopardy at that time.

Facility policy Abuse Prohibition/Vulnerable Adult dated 11/2025, identified guidelines for prevention of maltreatment of vulnerable adults in healthcare centers. Purpose: protect residents against abuse by anyone, to promptly report, document, and investigate all incidents of alleged or suspected abuse/neglect and determine probable cause of unknown injuries and identify and remedy any potentially abusive situations. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin

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F0609 SS = D	Continued from page 25 tears, or other injuries). A supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. The nurse will take the following actions to mitigate any potential for further abuse: a. If this is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed and human resources (HR) will be notified. Notification to the facility administrator will occur immediately for any incidents of resident abuse, alleged or suspected abuse, injury of unknown origin, neglect, financial exploitation, or involuntary seclusion. If the administrator is absent or unavailable, staff will follow the chain of command for notification. Abuse is defined as the willful (as used in definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm) infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition can cause physical harm, pain or mental anguish and include verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Suspected abuse shall be reported to OHFC online reporting process not later than 2 hours after forming the suspicion of abuse.	F0609		

Minnesota State Department of Health

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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 3/24/26 through 3/26/26, 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. The following complaint was reviewed during the survey. H54348641C (2803722)	20000		03/13/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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		