Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

RE: CCN: 245537
Cycle Start Date: March 25, 2025

Dear Administrator:

On April 8, 2025, we notified you a remedy was imposed. On May 5, 2025 the Minnesota Department 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 23, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 23, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 8, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 23, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 23, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Your request for a continuing waiver involving the deficiency cited under F912 - Bedrooms Measure at Least 80 Sq. Ft/resident at the time of the March 25, 2025 standard abbreviated survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 7, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

Re: Reinspection Results
Event ID: 7HOO12

Dear Administrator:

On April 22, 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 March 28, 2025. At this time these correction orders were found corrected.

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

Electronically delivered
April 9, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

RE: CCN: 245537
Cycle Start Date: March 25, 2025

Dear Administrator:

On April 8, 2025, we informed you of imposed enforcement remedies.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 23, 2025

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

On March 28, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 23, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 23, 2025.

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

As we notified you in our letter of April 8, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 23,

2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 25, 2025 (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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

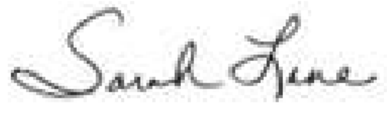
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments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

https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

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

Feel free to contact me if you have questions.

Sincerely,



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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 9, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

Re: State Nursing Home Licensing Orders
Event ID: 7HOO11

Dear Administrator:

The above facility was surveyed on March 26, 2025 through March 28, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00477	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET STARBUCK, MN 56381

(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) COMPLETE DATE
2 000	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 3/26/25 through 3/28/25, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H55372181C (MN00111739). As a result of the investigation, licensing orders 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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.	2 000		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights 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. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure dignified and respectful services for 4 of 6 residents (R2, R3, R4, R5) reviewed who reported concerns related to staff treatment. Findings include: R2's annual Minimum Data Set (MDS) dated 3/14/25, identified she had moderately impaired cognition and disorganized thinking or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject) that fluctuated and changed in severity two out of seven days of the week. She had impaired range of motion (ROM)	21805	F550 SS=E Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Immediate actions were taken to address concerns and support affected residents.	4/14/25

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21805	Continued From page 3 upper extremity on one side and bilaterally lower extremities. She required substantial/maximal assistance with upper and lower body dressing, personal hygiene and dependent upon staff for shower/bathing, toileting, roll left and right, sit to lying, lying to sitting, all transfers, and mobility. She was always incontinent of bowel and bladder. Medical diagnoses included: peripheral vascular disease (PVD) (arteries or veins become narrowed or blocked, reducing blood flow to the limbs, typically in the legs), arthritis, osteoporosis, dementia, hemiplegia/hemiparesis (a neurological condition that affects causing weakness or paralysis on one side of the body), seizure disorder/epilepsy, anxiety, and macular degeneration (an eye disease that can blur your central vision). R2's care plan dated 3/18/25, identified a self-care performance deficit and directed staff to transfer her with a Hoyer lift with assist of two staff, provide all ADLs, and turn and reposition in bed. She was at risk for impaired skin integrity and directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. During an interview on 3/27/25 at 11:24 a.m. R2 stated she had polio when she was two years old which resulted in no neck muscles and found it uncomfortable when she sat in the wheelchair. Staff hooked her up to the "harness" (lift sheet) to Hoyer lift, left the room, closed the door, and looked for assistance to transfer her. She stated it made her feel like a horse with a harness and had asked staff to wait until both staff arrived prior to when she was hooked up. Staff rushed when they used the Hoyer lift, had forgotten to move her legs/feet out of the way, pinched and bumped them when staff pushed the emergency button on	21805	One-on-one meetings were conducted with residents R2, R3, R4, and R5 to acknowledge their experiences and apologize for the treatment they received. Services were offered to support their emotional well-being, and corrective actions were completed on April 14, 2025. Staff education was provided on the same day, and audits will begin on April 18, 2025. To ensure other residents receive dignified and respectful care, efforts were made to identify any individuals who may have had similar experiences, and all residents were informed of their rights through informational conversations. Systemic changes were implemented, including a review and update of facility policies to emphasize dignity and respect. Staff training focused on positive interactions, communication, and empathy, along with mandatory reviews of revised protocols and policy. Additional education was provided on critical care practices such as turning, repositioning, lift usage, empathy, resident rights, abuse, neglect, and reporting procedures. Monthly audits of resident interactions will be conducted to maintain compliance with dignity and respect standards. Oversight and accountability measures were established, with the Director of Nursing, Assistant Administrator, administrator and Social services designee responsible for implementing and monitoring corrective actions. The Social Services Designee or delegate will facilitate one-on-one resident meetings to discuss care, and the Quality Assurance Committee will review audit results and	

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21805	Continued From page 4 the lift machine and lowered her down quickly. While staff positioned her to be transferred from bed to wheelchair today, she was instructed to place her hands on her chest and hold her head up. She reminded staff to be careful of her feet, while staff pulled the emergency lever on the Hoyer lever and lowered her down quickly into the wheelchair. She was afraid her head would be hit by the Hoyer lift bar that hung over her head. She had been knocked in the head more than once by the Hoyer bar while she was lowered too quickly. On another occasion she was lowered into the wheelchair and the loop on the lift sheet had hit her in the eye. Staff had pulled her shirt off quickly and her right arm hurt. Her daughter called DON and was told she would talk to staff. She also reported this to the director of nursing (DON) and was told she would talk to the staff. She felt safe but uncomfortable with staff and frustrated when she reported concerns, and no changes noted. She identified a nursing assistant (NA)-A that was not her favorite. NA-A handled her roughly and worked fast, always in a hurry, never hurt her but she had screamed and yelled when her right arm was not handled gently, no bruises or injuries thank goodness. She was able to assist when staff requested her to turn to her right side, grabbed the bed railing, but was not allowed the time, and turned quickly by NA-A. She had cried more than once, felt disrespected, did not feel like home to her, and wanted to move out of facility. NA-A had continued to use the emergency button on the Hoyer lift and reported how she was treated by NA-A to the DON and planned to talk with DON again today. She stated she felt staff could treat her better and with respect. R3's quarterly MDS dated 3/6/25, identified intact cognition with no behaviors. She required	21805	recommend further improvements as needed.	

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MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET STARBUCK, MN 56381

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21805	Continued From page 5 substantial/maximal assistance with upper and lower body dressing, personal hygiene, roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, dependent on staff for toileting hygiene and bathing/shower. She was unable to ambulate. She was always incontinent of bowel and bladder. Medical Diagnoses included: cancer, congestive heart failure, diabetes mellitus (DM), anxiety, obesity, and depression. R3's care plan dated 3/19/25 identified ADL self-care performance deficit and directed staff to establish a routine to provide a sense of security and confidence with resident, provide moderate assistance of one with bathing, bed mobility, incontinent brief changes, anticipate needs, and transfer with assist of two and sit to stand lift. Allow resident to accomplish tasks at her own pace, do not hurry them, and encourage independence only when resident was able to safely do so. She had potential for impaired skin integrity. Staff were directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. She was prescribed an anticoagulant and staff were directed to protect resident from injury and trauma. During an interview on 3/27/25 at 10:13 a.m. R3 stated staff transferred her with a stand lift. She was concerned about her tender feet when taken to the shower by NA-A. She was placed into the shower/tub, feet first, her feet had gotten bumped into the inside to the tub and was painful. She no longer allowed NA-A to take her to the tub anymore. NA-A was rough with how she handled her, reported to management, was told no one else complained about her, and nothing was done. She allowed NA-A to transfer her with the stand life in her room only but watched where her	21805		

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	00477	A. BUILDING: _____ B. WING _____	C 03/28/2025

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21805	Continued From page 6 feet were placed so that they did not get jammed somewhere. She stated she felt safe because she was able to speak up for herself but worried about those residents that were unable to say anything. NA-A had informed her not to tell her how to do her job when she encouraged her to slow down, watch her feet, and adjust incontinent brief when not placed properly. Her stools were horrible, runny, and when NA-A rushed while she placed the brief on improperly caused a mess in the bed, which not only caused quite the smell but embarrassment. NA-A told her she should spend some of her money on something to help the stool smell in her room. R4's quarterly MDS dated 12/16/25, identified intact cognition without behaviors. She had impairment ROM bilaterally upper and lower extremities. She required substantial/maximum assistance with oral hygiene, upper body dressing, personal hygiene, roll left and right, and dependent for all transfers, sit to lying, lying to sit, unable to walk, and used a motorized wheelchair for mobility. She had an indwelling catheter and frequently incontinent of bowel. Her diagnoses included: quadriplegic (a condition characterized by partial or complete paralysis of all four limbs, arms, and legs), depression, and anxiety. R4's care plan dated 3/24/25, identified she had an ADL self-care performance deficit and directed staff to allow sufficient time and assistance for her to dress and undress, she required assistance of two staff and a mechanical lift to transfer, and anticipate her needs. She had potential impairment to skin integrity of the coccyx related to quadriplegia. Staff were directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against	21805		

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21805	Continued From page 7 any sharp or hard surface. During an interview on 3/28/25 at 12:53 p.m. R4 stated the care at the facility was sometimes questionable. Staff rushed too much, lacked taking the time needed to complete tasks properly. Her catheter strap was located on the side of the leg and pants were not pulled up straight, later she had pressure marks on her leg. Staff failed to recognize the lift sheet was pulled up too tight between her legs during a transfer with the transfer lift and resulted in red marks in the groin area. She had not felt safe during a few of the total lift transfers especially on Tuesday when the lift sheet was placed too low on her hips and she had to be placed back on the bed crosswise during the transfer. She became anxious when things were not positioned correctly when she drove and when she had a spasm could have caused an accident. She preferred staff used the soaker sheet when they turned onto her side so that they avoided pulling /pushing on her. She was able to turn herself if only the staff would have slowed down an allowed her help. NA-A frequently used the emergency button on the total body lift machine, showed other staff how it was to be used, felt worse when she did, too fast and resulted in a bumped shoulder on the lift bar. NA-A had placed her in the shower chair, rushed too much, and bumped her feet. NA-A told her, another resident along with her should have not been placed in the same hallway, could not spend that much time helping us. There were a few other staff that had told her it had taken too long to take care of her. Those types of comments/actions of staff did not make her feel very well. She felt she was time consuming, angry, and irritated. She stated she told staff when they were rough with her during cares that hurt, to knock it off. She was in this	21805		

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21805	Continued From page 8 facility because she required help and unable to live at home and independent once the staff assisted her up out of bed in the morning and completed cares. She had told a staff NA about her concerns and felt comfortable talking to only certain staff about her concerns. R5's quarterly MDS 12/27/24, identified intact cognition with no behaviors. She had impaired bilateral lower extremities range of motion (ROM). She required substantial/maximal assistance with roll left and right, dependent on staff to provide oral/toileting/personal hygiene, shower/bathing, upper and lower dressing, sit to lying, lying to sitting, sit to stand, and all transfers. She was unable to ambulate and used a motorized wheelchair for mobility. She was occasionally incontinent of bowel and always incontinent of bladder. Her diagnoses included: CHF, DM, and arthritis. During an interview on 3/27/25 at 9:27 a.m. R5 stated NA-A was a little rough with her approach when she cared for her. She was unable to turn herself in bed, NA]-A was stronger than the rest of the staff and without warning would be pushed over to her side rather fast and was unexpected. NA-A was the only staff that rushed through cares, and she had not reported anything. She was a bigger resident than most and did not feel it was intentional but when she talked with other residents, they did feel it was. NA-A used the emergency button on the Hoyer lift when she transferred her. NA-A usually waited until her bottom was on the bed or until her wheelchair was reclined, braced herself and then the emergency button would be pushed. There were times when her back was not placed down on the bed, approximately four inches away and NA-A pushed the emergency button on the Hoyer lift,	21805		

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21805	Continued From page 9 and she felt a jolt. During an interview on 3/26/25 at 3:44 p.m. licensed practical nurse LPN-(A) stated on 3/24/25, she reported to the DON possible concerns she had regarding NA-A cares provided and transfer with a total lift machine. Later that same day, NA-B reported to her NA-A moved fast when she completed cares and transfers, used the emergency button on the total lift machine so that multiple residents were lowered down quickly into the chair and/or bed. She did not report that information and should have. During an observation on 3/26/25 at 4:45 p.m. NA-A and NA-B entered R2's room with a lift machine. R2 laid in bed on her back. Both NA's applied gloves and explained she would be transferred to her wheelchair for supper. Lift sheet, dark blue with green trim, was placed underneath her by rolling her slowly from side to side. Head of bed (HOB) was raised, and shoes applied. NA-A placed the loops of the lift sheet onto the lift machine and lifted her up off the bed with the remote control. NA-A moved the lift machine over to the wheelchair and slowly lowered her down onto the wheelchair. The emergency button was not used. NA-A and NA-B removed the lift sheet loops from the lift machine, tucked the lift sheet into the sides of her wheelchair and underneath her thighs, removed gloves, and sanitized their hands. During an interview on 3/26/25 at 4:56 p.m. NA-A stated the lift machine had an emergency button used to lower residents down quickly. She had used the emergency button once while she transferred a resident, and the battery was almost drained. She had not used the emergency button during a transfer since. Staff were educated the	21805		

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21805	Continued From page 10 emergency button should have not been used for regular transfers or when a resident was in the lift. A resident would not get injured if the emergency button were used and lowered too quickly. She treated residents well, provided cares efficiently, and safely. She had not witnessed any staff treat residents in a poor manner or received any complaints from residents. The DON interviewed her on 3/25/25, regarding transfers and cares completed on 3/24/25. During an interview on 3/26/25 at 5:20 p.m. LPN-B stated he had assisted NA's with transfers with the total lift machine. He had been informed by staff NA-A had been rough with R3. He talked to R3, and she told him NA-A was not the most gentle touch, seemed to feel it was not too terribly rough, and no other comments. He had not received any other complaints about NA-A and was that information was not reported. During an interview on 3/27/25 at 10:47 a.m. NA-D stated the emergency button on the total lift machine was to be used only during an emergency. She had completed total lift machine transfers with NA-A and encouraged by NA-A to use the emergency button during the transfers especially on those residents that were heavier, so they were lowered down faster. The emergency button on the total lift machine was hard to pull. She was instructed by NA-A on how to emergency button should have been used and when she did it jerked the resident while they remained in the lift sling. She had not witnessed a resident hurt by this process but when used frequently could have possibly caused an injury. She had noticed since 2/19/25, NA-A worked fast and there were three residents that had informed her NA-A provided rough care. R3 informed her	21805		

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21805	Continued From page 11 NA-A bumped her feet during transfers and refused to allow her to transfer or be pushed around by her anymore. R2 informed her during transfers had bumped her head with the lift machine bar, feet, and lowered quickly down into the bed or wheelchair. She was not sure if that was unusual, staff worked at different paces. R4 had told her staff rushed through cares, flipped over onto her side too fast, was not allowed time to assist with turns when able to, and felt frustrated and disrespected. The complaints were not reported but realized now she should have said something. During an interview on 3/27/25 at 12:10 p.m. NA-B stated NA-A was rough with the residents, very strong, and completed tasks quickly without thinking. She had told NA-A to slow down, it was not a race and would prevent injury to the residents. During repositioning or when a resident was turned NA-A used her hands, pushed on the wrong spot on the body they maybe sore already, and turned them quickly, causing more pain. She had seen NA-A transfer residents, without paying attention to the location of their feet and their head and they have gotten bumped. She had completed total lift machine transfers with NA-A and witnessed her rushing through the transfer placing the resident's safety at risk. She received complaints from residents R4, and R2, NA-A was rough and flipped them over too fast during cares. She has not witnessed any bruises or injuries. She had talked to LPN-A regarding her and resident concerns and encouraged residents to report concerns to the nurse on duty or the DON. The emergency button on the total lift machine was to be used only in an emergency, not daily. The facility had some heavier residents, was unsafe to be dropped down fast and could have possibility been injured. She had informed	21805		

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21805	Continued From page 12 staff if they did not like working with old people, treated them poorly, they should have looked for a different job and would be reported. During an interview on 3/27/25 at 2:46 p.m. NA-C stated she had noticed there were staff NA's were rough with residents when moved or repositioned with their hands instead of using the soaker pads. She witnessed R3 requested to be boosted up in bed and NA-D replied, no. She was in a resident's room and heard NA-A stated in front of the resident how annoyed she was when the resident used the bed remote and placed her bed up and down frequently, cord pulled out of the wall, happened every night, had to get down on the floor, and plugged it back in. Had not reported concerns right away and on 3/25/25, in the afternoon she reported her concerns to DON. During an interview on 3/28/25 at 10:04 a.m. DON stated she was not aware of any concerns with residents being treated inappropriately by staff. R2 complained about her wheelchair and was looking for another place to move to. R2's daughter had not contacted her regarding concerns on how she was being treated at the facility. On 3/24/25 she had interviewed five residents all located on the same wing in the facility. Those residents were asked how they were doing, any concerns, and all said things were fine. She stated the residents would have told her if something had bothered them. During an interview on 3/28/25 at 12:15 p.m. administrator stated she was unaware of any resident concerns treated inappropriately by staff. We have great policies, need to be followed, and concerns would be expected to be reported right away. When concerns were identified interviews were expected to be completed with all residents	21805		

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21805	Continued From page 13 in the facility. She had not received any complaints from staff or residents regarding staff. On 3/27/25, DON informed her about concerns and lack of staff reporting. Staff were terminated on 3/27/25. Facility policy Promoting Maintaining Resident Dignity undated identified it was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, which maintains resident's quality of life by recognizing each resident's individuality. Staff were expected to explain care or procedures before initiating the activity and speak respectfully to residents. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee to provide staff in-service regarding dignified resident treatment and maintain record of in-service provided and staff attendance. A designated staff could monitor the system to assure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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F 000	INITIAL COMMENTS On 3/26/25 through 3/28/25, 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 during the survey: H55372181C (MN00111739). 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.	F 000		
F 550 SS=E	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	F 550		4/14/25

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

Electronically Signed | 04/15/2025

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 promote the rights of the resident. §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 interview and record review the facility failed to ensure dignified and respectful services for 4 of 6 residents (R2, R3, R4, R5) reviewed who reported concerns related to staff treatment. Findings include: R2's annual Minimum Data Set (MDS) dated 3/14/25, identified she had moderately impaired cognition and disorganized thinking or incoherent (rambling or irrelevant conversation, unclear or	F 550	F550 SS=E Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible	

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F 550	Continued From page 2 illogical flow of ideas, unpredictable switching from subject to subject) that fluctuated and changed in severity two out of seven days of the week. She had impaired range of motion (ROM) upper extremity on one side and bilaterally lower extremities. She required substantial/maximal assistance with upper and lower body dressing, personal hygiene and dependent upon staff for shower/bathing, toileting, roll left and right, sit to lying, lying to sitting, all transfers, and mobility. She was always incontinent of bowel and bladder. Medical diagnoses included: peripheral vascular disease (PVD) (arteries or veins become narrowed or blocked, reducing blood flow to the limbs, typically in the legs), arthritis, osteoporosis, dementia, hemiplegia/hemiparesis (a neurological condition that affects causing weakness or paralysis on one side of the body), seizure disorder/epilepsy, anxiety, and macular degeneration (an eye disease that can blur your central vision). R2's care plan dated 3/18/25, identified a self-care performance deficit and directed staff to transfer her with a Hoyer lift with assist of two staff, provide all ADLs, and turn and reposition in bed. She was at risk for impaired skin integrity and directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. During an interview on 3/27/25 at 11:24 a.m. R2 stated she had polio when she was two years old which resulted in no neck muscles and found it uncomfortable when she sat in the wheelchair. Staff hooked her up to the "harness" (lift sheet) to Hoyer lift, left the room, closed the door, and looked for assistance to transfer her. She stated it made her feel like a horse with a harness and	F 550	allegation of compliance. Immediate actions were taken to address concerns and support affected residents. One-on-one meetings were conducted with residents R2, R3, R4, and R5 to acknowledge their experiences and apologize for the treatment they received. Services were offered to support their emotional well-being, and corrective actions were completed on April 14, 2025. Staff education was provided on the same day, and audits will begin on April 18, 2025. To ensure other residents receive dignified and respectful care, efforts were made to identify any individuals who may have had similar experiences, and all residents were informed of their rights through informational conversations. Systemic changes were implemented, including a review and update of facility policies to emphasize dignity and respect. Staff training focused on positive interactions, communication, and empathy, along with mandatory reviews of revised protocols and policy. Additional education was provided on critical care practices such as turning, repositioning, lift usage, empathy, resident rights, abuse, neglect, and reporting procedures. Monthly audits of resident interactions will be conducted to maintain compliance with dignity and respect standards. Oversight and accountability measures were established, with the Director of Nursing, Assistant Administrator, administrator and Social services designee responsible for implementing	

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F 550	Continued From page 3 had asked staff to wait until both staff arrived prior to when she was hooked up. Staff rushed when they used the Hoyer lift, had forgotten to move her legs/feet out of the way, pinched and bumped them when staff pushed the emergency button on the lift machine and lowered her down quickly. While staff positioned her to be transferred from bed to wheelchair today, she was instructed to place her hands on her chest and hold her head up. She reminded staff to be careful of her feet, while staff pulled the emergency lever on the Hoyer lever and lowered her down quickly into the wheelchair. She was afraid her head would be hit by the Hoyer lift bar that hung over her head. She had been knocked in the head more than once by the Hoyer bar while she was lowered too quickly. On another occasion she was lowered into the wheelchair and the loop on the lift sheet had hit her in the eye. Staff had pulled her shirt off quickly and her right arm hurt. Her daughter called DON and was told she would talk to staff. She also reported this to the director of nursing (DON) and was told she would talk to the staff. She felt safe but uncomfortable with staff and frustrated when she reported concerns, and no changes noted. She identified a nursing assistant (NA)-A that was not her favorite. NA-A handled her roughly and worked fast, always in a hurry, never hurt her but she had screamed and yelled when her right arm was not handled gently, no bruises or injuries thank goodness. She was able to assist when staff requested her to turn to her right side, grabbed the bed railing, but was not allowed the time, and turned quickly by NA-A. She had cried more than once, felt disrespected, did not feel like home to her, and wanted to move out of facility. NA-A had continued to use the emergency button on the Hoyer lift and reported how she was treated by NA-A to the DON and	F 550	and monitoring corrective actions. The Social Services Designee or delegate will facilitate one-on-one resident meetings to discuss care, and the Quality Assurance Committee will review audit results and recommend further improvements as needed.	

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F 550	Continued From page 4 planned to talk with DON again today. She stated she felt staff could treat her better and with respect. R3's quarterly MDS dated 3/6/25, identified intact cognition with no behaviors. She required substantial/maximal assistance with upper and lower body dressing, personal hygiene, roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, dependent on staff for toileting hygiene and bathing/shower. She was unable to ambulate. She was always incontinent of bowel and bladder. Medical Diagnoses included: cancer, congestive heart failure, diabetes mellitus (DM), anxiety, obesity, and depression. R3's care plan dated 3/19/25 identified ADL self-care performance deficit and directed staff to establish a routine to provide a sense of security and confidence with resident, provide moderate assistance of one with bathing, bed mobility, incontinent brief changes, anticipate needs, and transfer with assist of two and sit to stand lift. Allow resident to accomplish tasks at her own pace, do not hurry them, and encourage independence only when resident was able to safely do so. She had potential for impaired skin integrity. Staff were directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. She was prescribed an anticoagulant and staff were directed to protect resident from injury and trauma. During an interview on 3/27/25 at 10:13 a.m. R3 stated staff transferred her with a stand lift. She was concerned about her tender feet when taken to the shower by NA-A. She was placed into the shower/tub, feet first, her feet had gotten bumped	F 550		

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F 550	Continued From page 5 into the inside to the tub and was painful. She no longer allowed NA-A to take her to the tub anymore. NA-A was rough with how she handled her, reported to management, was told no one else complained about her, and nothing was done. She allowed NA-A to transfer her with the stand life in her room only but watched where her feet were placed so that they did not get jammed somewhere. She stated she felt safe because she was able to speak up for herself but worried about those residents that were unable to say anything. NA-A had informed her not to tell her how to do her job when she encouraged her to slow down, watch her feet, and adjust incontinent brief when not placed properly. Her stools were horrible, runny, and when NA-A rushed while she placed the brief on improperly caused a mess in the bed, which not only caused quite the smell but embarrassment. NA-A told her she should spend some of her money on something to help the stool smell in her room. R4's quarterly MDS dated 12/16/25, identified intact cognition without behaviors. She had impairment ROM bilaterally upper and lower extremities. She required substantial/maximum assistance with oral hygiene, upper body dressing, personal hygiene, roll left and right, and dependent for all transfers, sit to lying, lying to sit, unable to walk, and used a motorized wheelchair for mobility. She had an indwelling catheter and frequently incontinent of bowel. Her diagnoses included: quadriplegic (a condition characterized by partial or complete paralysis of all four limbs, arms, and legs), depression, and anxiety. R4's care plan dated 3/24/25, identified she had an ADL self-care performance deficit and directed	F 550		

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F 550	Continued From page 6 staff to allow sufficient time and assistance for her to dress and undress, she required assistance of two staff and a mechanical lift to transfer, and anticipate her needs. She had potential impairment to skin integrity of the coccyx related to quadriplegia. Staff were directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. During an interview on 3/28/25 at 12:53 p.m. R4 stated the care at the facility was sometimes questionable. Staff rushed too much, lacked taking the time needed to complete tasks properly. Her catheter strap was located on the side of the leg and pants were not pulled up straight, later she had pressure marks on her leg. Staff failed to recognize the lift sheet was pulled up too tight between her legs during a transfer with the transfer lift and resulted in red marks in the groin area. She had not felt safe during a few of the total lift transfers especially on Tuesday when the lift sheet was placed too low on her hips and she had to be placed back on the bed crosswise during the transfer. She became anxious when things were not positioned correctly when she drove and when she had a spasm could have caused an accident. She preferred staff used the soaker sheet when they turned onto her side so that they avoided pulling /pushing on her. She was able to turn herself if only the staff would have slowed down an allowed her help. NA-A frequently used the emergency button on the total body lift machine, showed other staff how it was to be used, felt worse when she did, too fast and resulted in a bumped shoulder on the lift bar. NA-A had placed her in the shower chair, rushed too much, and bumped her feet. NA-A told her, another resident along	F 550		

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F 550	Continued From page 7 with her should have not been placed in the same hallway, could not spend that much time helping us. There were a few other staff that had told her it had taken too long to take care of her. Those types of comments/actions of staff did not make her feel very well. She felt she was time consuming, angry, and irritated. She stated she told staff when they were rough with her during cares that hurt, to knock it off. She was in this facility because she required help and unable to live at home and independent once the staff assisted her up out of bed in the morning and completed cares. She had told a staff NA about her concerns and felt comfortable talking to only certain staff about her concerns. R5's quarterly MDS 12/27/24, identified intact cognition with no behaviors. She had impaired bilateral lower extremities range of motion (ROM). She required substantial/maximal assistance with roll left and right, dependent on staff to provide oral/toileting/personal hygiene, shower/bathing, upper and lower dressing, sit to lying, lying to sitting, sit to stand, and all transfers. She was unable to ambulate and used a motorized wheelchair for mobility. She was occasionally incontinent of bowel and always incontinent of bladder. Her diagnoses included: CHF, DM, and arthritis. During an interview on 3/27/25 at 9:27 a.m. R5 stated NA-A was a little rough with her approach when she cared for her. She was unable to turn herself in bed, NA]-A was stronger than the rest of the staff and without warning would be pushed over to her side rather fast and was unexpected. NA-A was the only staff that rushed through cares, and she had not reported anything. She was a bigger resident than most and did not feel it	F 550		

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F 550	Continued From page 8 was intentional but when she talked with other residents, they did feel it was. NA-A used the emergency button on the Hoyer lift when she transferred her. NA-A usually waited until her bottom was on the bed or until her wheelchair was reclined, braced herself and then the emergency button would be pushed. There were times when her back was not placed down on the bed, approximately four inches away and NA-A pushed the emergency button on the Hoyer lift, and she felt a jolt. During an interview on 3/26/25 at 3:44 p.m. licensed practical nurse LPN-(A) stated on 3/24/25, she reported to the DON possible concerns she had regarding NA-A cares provided and transfer with a total lift machine. Later that same day, NA-B reported to her NA-A moved fast when she completed cares and transfers, used the emergency button on the total lift machine so that multiple residents were lowered down quickly into the chair and/or bed. She did not report that information and should have. During an observation on 3/26/25 at 4:45 p.m. NA-A and NA-B entered R2's room with a lift machine. R2 laid in bed on her back. Both NA's applied gloves and explained she would be transferred to her wheelchair for supper. Lift sheet, dark blue with green trim, was placed underneath her by rolling her slowly from side to side. Head of bed (HOB) was raised, and shoes applied. NA-A placed the loops of the lift sheet onto the lift machine and lifted her up off the bed with the remote control. NA-A moved the lift machine over to the wheelchair and slowly lowered her down onto the wheelchair. The emergency button was not used. NA-A and NA-B removed the lift sheet loops from the lift machine,	F 550		

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F 550	Continued From page 9	F 550		

tucked the lift sheet into the sides of her wheelchair and underneath her thighs, removed gloves, and sanitized their hands.

During an interview on 3/26/25 at 4:56 p.m. NA-A stated the lift machine had an emergency button used to lower residents down quickly. She had used the emergency button once while she transferred a resident, and the battery was almost drained. She had not used the emergency button during a transfer since. Staff were educated the emergency button should have not been used for regular transfers or when a resident was in the lift. A resident would not get injured if the emergency button were used and lowered too quickly. She treated residents well, provided cares efficiently, and safely. She had not witnessed any staff treat residents in a poor manner or received any complaints from residents. The DON interviewed her on 3/25/25, regarding transfers and cares completed on 3/24/25.

During an interview on 3/26/25 at 5:20 p.m. LPN-B stated he had assisted NA's with transfers with the total lift machine. He had been informed by staff NA-A had been rough with R3. He talked to R3, and she told him NA-A was not the most gentle touch, seemed to feel it was not too terribly rough, and no other comments. He had not received any other complaints about NA-A and was that information was not reported.

During an interview on 3/27/25 at 10:47 a.m. NA-D stated the emergency button on the total lift machine was to be used only during an emergency. She had completed total lift machine transfers with NA-A and encouraged by NA-A to use the emergency button during the transfers

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F 550	Continued From page 10 especially on those residents that were heavier, so they were lowered down faster. The emergency button on the total lift machine was hard to pull. She was instructed by NA-A on how to emergency button should have been used and when she did it jerked the resident while they remained in the lift sling. She had not witnessed a resident hurt by this process but when used frequently could have possibly caused an injury. She had noticed since 2/19/25, NA-A worked fast and there were three residents that had informed her NA-A provided rough care. R3 informed her NA-A bumped her feet during transfers and refused to allow her to transfer or be pushed around by her anymore. R2 informed her during transfers had bumped her head with the lift machine bar, feet, and lowered quickly down into the bed or wheelchair. She was not sure if that was unusual, staff worked at different paces. R4 had told her staff rushed through cares, flipped over onto her side too fast, was not allowed time to assist with turns when able to, and felt frustrated and disrespected. The complaints were not reported but realized now she should have said something. During an interview on 3/27/25 at 12:10 p.m. NA-B stated NA-A was rough with the residents, very strong, and completed tasks quickly without thinking. She had told NA-A to slow down, it was not a race and would prevent injury to the residents. During repositioning or when a resident was turned NA-A used her hands, pushed on the wrong spot on the body they maybe sore already, and turned them quickly, causing more pain. She had seen NA-A transfer residents, without paying attention to the location of their feet and their head and they have gotten bumped. She had completed total lift machine transfers with NA-A	F 550		

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F 550	Continued From page 11 and witnessed her rushing through the transfer placing the resident's safety at risk. She received complaints from residents R4, and R2, NA-A was rough and flipped them over too fast during cares. She has not witnessed any bruises or injuries. She had talked to LPN-A regarding her and resident concerns and encouraged residents to report concerns to the nurse on duty or the DON. The emergency button on the total lift machine was to be used only in an emergency, not daily. The facility had some heavier residents, was unsafe to be dropped down fast and could have possibility been injured. She had informed staff if they did not like working with old people, treated them poorly, they should have looked for a different job and would be reported. During an interview on 3/27/25 at 2:46 p.m. NA-C stated she had noticed there were staff NA's were rough with residents when moved or repositioned with their hands instead of using the soaker pads. She witnessed R3 requested to be boosted up in bed and NA-D replied, no. She was in a resident's room and heard NA-A stated in front of the resident how annoyed she was when the resident used the bed remote and placed her bed up and down frequently, cord pulled out of the wall, happened every night, had to get down on the floor, and plugged it back in. Had not reported concerns right away and on 3/25/25, in the afternoon she reported her concerns to DON. During an interview on 3/28/25 at 10:04 a.m. DON stated she was not aware of any concerns with residents being treated inappropriately by staff. R2 complained about her wheelchair and was looking for another place to move to. R2's daughter had not contacted her regarding concerns on how she was being treated at the	F 550		

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F 550	Continued From page 12 facility. On 3/24/25 she had interviewed five residents all located on the same wing in the facility. Those residents were asked how they were doing, any concerns, and all said things were fine. She stated the residents would have told her if something had bothered them. During an interview on 3/28/25 at 12:15 p.m. administrator stated she was unaware of any resident concerns treated inappropriately by staff. We have great policies, need to be followed, and concerns would be expected to be reported right away. When concerns were identified interviews were expected to be completed with all residents in the facility. She had not received any complaints from staff or residents regarding staff. On 3/27/25, DON informed her about concerns and lack of staff reporting. Staff were terminated on 3/27/25. Facility policy Promoting Maintaining Resident Dignity undated identified it was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, which maintains resident's quality of life by recognizing each resident's individuality. Staff were expected to explain care or procedures before initiating the activity and speak respectfully to residents.	F 550		