Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2026

Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

RE: CCN: 245564

Cycle Start Date: March 4, 2026

Dear Administrator:

On March 4, 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 isolated deficiencies that constituted immediate jeopardy (Level J). 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 remedies 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 Mediare 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 4, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 4, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 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, Browns Valley Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 4, 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 4, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Browns Valley Health Center	114 JEFFERSON STREET SOUTH , BROWNS VALLEY, Minnesota, 56219

(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 3/2/26, through 3/4/26, 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 H55646982C (2785510) with a deficiency issued at F600 PAST NON-COMPLIANCE. Additionally, deficient practice was identified related to incidental findings at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in 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		
F0600 SS = SQC-J	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"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0600 SS = SQC-J	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 1 resident (R1) from abuse when nurse aid (NA)-B physically and verbally abused R1 during cares. This resulted in serious psychosocial harm for R1 who became withdrawn, had a decreased appetite, and increased crying following the incident. The IJ began on 2/21/26 at 7:45 p.m., when NA-B was witnessed to make derogatory statements, used foul and aggressive language, and slapped R1 on the backside. NA-B 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 3/4/25 at 1:00 p.m. The facility implemented corrective action by 2/25/25 prior to the start of the survey and therefore is issued as past non-compliance. Findings include: Facility incident report submitted 2/22/26 at 4:22 p.m., identified on 2/22/26 at 2:00 p.m., staff reported R1 was more tearful today with a decreased appetite. on-call nurse received a call from charge nurse and inquired if anything had been reported regarding concern from the previous evening shift. Director of nursing (DON) and administrator were notified, and an investigation was started. It was explained that on 2/21/26 at 7:45 p.m., two staff were caring for R1, the trained medication assistant (TMA)-A was outside R1's door and heard NA-B speaking loudly and demandingly to R1. Following, TMA-A asked NA-A who was in the room with her, what happened and stated NA-B was assisting R1 with peri cares, R1 swung her arms at staff and NA-B started raising her voice at R1 and used an open hand to slap R1’s bottom, stating, "if you want to act like a child, you will be treated like a child." R1’s quarterly Minimum Data Set (MDS) dated 2/20/26, identified she had unclear speech, with limited verbal and non-verbal skills, would respond adequately to simple, direct communication only, had disorganized thinking, and moderately impaired cognition with long-term and short-term memory loss. R1 was dependent upon staff for personal and toileting hygiene, all transfers, bathing, and lower body dressing. She was always incontinent of bladder and frequently	F0600		

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F0600 SS = SQC-J	Continued from page 2 incontinent of bowel. R1's medical diagnoses included: non-Alzheimer's dementia, depression, and a psychotic disorder. Medications taken during look back period: antipsychotic, antianxiety, and antidepressant. R1's care plan dated 11/18/25, identified activities of daily living (ADL) self-care performance deficit related to dementia. Staff were directed to aid of one for bathing and hygiene and assistance of two for toilet use, ambulation, transfers, bed mobility, and dressing. R1 had impaired cognitive function/dementia or intellectual disability and can act out with attention seeking behaviors towards others in line with estimated age of an 8-year-old per family. Staff were directed to face her when speaking, making eye contact, and reduce distractions. She understood simple, directive sentences. Provide R1 with necessary cues, stop and return if agitated. R1 used anti-anxiety mediations (Ativan) related to anxiety disorder. Her target behaviors included: peri area scratching, refusal to talk, slamming doors, and throwing objects. Staff were directed to use non-pharm interventions: leave her and return later to complete an activity to allow her time to calm self-down, do not ask me "what is wrong," use quiet voice, allow freedom to refuse as she is safe to do so. Observe R1 for changes in mood and update provider with concerns. R1's progress notes from 2/21/26 through 2/25/26, identified: -No documentation in progress notes for 2/21/26. -On 2/22/26 at 11:56 a.m., R1 was sitting in the coliseum in her wheelchair and started crying. When approached by writer, tried to talk to her and continued to cry. She was asked if she wanted to lay down and she shook her head yes. R1 was taken to her room and laid down. -On 2/22/26 at 12:11 p.m., R1 refused to get up for dinner and was assisted to the side of the bed. She placed her feet back in the bed and rested quietly at this time. -On 2/23/26 at 10:04 a.m., R1 was very vocal with staff this morning with cares when they tried to get her up. R1 calmed down after she got in her wheelchair. -On 2/23/26 at 2:03 p.m., Yelling at staff. God Damn [sic] it when they are toileting her. Staff redirected her to task at hand.	F0600		

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F0600 SS = SQC-J	Continued from page 3 -On 2/25/26 at 9:18 a.m., Yelling, hitting, and scratching staff when they were doing her morning cares. Tried to calm her. R1 was ok and went to breakfast after cares being done. -On 3/2/26 at 2:20 p.m., Late Entry: After initial report was filed. DON contacted provider via telephone and spoke to her about the incident. DON called guardian to discuss vulnerable adult (VA) was filed on R1 and she was safe and did not suffer any physical harm. Guardian was very thankful for the update. -On 3/2/26 Late Entry: On 2/22/26 at 9:30 a.m., R1 was taken to her room and laid down, a full body assessment was done and no bruises were noted. R1 did not verbalize any pain or discomfort. R1's Nursing Assistant (NA) Behavior Monitoring and Interventions Report from 2/16/26 through 2/26/26: - 2/16/26 at 7:32 p.m., screaming at others. Intervention: moved to calm environment. Behavior better/improved. -On 2/22/26 at 7:22 p.m., Sad, tearful, withdrawn, and isolating. Intervention: Provide calm environment. Behaviors: better/improved. -On 2/23/26 at 10:03 a.m., Expressed frustration/anger at others and agitated. Intervention: Toilet. Behaviors: worsened. -On 2/23/26 at 1:59 p.m., Screaming at others. No interventions identified. -On 2/24/26 at 9:53 a.m., Cursing at others, express frustration/anger at others, and agitated. Intervention: reapproach. Behaviors: improved. -On 2/25/26 at 1:59 p.m., Hitting and scratching others and physically aggressive towards others. Intervention: Provide calm environment and toilet. Behaviors worsened. -On 2/25/26 at 7:22 p.m., Hitting, scratching, physically aggressive to others, and screaming at others. Intervention: Provide calm environment and toilet. Behaviors worsened. -On 2/26/26 at 1:59 p.m., Hitting, scratching, physically aggressive to others, cursing and screaming	F0600		

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F0600 SS = SQC-J	Continued from page 4 at others. Intervention: Provide calm environment and toilet. Behaviors worsened. Review of NA Behavior Monitoring from 2/8/26 through 2/21/26, identified no behaviors were observed/documented from 2/8/26 through 2/15/26 and 2/17/26 through 2/21/26 (13 days). R1's nurse behavioral documentation from 2/1/26 through 2/28/26, my target behaviors (choices to choose from): hitting, kicking, yelling, animal-like noises, seeing/hearing things, tantrums, feeling down/having little energy, irritable, sad affect & refusing to talk. Peri-area-scratching causes self-harm, slamming doors, throwing objects. Non pharm: turn on country music, leave me and return later to complete an activity to allow me time to calm myself, do not "ask me what is wrong" use calm quiet voice, allow her freedom to refuse as she is safe to do so. Every day (day and night shift) check marks (indicated no behaviors) were entered except on two-day shifts 2/20/26 and 2/28/26 were left blank. NA-B's timecard identified on 2/21/26, scheduled to work from 6:30 p.m. to 7:00 a.m. Time clocked in 6:28 p.m. and time clocked out 7:01 a.m. Worked 12 hours. NA-B scheduled to work 2/22/26 at 6:30 p.m. to 7:00 a.m. no time entered. NA-A was not scheduled for any other shifts or dates. Employee Concern document dated 2/21/26, at 7:04 p.m. The purpose of this form is to document what performance or action is a concern based on facility core values. This form is routed to the department supervisor for further investigation and follow-up. Staff person completing report and witness to the incident: NA-A. Performance issue or concern (be specific): While putting R1 to bed at 7:04 p.m. during the washing and toileting, R1 was hollering while trying to wipe her. NA-B proceeded to be vocally aggressive, and likewise R1 has a hard time getting off the toilet and hollered. NA-B then smacked R1's butt and said "you wanna [sic] act like a child you can get treated like one," etc. NA-B termination document dated 2/27/26, identified discharged. Supervisor comments: employee did not respond regarding training, coming in, or texts.	F0600		

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F0600 SS = SQC-J	Continued from page 5 During an interview on 3/2/26 at 12:25 p.m., registered nurse (RN)-A stated R1 functioned at the level of an 8 to 10-year-old, occasionally swore, hit, kicked, slapped during cares, and rarely spoke in sentences. On 2/21/26, at approximately 6:00 p.m. she brought R1 to supper in the wheelchair and no behaviors were noted. On 2/22/26, she came back to work at 6:00 a.m. NA-B had worked the night shift (12 hours) and was still there when she arrived. She received report from licensed practical nurse (LPN)-A and there had been no mention about an incident with R1. RN-A completed treatment rounds when a NA approached her and asked, if she had heard what happened, adding, R1 and NA-B were yelling at each other yesterday. Additionally, a TMA-A informed her that she stood outside R1's closed door, heard her screaming and probably should have gone into the room. But then NA-A came out of the room with a funny look on her face (eyes wide open and bewildered look) and informed TMA-A, NA-B had told R1 to quit being a baby, grab the bar, fucking get up, go to the bathroom, because you are not a baby, and swatted R1 on her bottom. RN-A stated she was shocked and knew it was possible physical and verbal abuse. TMA-A informed her she reported the incident to the charge nurse LPN-A right away that evening right away. RN-A waited a couple more hours, most likely shouldn't have, but thought it had been reported to the on-call nurse. She called the on-call nurse and realized it had not been reported. Within 15 minutes of the call to the DON, she came to the facility. At 9:30 a.m. RN-A completed a skin assessment and no skin concerns noted. The skin assessment was not documented and should have been. RN-A verified NA-B had worked at the facility for approximately one month and she did not work directly with her. R1 rarely cried on the night shift, was unable to verbalize what was bothering her, would usually say "ugh ugh" and point at things, staff were expected to document her behaviors every shift in the electronic medical record. Follow-up interview on 3/3/26 at 5:15 p.m., RN-A stated on 2/22/26, R1 was out of bed and sat in her wheelchair for breakfast but refused to eat and started crying in the coliseum. RN-A stated she was unaware of the incident when she approached R1, tried to talk to her, but she kept crying. RN-A stated after she saw R1 crying, withdrawn, and refusing to eat, she knew something was wrong. She had known her for three years and had only seen her like this one other time. RN-A stated R1 does not cry for no reason, something was wrong. On 2/22/26, RN-A offered R1 snacks, meals	F0600		

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F0600 SS = SQC-J	Continued from page 6 and liquids and she refused all of them. This type of behavior for R1 was not considered normal, it was obvious something had happened. RN-A stated R1 functioned like a child, comparable to children, she would get really quiet and that's how she reacted on 2/22/26, like the incident made her feel sad. During an interview on 3/2/26 at 2:39 p.m., TMA-A stated on 2/21/26 at 6:45 p.m., she stood outside R1's closed door preparing medications and heard R1 and NA-B both yelling. NA-B stated hurry up and grab the fucking bar, you know how to fucking walk, so walk to the bed. The tone of NA-B 's voice was rude and aggressive. TMA-A remained at the medication cart until NA-A and NA-B exited R1's room. She was unaware NA-A was in the room and asked her what happened. NA-A informed TMA-A, NA-B had swatted R1 on the butt. At 7:15 p.m. she completed a medication count with the charge nurse LPN-A and informed her about the incident with R1. TMA-A stated she told LPN-A what she had heard and about the smack on the butt by NA-B. TMA-A stated because she considered this verbal and physical abuse and was not appropriate way for a resident to be treated under no circumstances, she assumed LPN-A would have called the nurse on call. NA-B continued to work with residents until at least 7:30 p.m. when TMA-A left for the day. TMA-A was surprised NA-B was not pulled off work and sent home so that something similar did not happen to another resident and no one would be around to see what happened. During an interview on 3/2/26 at 3:37 p.m., social service designee (SSD) stated R1's cognition was severely impaired with dementia, she was able to answer simple yes or no questions and chose not to speak at all at times. Staff were expected to respond to R1's behaviors by allowing her time and/or another staff to reapproach her. Staff would have been expected to monitor any residents unable to be interviewed after incident, during cares and report it to the nurse on duty. SSD stated she visited with R1 daily and had not seen any changes in behaviors. R1 had yelled at SSD this morning "no" but would not say anything more. During an interview on 3/2/26 at 7:51 p.m., NA-A stated on 2/21/26, she worked from 2:30 p.m. to 9:30 p.m. with NA-B. She did not have concerns about NA-B prior to the incident that night, other than NA-B's tone of voice threw her off because she could be loud and intimidating. At approximately 6:30 p.m., NA-A and NA-B assisted R1 in the bathroom. NA-A cleaned her bottom	F0600		

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F0600 SS = SQC-J	Continued from page 7 when charge nurse LPN-A entered the room and told NA-B, R1 could walk to the bed with the walker and left the room. While R1's brief was being placed she became combative, started yelling and grunting loudly, at that time NA-B stated, "stand up" and R1 responded "oh shut up." NA-B stated out loud, if you want to act like a child then you will be treated like one and with an open hand smacked her on the right buttock (skin to skin and sounded like a loud smack). NA-B grabbed R1's walker and said OK, now let's walk to bed. R1 was whining and whimpering like she was in pain, laid down on bed, pillows positioned under her legs, covered up with a blanket, and remote placed. NA-A stated NA-B was verbally and physically abusive, made her very uncomfortable, and cannot imagine how R1 felt. NA-A stated she felt uncomfortable in the bathroom with NA-B because of her stature, her tone of voice, which was loud and aggressive, her use of foul language and R1 was most likely feeling the same way. R1 was making grunting sounds like she was nervous. NA-A stated once she left R1's room she talked to TMA outside R1's door and was asked if NA-B had been aggressive and she told her yes but was afraid of retaliation from NA-B. Five minutes later she located the charge nurse LPN-A and reported the incident of abuse. NA-A was provided with a complaint form with not a lot of room to write, so she placed as much information in the small area as she could and placed it in the DON's box. NA-A felt like nothing was done to protect the residents. The incident should have been reported within two hours and found out the next day it was not reported until later the next day. NA-A stated NA-B was allowed to work after incident, assisted NA-A with another resident transfer and toileting. At 9:30 p.m. left the facility and NA-B remained working with residents. During an interview on 3/3/26 at 1:15 p.m., clinical coordinator LPN-C stated she was notified about the allegation of abuse incident on 2/22/26 at 2:00 p.m., by charge nurse RN-A instructed her to have TMA-A write out what she heard and when. She was on call the entire weekend and would have expected LPN-A to notify her on 2/21/26 immediately so that an investigation could start and reported according to the guidelines. LPN-C stated she was not notified on 2/21/26, for concerns of physical and verbal abuse. NA-B was allowed to finish working her shift on 2/21/26, but if she had been notified and known about the allegations, she would have removed her from the facility and the schedule until the investigation was completed. LPN-C stated she notified DON right away and came to facility immediately, arrived just after 2:00 p.m. and started to investigate with staff and resident interviews. The	F0600		

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F0600 SS = SQC-J	Continued from page 8 incident happened on 2/21/26 and there were concerns brought to our attention on 2/22/26 about physical and verbal abuse. During an interview on 3/3/26 at 2:40 a.m., LPN-A stated on 2/21/26 just after 7:00 p.m., TMA-A informed her she had stood outside R1's closed door preparing medications and heard raised voices. R1 cried out while staff completed cares. NA-A and NA-B came out of R1's room and NA-A and informed TMA-A she wanted to write a complaint about the other staff NA-B but did not want her to know about it. LPN-A provided NA-A with the complaint form to fill out. NA-A asked LPN-A what to do with the completed form. NA-A showed the form to LPN-A, asked if it looked right. LPN-A did not read the document and probably should have, and informed NA-A the form was to be submitted to the DON. LPN-A stated she received a phone call from DON the following day on 2/22/26 and asked if she was aware of the incident with R1. She told DON the staff involved had not offered any information about abuse or anything. LPN-A stated she had no idea until the next day NA-B had been aggressive towards R1. She was aware staff were swearing at R1 and that was concerning. She did not ask any specific questions and should have and should have made a report sooner. LPN-A stated she thought the staff would have told her NA-B hit R1, more attention would have been brought to it if they had. Knowing what she knew now, NA-B slapped R1's butt, roughed her up, swore at her and this was considered abuse. LPN-A stated she thought it was just another staff complaining about a staff due to age difference. LPN-A stated NA-B continued to work the remainder of the shift and answered call lights and cared for residents without supervision until at least 7:00 a.m. LPN-A assisted NA-B with part of her rounds on a few residents (check and changes and toileting) and did not see any concerns. NA-B's tone of voice was gruffer, not sweet at all, loud when she spoke, but appeared to be good with the residents. LPN-A stated she was unsure if NA-B had contact with R1 after the incident. LPN-A stated she was unaware of many things that night, should have asked more questions, sent NA-B home to protect the residents so that there would not have been any chances of her abusing other residents. During an interview on 3/3/26 at 2:53 p.m., DON stated that on 2/22/26 at approximately 1:45 p.m., she had received a call from on-call nurse LPN-A and asked her if she had received a call from the facility. The day charge nurse RN-A had called LPN-A and asked why NA-B remained on the schedule because staff had told her how NA-B had swatted R1. DON informed LPN-A	F0600		

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F0600 SS = SQC-J	Continued from page 9 she was not aware of this incident, immediately came to the facility, and hit the floor running. DON stated she opened her office door and found a written statement dated 2/22/26 from TMA-A and in the locked box dated 2/21/26 from NA-A. TMA-A was pulled into the DON's office to give oral statement and interview. NA-A informed DON she heard swearing and NA-B stated grab the fucking bar. DON asked TMA-A why she did not enter R1's room when she heard NA-B speak to R1 like that. TMA-A informed DON she did not want to leave R1's narcotics on the medication cart. DON stated she would have expected TMA-A to open R1's door and check to see what was going on, for the protection of the residents. DON stated TMA-A could have used her radio to contact the charge nurse LPN-A and asked her to come to R1's room immediately if she had concerns. On 2/22/26, NA-A was called in for an interview/statement. NA-A demonstrated on DON what she witnessed on 2/21/26. NA-A stated NA-B wiped R1's bottom and stated in a loud tone, if you want to act like a child, you can get treated like one and swatted her on the bottom with an open hand. NA-A did not indicate NA-B swore at R1. NA-A demonstrated physically on DON per her request, how she witnessed the incident when NA-B swatted R1's bottom. DON stated the swat did not feel like she was abused but felt it was not ok to do to a resident, and no staff should swat the bottom of any resident. At 7:00 p.m. on 2/21/26, TMA -A talked to LPN-B during a medication count and informed her she heard swearing and R1 was crying. Additionally, NA-A informed LPN-B after incident on 2/21/26, she had a concern about NA-B and requested a concern form. Form was given to NA-A, completed, and placed in DON's box. DON stated she would have expected the charge nurse LPN-A to have read what NA-A wrote, immediately assess R1's skin and bottom, and contact the on-call nurse LPN-B right away. We had only two hours to report abuse. DON would have wanted to make sure all the residents were safe, and the staff (NA-B) was suspended and no longer in the building so that residents would not suffer any other harm. R1 did not suffer any harm but there was potential for harm, and all residents have the potential for harm. DON stated she believed R1 experienced verbal abuse during this incident. NA-B continued to work on 2/21/26 after the incident until the following morning at 7:01 a.m. On 2/22/26. NA-B completed an interview over the phone; no notes were taken. DON requested and received NA-B's written statement that included the same information discussed on the phone on 2/22/26 and was suspended from work. The facility policy was not followed by the charge nurse LPN-A, regarding communicating the incident with the on-call nurse and if she had been notified in a timely manner, things would have been taken care of on	F0600		

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F0600 SS = SQC-J	Continued from page 10 Saturday night and NA-B suspended from work. Maltreatment was verified by the witnesses: TMA-A verified verbal abuse and NA-A verified verbal and physical abuse by NA-B. During an interview on 3/4/26 at 10:21 a.m. NA-E stated R1's cognition was comparable to autism spectrum, struggled with verbalizing how she felt and knew more than she was able to verbalize. NA-E stated she was familiar with R1 and worked with her for over five years. R1 was a friendly and interactive person, loved activities, animals especially dogs, and children. R1 experienced a mental decline which seemed to have started approximately three years ago. R1 can get quite aggressive and overwhelmed at times, interventions used to help avoid and/or deescalate behaviors were distraction with music/pop/popcorn/stuffed animals, reapproach, remain calm, talk to her in a quiet voice in few simple words, and avoid using a loud voice to tell her what you are about to do. NA-E stated on 2/22/26, she entered R1's room in the morning and she was dry, laid in a wet bed, got her up and had taken her to breakfast. R1 sat in her wheelchair and was very quiet, not aggressive, refused to eat or drink, started crying, and laid her down in bed per RN-A's request. R1 refused to respond verbally when asked what was bothering her. At 11:30 a.m. R1 placed her call light on, was incontinent of urine, care provided, again she was not making any noises, withdrawn and not aggressive like she usually was with cares, she was different than normal. At 1:00 p.m. NA-E noted R1 was not up for lunch, went to her room, informed her it was time for lunch and assisted her up to the side of the bed. R1 started to grunt, unable to keep herself from sitting up, NA-E supported her upper body with a hand, and R1 started to cry and said no. NA-E asked R1, don't you want to get up, and she stated no and laid back down. NA-E stated this behavior was not normal for R1 and reported to RN-A and on-call nurse LPN-B was called. R1 stayed in bed all day, did not eat, drink or attend activities. NA-E offered R1 pop with a straw in it (usually drank at least two to three pops a day) and not one drink accepted, which was odd for her. NA-E stated during the incident on 2/21/26, R1 most likely felt helpless and scared. She appeared impacted when she did not want to get out of bed, was exhausted, withdrawn, refused food and pop and just wanted to sleep the next day. Unable to interview NA-B, call placed on 3/2/26 at 3:15 p.m. unable to leave message, phone disconnected.	F0600		

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F0600 SS = SQC-J	Continued from page 11 Unable to interview family/guardian on 3/2/26 at 4:23 p.m. and 3/3/25 at 5:13 p.m. messages left, no return call received. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, identified care center will report any allegations of maltreatment of a vulnerable adult (VA) resident in our care center to the appropriate authorities as required by abuse reporting for Federal Regulations and maltreatment reporting for the Minnesota State Statues. Immediate notification to the administrator of any suspected maltreatment is necessary to fully assess the situation and proceed with reporting to officials according to regulation. Care center must report to the State Agency Minnesota Department of Health (MDH) any suspected maltreatment (alleged violations involving abuse neglect, financial exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) immediately but not later than 2 hours after the allegation was made. If alleged maltreatment occurs: Staff shall immediately report to their supervisor any suspected maltreatment, ensure the resident is safe, complete an initial assessment to determine if there is potential abuse, neglect or other type of maltreatment. The immediate supervisor or person responsible for implementing actions of Maltreatment Prohibition Policy shall: immediately suspend staff person(s) involved in the alleged maltreatment pending the outcome of the investigation. Begin investigating the alleged maltreatment, which may include resident and staff interviews, observations and medical record review and complete as much as possible within five working days as possible. Facility policy Maltreatment Prohibition Definitions dated 11/26/24, identified physical abuse was defined as: occurs when an individual is injured (hit, slapped, pinched, kicked, scratched, bitten, pushed, burned, controlling behavior through corporal punishment, assaulted or threatened with a weapon or inappropriately restrained). Verbal abuse was defined as: the use of oral, written, or gestured language that willfully includes derogatory terms to VA's or their families within hearing distance, regardless of their age, ability to comprehend, or disability. Psychological, emotional or mental abuse was defined as when a VA experiences trauma after exposure acts or coercive tactics. Examples include but are not limited to threats of punishment or deprivation, and	F0600		

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F0600 SS = SQC-J	Continued from page 12 harassment. The past noncompliance immediate jeopardy began on 2/21/26. The immediate jeopardy was removed and the deficient practice corrected by 2/25/26, after the facility implemented a systemic plan that included the following actions: -Reported Abuse to State Agency (SA). -Investigated the circumstances around allegations of physical and verbal abuse and implemented immediate resident protection. -Re-educated the staff on Abuse/Neglect, reporting, abuse prevention and resident rights, dementia, and vulnerable adult. -Education verified through interview and training records. The facility implemented corrective actions prior to the start of survey on 2/25/25 and therefore this is issued in past noncompliance.	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	F0609		

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F0609 SS = D	Continued from page 13 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 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 and physically abused by NA-B. Finding include: Facility incident report submitted 2/22/26 at 4:22 p.m., identified on 2/22/26 at 2:00 p.m. Staff reported R1 was more tearful today with a decreased appetite. on-call nurse received a call from charge nurse and inquired if anything had been reported regarding concern from the previous evening shift. DON and administrator were notified, and investigation started. It was explained that on 2/21/26 at 7:45 p.m., two staff were caring for R1, the trained medication assistant (TMA)-A was outside R1's door and heard NA-B speaking loudly and demandingly to R1. Following, TMA-A asked NA-A who was in the room with her, what happened and stated NA-B was assisting R1 with perineal cares, R1 swung her arms twice at staff during the care and NA-B started raising her voice at R1 and used an open hand to slap R1's bottom, stating, "if you want to act like a child, you will be treated like a child." R1's quarterly Minimum Data Set (MDS) dated 2/20/26, identified she had unclear speech, with limited verbal and non-verbal skills, would respond adequately to simple, direct communication only, had disorganized thinking, and moderately impaired cognition with long- and short-term memory loss. R1 was dependent upon staff for personal and toileting hygiene, all transfers, bathing, and lower body dressing. She was always incontinent of bladder and frequently incontinent of bowel. R1's medical diagnoses included: non-Alzheimer's dementia, depression, and a psychotic disorder. Medications taken during look back period: antipsychotic, antianxiety, and antidepressant.	F0609		

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F0609 SS = D	Continued from page 14 During an interview on 3/2/26 at 2:39 p.m., TMA-A stated on 2/21/26 at 6:45 p.m., she stood outside R1's closed door preparing medications and heard R1 and NA-B both yelling. NA-B stated hurry up and grab the fucking bar you know how to fucking walk so walk to the bed. The tone of NA-B 's voice was rude and aggressive. TMA remained at the medication cart until NA-A and NA-B exited R1's room. She was unaware NA-A was in the room and asked her what happened. NA-A informed TMA, NA-B had swatted R1 on the butt. At 7:15 p.m. she completed a medication count with the charge nurse LPN-A and informed her about the incident with R1. TMA stated she told LPN-A what she had heard and about the smack on the butt by NA-B. TMA stated because she considered this verbal and physical abuse and was not appropriate way for a resident to be treated under no circumstances, she assumed LPN-A would have called the nurse on call, LPN-B. NA-B continued to work with residents until at least 7:30 p.m. when TMA left for the day. TMA was surprised NA-B was not pulled off work and sent home so that something similar did not happen to another resident and no one would be around to see what happened. TMA stated she had trained NA-B the first day she worked at the facility and had no concerns prior to 2/21/26, it was a real surprise when she heard her yelling at R1. During an interview on 3/2/26 at 7:51 p.m. NA-A stated on 2/21/26, NA-A worked from 2:30 p.m. to 9:30 p.m. with NA-B. While assisting R1 in the bathroom, she became combative, started yelling and grunting loudly when NA-B stated, "stand up" and R1 responded "oh shut up." NA-B stated out loud, if you want to act like a child then you will be treated like one and with an open hand smacked her on the right buttock (skin to skin and sounded like a loud smack). NA-B grabbed R1's walker and said OK, now let's walk to bed. R1 was whining and whimpering like she was in pain, laid down on bed, pillows positioned under her legs, covered up with a blanket, and remote placed. NA-A stated NA-B was verbally and physically abusive, made her very uncomfortable, and cannot imagine how R1 felt. NA-A stated she felt uncomfortable in the bathroom with NA-B because of her stature, her tone of voice, which was loud and aggressive, her use of foul language and R1 was most likely feeling the same way. R1 was making grunting sounds like she was nervous. NA-A stated once she left R1's room she talked to TMA-A, they reported the abuse to the charge nurse LPN-A and was provided with a complaint form to complete and placed it in the DON's box. NA-A felt like nothing was done to protect the residents. The incident should have been reported within two hours and found out the next day it was not	F0609		

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F0609 SS = D	Continued from page 15 reported until later the next day. NA-A stated NA-B was allowed to work after incident, assisted NA-A with another resident transfer and toileting. At 9:30 p.m. left the facility and NA-B remained working with residents. During an interview on 3/3/26 at 2:40 a.m., LPN-A stated that on 2/21/26 just after 7:00 p.m., TMA-A informed her she had stood outside R1's closed door preparing medications and heard raised voices. R1 cried out while staff completed cares. NA-A and NA-B came out of R1's room and NA-A and informed TMA-A she wanted to write a complaint about the other staff NA-B but did not want her to know about it. LPN-A provided NA-A with the complaint form to fill out. NA-A asked LPN-A what to do with the completed form. NA-A showed the form to LPN-A, asked if it looked right. LPN-A did not read the document and probably should have, and informed NA-A the form was to be submitted to DON. LPN-A stated she received a phone call from DON the following day on 2/22/26 and asked if she was aware of the incident with R1. She told DON the staff involved had not offered any information about abuse or anything. LPN-A stated she had no idea until the next day NA-B had been aggressive towards R1. She was aware staff were swearing at R1 and that was concerning. She did not ask any specific questions and should have and should have made a report sooner. LPN-A stated she thought the staff would have told her NA-B hit R1, more attention would have been brought to it if they had. Knowing what she knew now, NA-B slapped R1's butt, roughed her up, swore at her and this was considered abuse. LPN-A stated she thought it was just another staff complaining about a staff due to age difference. LPN-A stated NA-B continued to work the remainder of the shift and answered call lights and cared for residents without supervision until at least 7:00 a.m. LPN-A assisted NA-B with part of her rounds on a few residents (check and changes and toileting) and did not see any concerns. NA-B's tone of voice was gruffer, not sweet at all, loud when she spoke, but appeared to be good with the residents. LPN-A stated she was unsure if NA-B had contact with R1 after the incident. LPN-A stated she was unaware of many things that night, should have asked more questions, sent NA-B home to protect the residents so that there would not have been any chances of her abusing other residents. During an interview on 3/3/26 at 2:53 p.m., DON stated she would have expected LPN-A to have read what NA-A wrote, immediately assess R1's skin and bottom, and contact the on-call nurse LPN-B right away. We had only two hours to report abuse. DON would have wanted to make sure all the residents were safe, and the staff	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Browns Valley Health Center	114 JEFFERSON STREET SOUTH , BROWNS VALLEY, Minnesota, 56219

(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
F0609 SS = D	Continued from page 16 (NA-B) was suspended and no longer in the building so that residents would not suffer any other harm. R1 did not suffer any harm but there was potential for harm, and all residents have the potential for harm. DON stated she believed R1 experienced verbal abuse during this incident. NA-B continued to work on 2/21/26, after the incident until the following morning at 7:01 a.m. LPN-A employee records did indicate she was retrained related to abuse and neglect reporting on 2/23/26. According to the facility schedule, LPN-A was allowed to work on 2/22/26, prior to this training. Additionally, the facility had yet to retrain all employees on abuse and neglect reporting policies prior to survey entrance. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, identified immediate notification to the administrator of any suspected maltreatment is necessary in order to fully assess the situation and proceed with reporting to officials according to regulation. Care center must report to the State Agency (Minnesota Department of Heath) (MDH) any suspected maltreatment (all alleged violations involving abuse, neglect, financial exploitation or maltreatment, including injuries of unknown source and misappropriation of property) immediately, but not later than 2 hours after the allegation is made.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0610		

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F0610 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide sufficient resident protections and assessment following an allegation of abuse for 1 of 1 resident (R1) following a staff to resident abuse allegation. Additionally, the facility failed to complete a thorough investigation following a staff to resident abuse allegation for 1 of 1 resident (R1) when only verbally responsive residents were interviewed for concerns of abuse. Findings include: Facility incident report submitted 2/22/26 at 4:22 p.m., identified on 2/22/26 at 2:00 p.m. Staff reported R1 was more tearful today with a decreased appetite. on-call nurse received a call from charge nurse and inquired if anything had been reported regarding concern from the previous evening shift. DON and administrator were notified, and investigation started. It was explained that on 2/21/26 at 7:45 p.m., two staff were caring for R1, the trained medication assistant (TMA)-A was outside R1's door and heard NA-B speaking loudly and demandingly to R1. Following, TMA-A asked NA-A who was in the room with her, what happened and stated NA-B was assisting R1 with perineal cares, R1 swung her arms twice at staff during the care and NA-B started raising her voice at R1 and used an open hand to slap R1’s bottom, stating, "if you want to act like a child, you will be treated like a child." R1’s quarterly Minimum Data Set (MDS) dated 2/20/26, identified she was admitted to the facility on 12/28/11. She had unclear speech, responded adequately to simple, direct communication only, disorganized thinking, moderately impaired cognition with long and short term memory loss. R1 was dependent upon staff for all cares and transfers. R1’s medical diagnoses included: non-Alzheimer’s dementia, depression, and a psychotic disorder. During an interview on 3/2/26 at 12:25 p.m., registered nurse (RN)-A stated on 2/21/26, at approximately 6:00 p.m. she brought R1 to supper in the wheelchair and no behaviors were noted. On 2/22/26, she came back to work at 6:00 a.m. NA-B had worked the night shift (12 hours) and was still there when she arrived. She received report from LPN-A and there had been no mention about an incident with R1. TMA-A informed her she reported the incident to the charge nurse LPN-A right away that evening right. RN-A waited a couple more hours, most	F0610		

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F0610 SS = D	Continued from page 18 likely shouldn't have, but thought it had been reported to the on-call nurse. She called the on-call nurse after lunch and realized it had not been reported. Within 15 minutes of the call to the DON, she came to the facility. At 9:30 a.m. RN-A completed a skin assessment and no skin concerns noted. The skin assessment was not documented and should have been. RN-A verified NA-B had worked at facility for approximately one month and she did not work directly with her. R1 rarely cried on the night shift, was unable to verbalize what was bothering her, would usually say "ugh ugh" and point at things, staff were expected to document her behaviors every shift in the electronic medical record. R1's medical records lacked evidence of a skin check completed on R1 following initial report of allegation of abuse or the following day. During an interview on 3/2/26 at 2:39 p.m., TMA-A stated on 2/21/26 at 6:45 p.m., she stood outside R1's closed door preparing medications and heard R1 and NA-B both yelling. NA-B stated hurry up and grab the fucking bar you know how to fucking walk so walk to the bed. The tone of NA-B 's voice was rude and aggressive. TMA-A remained at the medication cart until NA-A and NA-B exited R1's room. She was unaware NA-A was in the room and asked her what happened. NA-A informed TMA-A, NA-B had swatted R1 on the butt. At 7:15 p.m. she completed a medication count with the charge nurse LPN-A and informed her about the incident with R1. TMA-A stated she told LPN-A what she had heard and about the smack on the butt by NA-B. TMA-A stated because she considered this verbal and physical abuse and was not appropriate way for a resident to be treated under no circumstances, she assumed LPN-A would have called the nurse on call, LPN-B. NA-B continued to work with residents until at least 7:30 p.m. when TMA left for the day. TMA was surprised NA-B was not pulled off work and sent home so that something similar did not happen to another resident and no one would be around to see what happened. During an interview on 3/2/26 at 3:37 p.m., social service designee (SSD) stated staff would have been expected to monitor any residents unable to be interviewed after incident, during cares and report it to the nurse on duty. SSD stated she visited with R1 daily and had not seen any changes in behaviors. R1 had yelled at SSD this morning "no" but would not say anything more. During an interview on 3/2/26 at 7:51 p.m. NA-A stated	F0610		

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F0610 SS = D	Continued from page 19 she worked from 2:30 p.m. to 9:30 p.m. with NA-B on 2/21/26 and at approximately 6:30 p.m. NA-B was verbally and physically abusive during R1's evening cares. While R1's brief was being placed she became combative and NA-B stated, stand up and R1 responded oh shut up. NA-B stated out loud, if you want to act like a child then you will be treated like one and with an open hand smacked her on the right buttock (skin to skin and sounded like a loud smack). NA-B grabbed R1's walker and said OK, now let's walk to bed. R1 was whining and whimpering like she was in pain, this made NA-A very uncomfortable, and she cannot imagine how R1 felt. NA-A stated she felt uncomfortable in the bathroom with NA-B, she was taller, her tone of voice was loud and aggressive, and she used inappropriate language. R1 was most likely feeling the same way but unable to verbalize how she was feeling and made grunting sounds like she was nervous. NA-A stated once she left R1's room she talked to TMA -A outside R1's door and was asked if NA-B had been aggressive and she told her yes and was afraid of retaliation from NA-B and moved down the hallway with TMA to discuss. Five minutes later she located the charge nurse LPN-A and informed her NA-B had been verbally aggressive and smacked her on her right buttock. LPN-A shook her head and said oh my. NA-A was provided with the complaint form with not a lot of room to write so placed as much information in the small area as she could and placed it in the DON's box. NA-A felt like nothing was done to protect the residents. The incident should have been reported within two hours and found out the next day it was not reported until later the next day. NA-A stated NA-B was allowed to work after incident, assisted NA-A with another resident transfer and toileting. At 9:30 p.m. left the facility and NA-B remained in facility working with residents. During an interview on 3/3/26 at 1:15 p.m. clinical coordinator LPN-C stated she was notified about R1's incident on 2/22/26 at 2:00 p.m. by charge nurse RN-A. NA-B was allowed to finish working her shift on 2/21/26, but if she had been notified and known about the allegations, she would have removed her from the facility and schedule until the investigation was completed. If the allegations were accurate or correct, we would not want it to continue happening and for the safety of the residents. LPN-C stated she notified DON right away and came to facility immediately, arrived just after 2:00 p.m. and started to investigate with staff and resident interviews. The incident happened on 2/21/26 and there were concerns brought to our attention on 2/22/26 about physical and verbal abuse. LPN-C stated she worked her way down each resident	F0610		

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F0610 SS = D	Continued from page 20 hallway randomly interviewed those residents located in their room for a total of 11. LPN-C was unable to verify how or if resident skin checks or behavior chart checks were completed after the incident and recommended checking with DON. LPN-C verified during interview no documentation located in R1's electronic medical record on 2/21/26 regarding the incident and seemed unusual. DON requested RN-A complete R1's assessment on 2/22/26 and would have expected her to document her findings when done. During an interview on 3/3/26 at 2:53 p.m., DON stated she would have expected the charge nurse LPN-A to have read what NA-A wrote, immediately assess R1's skin and bottom, and contact the on-call nurse LPN-B right away. The staff nurses check R1's skin when they complete her treatments every shift and the NAs are always monitoring R1's skin and report unusual skin issues. We should have probably monitored R1's skin at least each shift for three days to ensure no bruise came or was identified to make sure R1 did not have any injuries as a result of the allegations. We would have wanted to make sure all the residents were safe, and the staff (NA-B) was suspended and no longer in the building so that residents would not suffer any other harm. R1 did not suffer any harm but there was potential for harm, and all residents have the potential for harm. DON stated she believed R1 experienced verbal abuse during this incident. NA-B continued to work on 2/21/26 after the incident until the following morning at 7:01 a.m. On 2/22/26, NA-B completed an interview on the phone, no notes were taken. DON requested and received NA-B's written statement that included the same information discussed on the phone on 2/22/26 and was suspended from work. Additional staff involved in the allegation were interviewed and no other staff interviews were completed. DON stated the night staff should have been interviewed that worked with NA-B, especially the NA working the night shift with NA-B that night. The policy was followed, indicated staff interviews. There were no skin checks completed on all residents after the incident. DON stated she would have expected herself to review resident behavior charting to make sure something was not missed and important to see if there was anything unusual out of the norm to help protect the residents. The facility policy was not followed by the charge nurse LPN-A, regarding communicating the incident with the on-call nurse and if she had been notified in a timely manner, things would have been taken care of on Saturday night and NA-B suspended from work. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, identified staff shall immediately report to	F0610		

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F0610 SS = D	Continued from page 21 their supervisor any suspected maltreatment. The supervisor shall first ensure the resident is safe and complete and initial assessment in order to determine if there is potential abuse, neglect or other type of maltreatment. The immediate supervisor or person responsible for the implementing actions of the Maltreatment Prohibition Policy shall: 1. Immediately suspend staff person(s) involved in the alleged maltreatment pending the outcome of the investigation. 2. Begin conducting an investigation of the alleged maltreatment, which may include resident and staff interviews, observations, and medical record review. The investigation shall be completed as much as able within five working days, at which time the investigation findings will be updated on the MDH/OHFC website.	F0610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2026

Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

Re: Event ID: 1F225B-H1

Dear Administrator:

The above facility survey was completed on March 4, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/04/2026**

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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 3/2/26 through 3/4/26, 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. H55646982C (2785510)	20000		

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/04/2026**

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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		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 23, 2026

Administrator
Browns Valley Health Center
114 JEFFERSON STREET SOUTH
BROWNS VALLEY, MN 56219

RE: CCN: 245564
Cycle Start Date: March 4, 2026

Dear Administrator:

On March 19, 2026, we notified you a remedy was imposed. On April 16, 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 16, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 4, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 19, 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 4, 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

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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F0000	INITIAL COMMENTS On 3/2/26, through 3/4/26, 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 H55646982C (2785510) with a deficiency issued at F600 PAST NON-COMPLIANCE. Additionally, deficient practice was identified related to incidental findings at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in 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		03/31/2026
F0600 SS = SQC-J	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"	03/24/2026

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

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F0600 SS = SQC-J	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 1 resident (R1) from abuse when nurse aid (NA)-B physically and verbally abused R1 during cares. This resulted in serious psychosocial harm for R1 who became withdrawn, had a decreased appetite, and increased crying following the incident. The IJ began on 2/21/26 at 7:45 p.m., when NA-B was witnessed to make derogatory statements, used foul and aggressive language, and slapped R1 on the backside. NA-B 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 3/4/25 at 1:00 p.m. The facility implemented corrective action by 2/25/25 prior to the start of the survey and therefore is issued as past non-compliance. Findings include: Facility incident report submitted 2/22/26 at 4:22 p.m., identified on 2/22/26 at 2:00 p.m., staff reported R1 was more tearful today with a decreased appetite. on-call nurse received a call from charge nurse and inquired if anything had been reported regarding concern from the previous evening shift. Director of nursing (DON) and administrator were notified, and an investigation was started. It was explained that on 2/21/26 at 7:45 p.m., two staff were caring for R1, the trained medication assistant (TMA)-A was outside R1's door and heard NA-B speaking loudly and demandingly to R1. Following, TMA-A asked NA-A who was in the room with her, what happened and stated NA-B was assisting R1 with peri cares, R1 swung her arms at staff and NA-B started raising her voice at R1 and used an open hand to slap R1’s bottom, stating, "if you want to act like a child, you will be treated like a child." R1’s quarterly Minimum Data Set (MDS) dated 2/20/26, identified she had unclear speech, with limited verbal and non-verbal skills, would respond adequately to simple, direct communication only, had disorganized thinking, and moderately impaired cognition with long-term and short-term memory loss. R1 was dependent upon staff for personal and toileting hygiene, all transfers, bathing, and lower body dressing. She was always incontinent of bladder and frequently	F0600		

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F0600 SS = SQC-J	Continued from page 2 incontinent of bowel. R1's medical diagnoses included: non-Alzheimer's dementia, depression, and a psychotic disorder. Medications taken during look back period: antipsychotic, antianxiety, and antidepressant. R1's care plan dated 11/18/25, identified activities of daily living (ADL) self-care performance deficit related to dementia. Staff were directed to aid of one for bathing and hygiene and assistance of two for toilet use, ambulation, transfers, bed mobility, and dressing. R1 had impaired cognitive function/dementia or intellectual disability and can act out with attention seeking behaviors towards others in line with estimated age of an 8-year-old per family. Staff were directed to face her when speaking, making eye contact, and reduce distractions. She understood simple, directive sentences. Provide R1 with necessary cues, stop and return if agitated. R1 used anti-anxiety mediations (Ativan) related to anxiety disorder. Her target behaviors included: peri area scratching, refusal to talk, slamming doors, and throwing objects. Staff were directed to use non-pharm interventions: leave her and return later to complete an activity to allow her time to calm self-down, do not ask me "what is wrong," use quiet voice, allow freedom to refuse as she is safe to do so. Observe R1 for changes in mood and update provider with concerns. R1's progress notes from 2/21/26 through 2/25/26, identified: -No documentation in progress notes for 2/21/26. -On 2/22/26 at 11:56 a.m., R1 was sitting in the coliseum in her wheelchair and started crying. When approached by writer, tried to talk to her and continued to cry. She was asked if she wanted to lay down and she shook her head yes. R1 was taken to her room and laid down. -On 2/22/26 at 12:11 p.m., R1 refused to get up for dinner and was assisted to the side of the bed. She placed her feet back in the bed and rested quietly at this time. -On 2/23/26 at 10:04 a.m., R1 was very vocal with staff this morning with cares when they tried to get her up. R1 calmed down after she got in her wheelchair. -On 2/23/26 at 2:03 p.m., Yelling at staff. God Damn [sic] it when they are toileting her. Staff redirected her to task at hand.	F0600		

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F0600 SS = SQC-J	Continued from page 3 -On 2/25/26 at 9:18 a.m., Yelling, hitting, and scratching staff when they were doing her morning cares. Tried to calm her. R1 was ok and went to breakfast after cares being done. -On 3/2/26 at 2:20 p.m., Late Entry: After initial report was filed. DON contacted provider via telephone and spoke to her about the incident. DON called guardian to discuss vulnerable adult (VA) was filed on R1 and she was safe and did not suffer any physical harm. Guardian was very thankful for the update. -On 3/2/26 Late Entry: On 2/22/26 at 9:30 a.m., R1 was taken to her room and laid down, a full body assessment was done and no bruises were noted. R1 did not verbalize any pain or discomfort. R1's Nursing Assistant (NA) Behavior Monitoring and Interventions Report from 2/16/26 through 2/26/26: - 2/16/26 at 7:32 p.m., screaming at others. Intervention: moved to calm environment. Behavior better/improved. -On 2/22/26 at 7:22 p.m., Sad, tearful, withdrawn, and isolating. Intervention: Provide calm environment. Behaviors: better/improved. -On 2/23/26 at 10:03 a.m., Expressed frustration/anger at others and agitated. Intervention: Toilet. Behaviors: worsened. -On 2/23/26 at 1:59 p.m., Screaming at others. No interventions identified. -On 2/24/26 at 9:53 a.m., Cursing at others, express frustration/anger at others, and agitated. Intervention: reapproach. Behaviors: improved. -On 2/25/26 at 1:59 p.m., Hitting and scratching others and physically aggressive towards others. Intervention: Provide calm environment and toilet. Behaviors worsened. -On 2/25/26 at 7:22 p.m., Hitting, scratching, physically aggressive to others, and screaming at others. Intervention: Provide calm environment and toilet. Behaviors worsened. -On 2/26/26 at 1:59 p.m., Hitting, scratching, physically aggressive to others, cursing and screaming	F0600		

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F0600 SS = SQC-J	Continued from page 4 at others. Intervention: Provide calm environment and toilet. Behaviors worsened. Review of NA Behavior Monitoring from 2/8/26 through 2/21/26, identified no behaviors were observed/documented from 2/8/26 through 2/15/26 and 2/17/26 through 2/21/26 (13 days). R1's nurse behavioral documentation from 2/1/26 through 2/28/26, my target behaviors (choices to choose from): hitting, kicking, yelling, animal-like noises, seeing/hearing things, tantrums, feeling down/having little energy, irritable, sad affect & refusing to talk. Peri-area-scratching causes self-harm, slamming doors, throwing objects. Non pharm: turn on country music, leave me and return later to complete an activity to allow me time to calm myself, do not "ask me what is wrong" use calm quiet voice, allow her freedom to refuse as she is safe to do so. Every day (day and night shift) check marks (indicated no behaviors) were entered except on two-day shifts 2/20/26 and 2/28/26 were left blank. NA-B's timecard identified on 2/21/26, scheduled to work from 6:30 p.m. to 7:00 a.m. Time clocked in 6:28 p.m. and time clocked out 7:01 a.m. Worked 12 hours. NA-B scheduled to work 2/22/26 at 6:30 p.m. to 7:00 a.m. no time entered. NA-A was not scheduled for any other shifts or dates. Employee Concern document dated 2/21/26, at 7:04 p.m. The purpose of this form is to document what performance or action is a concern based on facility core values. This form is routed to the department supervisor for further investigation and follow-up. Staff person completing report and witness to the incident: NA-A. Performance issue or concern (be specific): While putting R1 to bed at 7:04 p.m. during the washing and toileting, R1 was hollering while trying to wipe her. NA-B proceeded to be vocally aggressive, and likewise R1 has a hard time getting off the toilet and hollered. NA-B then smacked R1's butt and said "you wanna [sic] act like a child you can get treated like one," etc. NA-B termination document dated 2/27/26, identified discharged. Supervisor comments: employee did not respond regarding training, coming in, or texts.	F0600		

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F0600 SS = SQC-J	Continued from page 5 During an interview on 3/2/26 at 12:25 p.m., registered nurse (RN)-A stated R1 functioned at the level of an 8 to 10-year-old, occasionally swore, hit, kicked, slapped during cares, and rarely spoke in sentences. On 2/21/26, at approximately 6:00 p.m. she brought R1 to supper in the wheelchair and no behaviors were noted. On 2/22/26, she came back to work at 6:00 a.m. NA-B had worked the night shift (12 hours) and was still there when she arrived. She received report from licensed practical nurse (LPN)-A and there had been no mention about an incident with R1. RN-A completed treatment rounds when a NA approached her and asked, if she had heard what happened, adding, R1 and NA-B were yelling at each other yesterday. Additionally, a TMA-A informed her that she stood outside R1's closed door, heard her screaming and probably should have gone into the room. But then NA-A came out of the room with a funny look on her face (eyes wide open and bewildered look) and informed TMA-A, NA-B had told R1 to quit being a baby, grab the bar, fucking get up, go to the bathroom, because you are not a baby, and swatted R1 on her bottom. RN-A stated she was shocked and knew it was possible physical and verbal abuse. TMA-A informed her she reported the incident to the charge nurse LPN-A right away that evening right away. RN-A waited a couple more hours, most likely shouldn't have, but thought it had been reported to the on-call nurse. She called the on-call nurse and realized it had not been reported. Within 15 minutes of the call to the DON, she came to the facility. At 9:30 a.m. RN-A completed a skin assessment and no skin concerns noted. The skin assessment was not documented and should have been. RN-A verified NA-B had worked at the facility for approximately one month and she did not work directly with her. R1 rarely cried on the night shift, was unable to verbalize what was bothering her, would usually say "ugh ugh" and point at things, staff were expected to document her behaviors every shift in the electronic medical record. Follow-up interview on 3/3/26 at 5:15 p.m., RN-A stated on 2/22/26, R1 was out of bed and sat in her wheelchair for breakfast but refused to eat and started crying in the coliseum. RN-A stated she was unaware of the incident when she approached R1, tried to talk to her, but she kept crying. RN-A stated after she saw R1 crying, withdrawn, and refusing to eat, she knew something was wrong. She had known her for three years and had only seen her like this one other time. RN-A stated R1 does not cry for no reason, something was wrong. On 2/22/26, RN-A offered R1 snacks, meals	F0600		

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F0600 SS = SQC-J	Continued from page 6 and liquids and she refused all of them. This type of behavior for R1 was not considered normal, it was obvious something had happened. RN-A stated R1 functioned like a child, comparable to children, she would get really quiet and that's how she reacted on 2/22/26, like the incident made her feel sad. During an interview on 3/2/26 at 2:39 p.m., TMA-A stated on 2/21/26 at 6:45 p.m., she stood outside R1's closed door preparing medications and heard R1 and NA-B both yelling. NA-B stated hurry up and grab the fucking bar, you know how to fucking walk, so walk to the bed. The tone of NA-B 's voice was rude and aggressive. TMA-A remained at the medication cart until NA-A and NA-B exited R1's room. She was unaware NA-A was in the room and asked her what happened. NA-A informed TMA-A, NA-B had swatted R1 on the butt. At 7:15 p.m. she completed a medication count with the charge nurse LPN-A and informed her about the incident with R1. TMA-A stated she told LPN-A what she had heard and about the smack on the butt by NA-B. TMA-A stated because she considered this verbal and physical abuse and was not appropriate way for a resident to be treated under no circumstances, she assumed LPN-A would have called the nurse on call. NA-B continued to work with residents until at least 7:30 p.m. when TMA-A left for the day. TMA-A was surprised NA-B was not pulled off work and sent home so that something similar did not happen to another resident and no one would be around to see what happened. During an interview on 3/2/26 at 3:37 p.m., social service designee (SSD) stated R1's cognition was severely impaired with dementia, she was able to answer simple yes or no questions and chose not to speak at all at times. Staff were expected to respond to R1's behaviors by allowing her time and/or another staff to reapproach her. Staff would have been expected to monitor any residents unable to be interviewed after incident, during cares and report it to the nurse on duty. SSD stated she visited with R1 daily and had not seen any changes in behaviors. R1 had yelled at SSD this morning "no" but would not say anything more. During an interview on 3/2/26 at 7:51 p.m., NA-A stated on 2/21/26, she worked from 2:30 p.m. to 9:30 p.m. with NA-B. She did not have concerns about NA-B prior to the incident that night, other than NA-B's tone of voice threw her off because she could be loud and intimidating. At approximately 6:30 p.m., NA-A and NA-B assisted R1 in the bathroom. NA-A cleaned her bottom	F0600		

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F0600 SS = SQC-J	Continued from page 7 when charge nurse LPN-A entered the room and told NA-B, R1 could walk to the bed with the walker and left the room. While R1's brief was being placed she became combative, started yelling and grunting loudly, at that time NA-B stated, "stand up" and R1 responded "oh shut up." NA-B stated out loud, if you want to act like a child then you will be treated like one and with an open hand smacked her on the right buttock (skin to skin and sounded like a loud smack). NA-B grabbed R1's walker and said OK, now let's walk to bed. R1 was whining and whimpering like she was in pain, laid down on bed, pillows positioned under her legs, covered up with a blanket, and remote placed. NA-A stated NA-B was verbally and physically abusive, made her very uncomfortable, and cannot imagine how R1 felt. NA-A stated she felt uncomfortable in the bathroom with NA-B because of her stature, her tone of voice, which was loud and aggressive, her use of foul language and R1 was most likely feeling the same way. R1 was making grunting sounds like she was nervous. NA-A stated once she left R1's room she talked to TMA outside R1's door and was asked if NA-B had been aggressive and she told her yes but was afraid of retaliation from NA-B. Five minutes later she located the charge nurse LPN-A and reported the incident of abuse. NA-A was provided with a complaint form with not a lot of room to write, so she placed as much information in the small area as she could and placed it in the DON's box. NA-A felt like nothing was done to protect the residents. The incident should have been reported within two hours and found out the next day it was not reported until later the next day. NA-A stated NA-B was allowed to work after incident, assisted NA-A with another resident transfer and toileting. At 9:30 p.m. left the facility and NA-B remained working with residents. During an interview on 3/3/26 at 1:15 p.m., clinical coordinator LPN-C stated she was notified about the allegation of abuse incident on 2/22/26 at 2:00 p.m., by charge nurse RN-A instructed her to have TMA-A write out what she heard and when. She was on call the entire weekend and would have expected LPN-A to notify her on 2/21/26 immediately so that an investigation could start and reported according to the guidelines. LPN-C stated she was not notified on 2/21/26, for concerns of physical and verbal abuse. NA-B was allowed to finish working her shift on 2/21/26, but if she had been notified and known about the allegations, she would have removed her from the facility and the schedule until the investigation was completed. LPN-C stated she notified DON right away and came to facility immediately, arrived just after 2:00 p.m. and started to investigate with staff and resident interviews. The	F0600		

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F0600 SS = SQC-J	Continued from page 8 incident happened on 2/21/26 and there were concerns brought to our attention on 2/22/26 about physical and verbal abuse. During an interview on 3/3/26 at 2:40 a.m., LPN-A stated on 2/21/26 just after 7:00 p.m., TMA-A informed her she had stood outside R1's closed door preparing medications and heard raised voices. R1 cried out while staff completed cares. NA-A and NA-B came out of R1's room and NA-A and informed TMA-A she wanted to write a complaint about the other staff NA-B but did not want her to know about it. LPN-A provided NA-A with the complaint form to fill out. NA-A asked LPN-A what to do with the completed form. NA-A showed the form to LPN-A, asked if it looked right. LPN-A did not read the document and probably should have, and informed NA-A the form was to be submitted to the DON. LPN-A stated she received a phone call from DON the following day on 2/22/26 and asked if she was aware of the incident with R1. She told DON the staff involved had not offered any information about abuse or anything. LPN-A stated she had no idea until the next day NA-B had been aggressive towards R1. She was aware staff were swearing at R1 and that was concerning. She did not ask any specific questions and should have and should have made a report sooner. LPN-A stated she thought the staff would have told her NA-B hit R1, more attention would have been brought to it if they had. Knowing what she knew now, NA-B slapped R1's butt, roughed her up, swore at her and this was considered abuse. LPN-A stated she thought it was just another staff complaining about a staff due to age difference. LPN-A stated NA-B continued to work the remainder of the shift and answered call lights and cared for residents without supervision until at least 7:00 a.m. LPN-A assisted NA-B with part of her rounds on a few residents (check and changes and toileting) and did not see any concerns. NA-B's tone of voice was gruffer, not sweet at all, loud when she spoke, but appeared to be good with the residents. LPN-A stated she was unsure if NA-B had contact with R1 after the incident. LPN-A stated she was unaware of many things that night, should have asked more questions, sent NA-B home to protect the residents so that there would not have been any chances of her abusing other residents. During an interview on 3/3/26 at 2:53 p.m., DON stated that on 2/22/26 at approximately 1:45 p.m., she had received a call from on-call nurse LPN-A and asked her if she had received a call from the facility. The day charge nurse RN-A had called LPN-A and asked why NA-B remained on the schedule because staff had told her how NA-B had swatted R1. DON informed LPN-A	F0600		

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F0600 SS = SQC-J	Continued from page 9 she was not aware of this incident, immediately came to the facility, and hit the floor running. DON stated she opened her office door and found a written statement dated 2/22/26 from TMA-A and in the locked box dated 2/21/26 from NA-A. TMA-A was pulled into the DON's office to give oral statement and interview. NA-A informed DON she heard swearing and NA-B stated grab the fucking bar. DON asked TMA-A why she did not enter R1's room when she heard NA-B speak to R1 like that. TMA-A informed DON she did not want to leave R1's narcotics on the medication cart. DON stated she would have expected TMA-A to open R1's door and check to see what was going on, for the protection of the residents. DON stated TMA-A could have used her radio to contact the charge nurse LPN-A and asked her to come to R1's room immediately if she had concerns. On 2/22/26, NA-A was called in for an interview/statement. NA-A demonstrated on DON what she witnessed on 2/21/26. NA-A stated NA-B wiped R1's bottom and stated in a loud tone, if you want to act like a child, you can get treated like one and swatted her on the bottom with an open hand. NA-A did not indicate NA-B swore at R1. NA-A demonstrated physically on DON per her request, how she witnessed the incident when NA-B swatted R1's bottom. DON stated the swat did not feel like she was abused but felt it was not ok to do to a resident, and no staff should swat the bottom of any resident. At 7:00 p.m. on 2/21/26, TMA -A talked to LPN-B during a medication count and informed her she heard swearing and R1 was crying. Additionally, NA-A informed LPN-B after incident on 2/21/26, she had a concern about NA-B and requested a concern form. Form was given to NA-A, completed, and placed in DON's box. DON stated she would have expected the charge nurse LPN-A to have read what NA-A wrote, immediately assess R1's skin and bottom, and contact the on-call nurse LPN-B right away. We had only two hours to report abuse. DON would have wanted to make sure all the residents were safe, and the staff (NA-B) was suspended and no longer in the building so that residents would not suffer any other harm. R1 did not suffer any harm but there was potential for harm, and all residents have the potential for harm. DON stated she believed R1 experienced verbal abuse during this incident. NA-B continued to work on 2/21/26 after the incident until the following morning at 7:01 a.m. On 2/22/26. NA-B completed an interview over the phone; no notes were taken. DON requested and received NA-B's written statement that included the same information discussed on the phone on 2/22/26 and was suspended from work. The facility policy was not followed by the charge nurse LPN-A, regarding communicating the incident with the on-call nurse and if she had been notified in a timely manner, things would have been taken care of on	F0600		

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F0600 SS = SQC-J	Continued from page 10 Saturday night and NA-B suspended from work. Maltreatment was verified by the witnesses: TMA-A verified verbal abuse and NA-A verified verbal and physical abuse by NA-B. During an interview on 3/4/26 at 10:21 a.m. NA-E stated R1's cognition was comparable to autism spectrum, struggled with verbalizing how she felt and knew more than she was able to verbalize. NA-E stated she was familiar with R1 and worked with her for over five years. R1 was a friendly and interactive person, loved activities, animals especially dogs, and children. R1 experienced a mental decline which seemed to have started approximately three years ago. R1 can get quite aggressive and overwhelmed at times, interventions used to help avoid and/or deescalate behaviors were distraction with music/pop/popcorn/stuffed animals, reapproach, remain calm, talk to her in a quiet voice in few simple words, and avoid using a loud voice to tell her what you are about to do. NA-E stated on 2/22/26, she entered R1's room in the morning and she was dry, laid in a wet bed, got her up and had taken her to breakfast. R1 sat in her wheelchair and was very quiet, not aggressive, refused to eat or drink, started crying, and laid her down in bed per RN-A's request. R1 refused to respond verbally when asked what was bothering her. At 11:30 a.m. R1 placed her call light on, was incontinent of urine, care provided, again she was not making any noises, withdrawn and not aggressive like she usually was with cares, she was different than normal. At 1:00 p.m. NA-E noted R1 was not up for lunch, went to her room, informed her it was time for lunch and assisted her up to the side of the bed. R1 started to grunt, unable to keep herself from sitting up, NA-E supported her upper body with a hand, and R1 started to cry and said no. NA-E asked R1, don't you want to get up, and she stated no and laid back down. NA-E stated this behavior was not normal for R1 and reported to RN-A and on-call nurse LPN-B was called. R1 stayed in bed all day, did not eat, drink or attend activities. NA-E offered R1 pop with a straw in it (usually drank at least two to three pops a day) and not one drink accepted, which was odd for her. NA-E stated during the incident on 2/21/26, R1 most likely felt helpless and scared. She appeared impacted when she did not want to get out of bed, was exhausted, withdrawn, refused food and pop and just wanted to sleep the next day. Unable to interview NA-B, call placed on 3/2/26 at 3:15 p.m. unable to leave message, phone disconnected.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

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F0600 SS = SQC-J	Continued from page 11 Unable to interview family/guardian on 3/2/26 at 4:23 p.m. and 3/3/25 at 5:13 p.m. messages left, no return call received. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, identified care center will report any allegations of maltreatment of a vulnerable adult (VA) resident in our care center to the appropriate authorities as required by abuse reporting for Federal Regulations and maltreatment reporting for the Minnesota State Statues. Immediate notification to the administrator of any suspected maltreatment is necessary to fully assess the situation and proceed with reporting to officials according to regulation. Care center must report to the State Agency Minnesota Department of Health (MDH) any suspected maltreatment (alleged violations involving abuse neglect, financial exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) immediately but not later than 2 hours after the allegation was made. If alleged maltreatment occurs: Staff shall immediately report to their supervisor any suspected maltreatment, ensure the resident is safe, complete an initial assessment to determine if there is potential abuse, neglect or other type of maltreatment. The immediate supervisor or person responsible for implementing actions of Maltreatment Prohibition Policy shall: immediately suspend staff person(s) involved in the alleged maltreatment pending the outcome of the investigation. Begin investigating the alleged maltreatment, which may include resident and staff interviews, observations and medical record review and complete as much as possible within five working days as possible. Facility policy Maltreatment Prohibition Definitions dated 11/26/24, identified physical abuse was defined as: occurs when an individual is injured (hit, slapped, pinched, kicked, scratched, bitten, pushed, burned, controlling behavior through corporal punishment, assaulted or threatened with a weapon or inappropriately restrained). Verbal abuse was defined as: the use of oral, written, or gestured language that willfully includes derogatory terms to VA's or their families within hearing distance, regardless of their age, ability to comprehend, or disability. Psychological, emotional or mental abuse was defined as when a VA experiences trauma after exposure acts or coercive tactics. Examples include but are not limited to threats of punishment or deprivation, and	F0600		

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F0600 SS = SQC-J	Continued from page 12 harassment. The past noncompliance immediate jeopardy began on 2/21/26. The immediate jeopardy was removed and the deficient practice corrected by 2/25/26, after the facility implemented a systemic plan that included the following actions: -Reported Abuse to State Agency (SA). -Investigated the circumstances around allegations of physical and verbal abuse and implemented immediate resident protection. -Re-educated the staff on Abuse/Neglect, reporting, abuse prevention and resident rights, dementia, and vulnerable adult. -Education verified through interview and training records. The facility implemented corrective actions prior to the start of survey on 2/25/25 and therefore this is issued in past noncompliance.	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	F0609	The allegation referenced in the Statement of Deficiencies was immediately reviewed by the Administrator and Director of Nursing. The required report was submitted to the State Survey Agency, and the investigation was completed. (R1) was assessed and found to have no physical injuries. No residents experienced harm as a result of the reporting delay. All documentation related to the allegation has been corrected and finalized. A facility wide audit of all incidents, grievances, and allegations from the previous 90 days was conducted to ensure that all allegations of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation were reported within the required 2 hour/24 hour timeframes and that all 5 day investigation reports were submitted timely. No additional reporting delays were identified. The facility's Maltreatment Reporting Guidelines and Maltreatment Investigation Policy were reviewed with staff, including:	04/01/2026

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F0609 SS = D	Continued from page 13 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 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 and physically abused by NA-B. Finding include: Facility incident report submitted 2/22/26 at 4:22 p.m., identified on 2/22/26 at 2:00 p.m. Staff reported R1 was more tearful today with a decreased appetite. on-call nurse received a call from charge nurse and inquired if anything had been reported regarding concern from the previous evening shift. DON and administrator were notified, and investigation started. It was explained that on 2/21/26 at 7:45 p.m., two staff were caring for R1, the trained medication assistant (TMA)-A was outside R1's door and heard NA-B speaking loudly and demandingly to R1. Following, TMA-A asked NA-A who was in the room with her, what happened and stated NA-B was assisting R1 with perineal cares, R1 swung her arms twice at staff during the care and NA-B started raising her voice at R1 and used an open hand to slap R1’s bottom, stating, "if you want to act like a child, you will be treated like a child." R1’s quarterly Minimum Data Set (MDS) dated 2/20/26, identified she had unclear speech, with limited verbal and non-verbal skills, would respond adequately to simple, direct communication only, had disorganized thinking, and moderately impaired cognition with long- and short-term memory loss. R1 was dependent upon staff for personal and toileting hygiene, all transfers, bathing, and lower body dressing. She was always incontinent of bladder and frequently incontinent of bowel. R1’s medical diagnoses included: non-Alzheimer’s dementia, depression, and a psychotic disorder. Medications taken during look back period: antipsychotic, antianxiety, and antidepressant.	F0609	Continued from page 13 • Immediate reporting requirements • 2 hour and 24 hour reporting rules • 5 day investigation submission requirements • Staff responsibilities and communication pathways All staff completed required education on 03/02/2026, including: Maltreatment Prohibition Definitions Maltreatment Investigation and Reporting Maltreatment Reporting Guidelines Stress Management Abuse Prevention and Resident Rights Vulnerable Adult • Dementia Management These systemic changes reinforce timely reporting, accurate documentation, and clear communication pathways. The Director of Nursing or designee will conduct: Daily audits of all incident reports and allegations for 1 weeks Triweekly audits for 3 weeks Bi-weekly audits for 2 weeks Weekly x 1 month Each audit will verify: Vulnerable adult concerns or signs of suspected abuse or neglect. Whether the Charge Nurse was notified. Whether the On Call Nurse was notified. Whether the concern was reportable and, if so, whether it was reported timely. Documentation completeness and accuracy Audit results will be reviewed during QAPI meetings. Any identified issues will result in immediate corrective action. The facility will be in full compliance by April 1,	

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F0609 SS = D	Continued from page 14 During an interview on 3/2/26 at 2:39 p.m., TMA-A stated on 2/21/26 at 6:45 p.m., she stood outside R1's closed door preparing medications and heard R1 and NA-B both yelling. NA-B stated hurry up and grab the fucking bar you know how to fucking walk so walk to the bed. The tone of NA-B 's voice was rude and aggressive. TMA remained at the medication cart until NA-A and NA-B exited R1's room. She was unaware NA-A was in the room and asked her what happened. NA-A informed TMA, NA-B had swatted R1 on the butt. At 7:15 p.m. she completed a medication count with the charge nurse LPN-A and informed her about the incident with R1. TMA stated she told LPN-A what she had heard and about the smack on the butt by NA-B. TMA stated because she considered this verbal and physical abuse and was not appropriate way for a resident to be treated under no circumstances, she assumed LPN-A would have called the nurse on call, LPN-B. NA-B continued to work with residents until at least 7:30 p.m. when TMA left for the day. TMA was surprised NA-B was not pulled off work and sent home so that something similar did not happen to another resident and no one would be around to see what happened. TMA stated she had trained NA-B the first day she worked at the facility and had no concerns prior to 2/21/26, it was a real surprise when she heard her yelling at R1. During an interview on 3/2/26 at 7:51 p.m. NA-A stated on 2/21/26, NA-A worked from 2:30 p.m. to 9:30 p.m. with NA-B. While assisting R1 in the bathroom, she became combative, started yelling and grunting loudly when NA-B stated, "stand up" and R1 responded "oh shut up." NA-B stated out loud, if you want to act like a child then you will be treated like one and with an open hand smacked her on the right buttock (skin to skin and sounded like a loud smack). NA-B grabbed R1's walker and said OK, now let's walk to bed. R1 was whining and whimpering like she was in pain, laid down on bed, pillows positioned under her legs, covered up with a blanket, and remote placed. NA-A stated NA-B was verbally and physically abusive, made her very uncomfortable, and cannot imagine how R1 felt. NA-A stated she felt uncomfortable in the bathroom with NA-B because of her stature, her tone of voice, which was loud and aggressive, her use of foul language and R1 was most likely feeling the same way. R1 was making grunting sounds like she was nervous. NA-A stated once she left R1's room she talked to TMA-A, they reported the abuse to the charge nurse LPN-A and was provided with a complaint form to complete and placed it in the DON's box. NA-A felt like nothing was done to protect the residents. The incident should have been reported within two hours and found out the next day it was not	F0609	Continued from page 14 2026.	

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F0609 SS = D	Continued from page 15 reported until later the next day. NA-A stated NA-B was allowed to work after incident, assisted NA-A with another resident transfer and toileting. At 9:30 p.m. left the facility and NA-B remained working with residents. During an interview on 3/3/26 at 2:40 a.m., LPN-A stated that on 2/21/26 just after 7:00 p.m., TMA-A informed her she had stood outside R1's closed door preparing medications and heard raised voices. R1 cried out while staff completed cares. NA-A and NA-B came out of R1's room and NA-A and informed TMA-A she wanted to write a complaint about the other staff NA-B but did not want her to know about it. LPN-A provided NA-A with the complaint form to fill out. NA-A asked LPN-A what to do with the completed form. NA-A showed the form to LPN-A, asked if it looked right. LPN-A did not read the document and probably should have, and informed NA-A the form was to be submitted to DON. LPN-A stated she received a phone call from DON the following day on 2/22/26 and asked if she was aware of the incident with R1. She told DON the staff involved had not offered any information about abuse or anything. LPN-A stated she had no idea until the next day NA-B had been aggressive towards R1. She was aware staff were swearing at R1 and that was concerning. She did not ask any specific questions and should have and should have made a report sooner. LPN-A stated she thought the staff would have told her NA-B hit R1, more attention would have been brought to it if they had. Knowing what she knew now, NA-B slapped R1's butt, roughed her up, swore at her and this was considered abuse. LPN-A stated she thought it was just another staff complaining about a staff due to age difference. LPN-A stated NA-B continued to work the remainder of the shift and answered call lights and cared for residents without supervision until at least 7:00 a.m. LPN-A assisted NA-B with part of her rounds on a few residents (check and changes and toileting) and did not see any concerns. NA-B's tone of voice was gruffer, not sweet at all, loud when she spoke, but appeared to be good with the residents. LPN-A stated she was unsure if NA-B had contact with R1 after the incident. LPN-A stated she was unaware of many things that night, should have asked more questions, sent NA-B home to protect the residents so that there would not have been any chances of her abusing other residents. During an interview on 3/3/26 at 2:53 p.m., DON stated she would have expected LPN-A to have read what NA-A wrote, immediately assess R1's skin and bottom, and contact the on-call nurse LPN-B right away. We had only two hours to report abuse. DON would have wanted to make sure all the residents were safe, and the staff	F0609		

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F0609 SS = D	Continued from page 16 (NA-B) was suspended and no longer in the building so that residents would not suffer any other harm. R1 did not suffer any harm but there was potential for harm, and all residents have the potential for harm. DON stated she believed R1 experienced verbal abuse during this incident. NA-B continued to work on 2/21/26, after the incident until the following morning at 7:01 a.m. LPN-A employee records did indicate she was retrained related to abuse and neglect reporting on 2/23/26. According to the facility schedule, LPN-A was allowed to work on 2/22/26, prior to this training. Additionally, the facility had yet to retrain all employees on abuse and neglect reporting policies prior to survey entrance. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, identified immediate notification to the administrator of any suspected maltreatment is necessary in order to fully assess the situation and proceed with reporting to officials according to regulation. Care center must report to the State Agency (Minnesota Department of Heath) (MDH) any suspected maltreatment (all alleged violations involving abuse, neglect, financial exploitation or maltreatment, including injuries of unknown source and misappropriation of property) immediately, but not later than 2 hours after the allegation is made.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0610	Browns Valley Health Center's intent is to ensure all residents are thoroughly investigated through interviews with all cognitively intact residents. For residents that are nonverbal and /or not cognitively intact the facility will initiate behavior monitoring and skin checks to identify any potential signs of Maltreatment. R1 had a full body assessment completed to assess for injuries, pain or discomfort. Social Service Designee was directed to visit with R1to complete routine safety checks and comfort checks. R1's representative was notified in accordance with facility policy and regulatory requirements. The facility will immediately remove the alleged perpetrator from resident cares pending investigation. A mandatory reporting template was developed for Charge Nurses to ensure all events requiring reporting are immediately flagged. The Director of Nursing or Designee will review the previous 90 days of incidents, nurses' notes and grievance reports to identify any unreported or late reported allegations. No additional findings were noted.	04/01/2026

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F0610 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide sufficient resident protections and assessment following an allegation of abuse for 1 of 1 resident (R1) following a staff to resident abuse allegation. Additionally, the facility failed to complete a thorough investigation following a staff to resident abuse allegation for 1 of 1 resident (R1) when only verbally responsive residents were interviewed for concerns of abuse. Findings include: Facility incident report submitted 2/22/26 at 4:22 p.m., identified on 2/22/26 at 2:00 p.m. Staff reported R1 was more tearful today with a decreased appetite. on-call nurse received a call from charge nurse and inquired if anything had been reported regarding concern from the previous evening shift. DON and administrator were notified, and investigation started. It was explained that on 2/21/26 at 7:45 p.m., two staff were caring for R1, the trained medication assistant (TMA)-A was outside R1's door and heard NA-B speaking loudly and demandingly to R1. Following, TMA-A asked NA-A who was in the room with her, what happened and stated NA-B was assisting R1 with perineal cares, R1 swung her arms twice at staff during the care and NA-B started raising her voice at R1 and used an open hand to slap R1’s bottom, stating, "if you want to act like a child, you will be treated like a child." R1’s quarterly Minimum Data Set (MDS) dated 2/20/26, identified she was admitted to the facility on 12/28/11. She had unclear speech, responded adequately to simple, direct communication only, disorganized thinking, moderately impaired cognition with long and short term memory loss. R1 was dependent upon staff for all cares and transfers. R1’s medical diagnoses included: non-Alzheimer’s dementia, depression, and a psychotic disorder. During an interview on 3/2/26 at 12:25 p.m., registered nurse (RN)-A stated on 2/21/26, at approximately 6:00 p.m. she brought R1 to supper in the wheelchair and no behaviors were noted. On 2/22/26, she came back to work at 6:00 a.m. NA-B had worked the night shift (12 hours) and was still there when she arrived. She received report from LPN-A and there had been no mention about an incident with R1. TMA-A informed her she reported the incident to the charge nurse LPN-A right away that evening right. RN-A waited a couple more hours, most	F0610	Continued from page 17 The facility reviewed the Maltreatment Investigating and reporting Policy no revisions made. A poster outlining reporting requirements was posted in the nurse’s station and breakroom. All staff were educated on the following Policies and Required to complete the following Educare course: Completed on 03/02/2026 Maltreatment Prohibition Definitions Maltreatment Investigation and Reporting Maltreatment Reporting Guidelines Training on Stress Management Abuse prevention and Resident Rights Vulnerable Adult Dementia Management The DON or designee will audit all incident reports weekly for four (4) weeks, then monthly for four (4) months. Audits will verify: Allegations are correctly identified. Reports are submitted within required timeframes. Audit results will be reviewed during QAPI meetings. Any identified issues will result in immediate corrective action. The facility will be in compliance by 4-17-26	

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F0610 SS = D	Continued from page 18 likely shouldn't have, but thought it had been reported to the on-call nurse. She called the on-call nurse after lunch and realized it had not been reported. Within 15 minutes of the call to the DON, she came to the facility. At 9:30 a.m. RN-A completed a skin assessment and no skin concerns noted. The skin assessment was not documented and should have been. RN-A verified NA-B had worked at facility for approximately one month and she did not work directly with her. R1 rarely cried on the night shift, was unable to verbalize what was bothering her, would usually say "ugh ugh" and point at things, staff were expected to document her behaviors every shift in the electronic medical record. R1's medical records lacked evidence of a skin check completed on R1 following initial report of allegation of abuse or the following day. During an interview on 3/2/26 at 2:39 p.m., TMA-A stated on 2/21/26 at 6:45 p.m., she stood outside R1's closed door preparing medications and heard R1 and NA-B both yelling. NA-B stated hurry up and grab the fucking bar you know how to fucking walk so walk to the bed. The tone of NA-B 's voice was rude and aggressive. TMA-A remained at the medication cart until NA-A and NA-B exited R1's room. She was unaware NA-A was in the room and asked her what happened. NA-A informed TMA-A, NA-B had swatted R1 on the butt. At 7:15 p.m. she completed a medication count with the charge nurse LPN-A and informed her about the incident with R1. TMA-A stated she told LPN-A what she had heard and about the smack on the butt by NA-B. TMA-A stated because she considered this verbal and physical abuse and was not appropriate way for a resident to be treated under no circumstances, she assumed LPN-A would have called the nurse on call, LPN-B. NA-B continued to work with residents until at least 7:30 p.m. when TMA left for the day. TMA was surprised NA-B was not pulled off work and sent home so that something similar did not happen to another resident and no one would be around to see what happened. During an interview on 3/2/26 at 3:37 p.m., social service designee (SSD) stated staff would have been expected to monitor any residents unable to be interviewed after incident, during cares and report it to the nurse on duty. SSD stated she visited with R1 daily and had not seen any changes in behaviors. R1 had yelled at SSD this morning "no" but would not say anything more. During an interview on 3/2/26 at 7:51 p.m. NA-A stated	F0610		

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(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
F0610 SS = D	Continued from page 19 she worked from 2:30 p.m. to 9:30 p.m. with NA-B on 2/21/26 and at approximately 6:30 p.m. NA-B was verbally and physically abusive during R1's evening cares. While R1's brief was being placed she became combative and NA-B stated, stand up and R1 responded oh shut up. NA-B stated out loud, if you want to act like a child then you will be treated like one and with an open hand smacked her on the right buttock (skin to skin and sounded like a loud smack). NA-B grabbed R1's walker and said OK, now let's walk to bed. R1 was whining and whimpering like she was in pain, this made NA-A very uncomfortable, and she cannot imagine how R1 felt. NA-A stated she felt uncomfortable in the bathroom with NA-B, she was taller, her tone of voice was loud and aggressive, and she used inappropriate language. R1 was most likely feeling the same way but unable to verbalize how she was feeling and made grunting sounds like she was nervous. NA-A stated once she left R1's room she talked to TMA -A outside R1's door and was asked if NA-B had been aggressive and she told her yes and was afraid of retaliation from NA-B and moved down the hallway with TMA to discuss. Five minutes later she located the charge nurse LPN-A and informed her NA-B had been verbally aggressive and smacked her on her right buttock. LPN-A shook her head and said oh my. NA-A was provided with the complaint form with not a lot of room to write so placed as much information in the small area as she could and placed it in the DON's box. NA-A felt like nothing was done to protect the residents. The incident should have been reported within two hours and found out the next day it was not reported until later the next day. NA-A stated NA-B was allowed to work after incident, assisted NA-A with another resident transfer and toileting. At 9:30 p.m. left the facility and NA-B remained in facility working with residents. During an interview on 3/3/26 at 1:15 p.m. clinical coordinator LPN-C stated she was notified about R1's incident on 2/22/26 at 2:00 p.m. by charge nurse RN-A. NA-B was allowed to finish working her shift on 2/21/26, but if she had been notified and known about the allegations, she would have removed her from the facility and schedule until the investigation was completed. If the allegations were accurate or correct, we would not want it to continue happening and for the safety of the residents. LPN-C stated she notified DON right away and came to facility immediately, arrived just after 2:00 p.m. and started to investigate with staff and resident interviews. The incident happened on 2/21/26 and there were concerns brought to our attention on 2/22/26 about physical and verbal abuse. LPN-C stated she worked her way down each resident	F0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Browns Valley Health Center	114 JEFFERSON STREET SOUTH , BROWNS VALLEY, Minnesota, 56219

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F0610 SS = D	Continued from page 20 hallway randomly interviewed those residents located in their room for a total of 11. LPN-C was unable to verify how or if resident skin checks or behavior chart checks were completed after the incident and recommended checking with DON. LPN-C verified during interview no documentation located in R1's electronic medical record on 2/21/26 regarding the incident and seemed unusual. DON requested RN-A complete R1's assessment on 2/22/26 and would have expected her to document her findings when done. During an interview on 3/3/26 at 2:53 p.m., DON stated she would have expected the charge nurse LPN-A to have read what NA-A wrote, immediately assess R1's skin and bottom, and contact the on-call nurse LPN-B right away. The staff nurses check R1's skin when they complete her treatments every shift and the NAs are always monitoring R1's skin and report unusual skin issues. We should have probably monitored R1's skin at least each shift for three days to ensure no bruise came or was identified to make sure R1 did not have any injuries as a result of the allegations. We would have wanted to make sure all the residents were safe, and the staff (NA-B) was suspended and no longer in the building so that residents would not suffer any other harm. R1 did not suffer any harm but there was potential for harm, and all residents have the potential for harm. DON stated she believed R1 experienced verbal abuse during this incident. NA-B continued to work on 2/21/26 after the incident until the following morning at 7:01 a.m. On 2/22/26, NA-B completed an interview on the phone, no notes were taken. DON requested and received NA-B's written statement that included the same information discussed on the phone on 2/22/26 and was suspended from work. Additional staff involved in the allegation were interviewed and no other staff interviews were completed. DON stated the night staff should have been interviewed that worked with NA-B, especially the NA working the night shift with NA-B that night. The policy was followed, indicated staff interviews. There were no skin checks completed on all residents after the incident. DON stated she would have expected herself to review resident behavior charting to make sure something was not missed and important to see if there was anything unusual out of the norm to help protect the residents. The facility policy was not followed by the charge nurse LPN-A, regarding communicating the incident with the on-call nurse and if she had been notified in a timely manner, things would have been taken care of on Saturday night and NA-B suspended from work. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, identified staff shall immediately report to	F0610		

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F0610 SS = D	Continued from page 21 their supervisor any suspected maltreatment. The supervisor shall first ensure the resident is safe and complete and initial assessment in order to determine if there is potential abuse, neglect or other type of maltreatment. The immediate supervisor or person responsible for the implementing actions of the Maltreatment Prohibition Policy shall: 1. Immediately suspend staff person(s) involved in the alleged maltreatment pending the outcome of the investigation. 2. Begin conducting an investigation of the alleged maltreatment, which may include resident and staff interviews, observations, and medical record review. The investigation shall be completed as much as able within five working days, at which time the investigation findings will be updated on the MDH/OHFC website.	F0610		

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 3/2/26 through 3/4/26, 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. H55646982C (2785510)	20000		03/27/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/04/2026**

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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		