Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 27, 2026

Administrator
ST WILLIAMS LIVING CENTER
212 WEST SOO STREET, BOX 30
PARKERS PRAIRIE, MN 56361

RE: CCN: 245588
Cycle Start Date: December 15, 2025

Dear Administrator:

On January 14, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

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January 27, 2026

Administrator
ST WILLIAMS LIVING CENTER
212 WEST SOO STREET, BOX 30
PARKERS PRAIRIE, MN 56361

Re: Reinspection Results
Event ID: 1DE19C-H2

Dear Administrator:

On January 14, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 15, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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December 30, 2025

Administrator
ST WILLIAMS LIVING CENTER
212 WEST SOO STREET, BOX 30
PARKERS PRAIRIE, MN 56361

RE: CCN:245588
Cycle Start Date: December 15, 2025

Dear Administrator:

On December 15, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 15, 2026, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 15, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

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Administrator
ST WILLIAMS LIVING CENTER
212 WEST SOO STREET, BOX 30
PARKERS PRAIRIE, MN 56361

Re: State Nursing Home Licensing Orders
Event ID: 1DE19C-H1

Dear Administrator:

The above facility survey was completed on December 15, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAMS LIVING CENTER	**212 WEST SOO STREET, BOX 30 , PARKERS PRAIRIE, Minnesota, 56361**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/12/25, and 12/15/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		01/14/2026

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 **12/15/2025**

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20000	Continued from page 1 The following complaint was reviewed: H55888062C (2671192) with a licensing order issued at 0265. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria	20265	CORRECTED	01/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/15/2025**

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20265	Continued from page 2 which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and representative were notified of increased right hip pain and bruising for 1 of 1 resident (R1) reviewed for injury of unknown origin. Findings include: R1's annual Minimum Data Set (MDS) dated 10/17/25, identified R1 entered facility on 10/31/24, from a skilled nursing facility (SNF). He had minimal difficulty with hearing and impaired vision (sees large print, not regular print in newspaper/books). He was severely cognitively impaired without behaviors. He was dependent for toileting hygiene, required substantial/maximal assistance for all transfers, frequently incontinent of bladder, and occasionally incontinent of bowel. Diagnoses included atrial fibrillation (a common heart arrhythmia where the upper chambers (atria) quiver instead of contracting effectively, leading to an irregular and significantly increasing stroke risk) arthritis, Non-Alzhemier's dementia (a group of neurodegenerative disorders, like vascular dementia that affects cognition, behavior, and	20265		

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20265	Continued from page 3 function often involving blood flow issues (vascular) or protein deposits (Lewy bodies), anxiety, depression, history of falling), anxiety, and depression. Currently taking an anticoagulant (blood thinner, reduces blood clotting, may bruise easily and take longer for bleeding to stop). R1's orders from 11/15/25 to 11/20/25, identified: -7/21/25, Acetaminophen (Tylenol) oral tablet. Give 1000 milligrams (mg) by mouth (po) every 6 hours as needed for moderate to severe pain. Do not exceed 3000 mg in 24 hours. Hold dates: 11/17/25 to 11/24/25. -7/21/25, Acetaminophen oral tablet. Give 500 mg by mouth every 6 hours as needed for mild pain. Do not exceed 3000 mg in 24 hours. Hold dates: 11/17/25 to 11/24/25. -11/5/25, Apixaban (a blood thinner used to prevent blood clots and stroke) tablet. Give 5mg by mouth two times a day related to paroxysmal Atrial Fibrillation. -11/15/25, bruise posterior right (R) upper leg into thigh. Right hip. Every shift until resolved. Discontinued on 12/17/25. -11/18/25, charting bruising R hip/leg: signs and symptoms (s/s) of improvement, pain, s/s of infection, interventions/treatments every day shift for 14 days. Discontinued on 12/19/25. -11/20/25, charting bruising to R hip/leg and R low back/flank s/s of improvement, pain, s/s of infection, interventions, and treatments every day shift for 14 days. Discontinued 12/4/25. R1's electronic medication administration record (EMAR) from 11/8/25 through 11/17/25, identified: Tylenol 500 mg was administered three times from 11/8/25 through 11/10/25, for right hip pain ranged from two to four on a scale of zero to 10. Tylenol 1000 mg was administered six times from 11/11/25 through 11/17/25, for right hip pain ranged from three to eight on a scale of zero to10. R1's care plan dated 12/17/25, identified: all transfers (started 10/9/25) sit to stand with assist of two and as needed (PRN) Hoyer lift (full body mechanical lift) for pain or difficulty standing/following directions, resolved on 12/17/25.	20265		

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20265	Continued from page 4 Transfer (started on 12/17/25) Hoyer lift with two assist using the hourglass large sling for all transfers. Potential for falls related to weakness, history of falls, cognitive impairment with impaired safety awareness, visual deficit/blind in right eye, use of psychotropic medications, and impaired balance. Staff were directed to approach from front or left side, floor mat, hi/low bed, toileting schedule, provide a safe environment, gripper socks, anti-reverse brakes on wheelchair, and call don't fall sign place in room and bathroom. He had knee pain due to arthritis, right artificial knee joint and restless leg syndrome (RLS). Impaired cognition related to short term memory problem, time orientation difficulty, and difficulty hearing. Staff were directed to report changes in cognitive status. R1 was a vulnerable adult related to assistance needed for activities of daily living (ADLS), impaired communication and decision-making skills, and impaired mobility. Staff were directed to listed to his concerns and report any inappropriate or suspicious behaviors to the proper authorities. R1's progress notes from 11/10/24, through 11/17/25, identified: -On 11/10/25 at 4:24 a.m., noted during cares an approximate four centimeter (cm) scabbed scratch area noted on right hip located where the edge of the brief touches his skin. -On 11/10/25 at 7:41 p.m., gave 500 mg Tylenol po every six hours PRN for mild pain. R1 grimacing and with rolling and repositioning. Follow-up at 8:49 p.m., effective pain zero out of 10. -11/10/25 at 11:17 p.m., Weekly skin inspection has multiple scabbed areas on right lower extremity and face. No bruising. -11/11/25 at 5:38 p.m., Gave 1000 mg Tylenol po every six hours PRN for moderate to severe pain. R1 jumpy in wheelchair seat at evening meal. Reporting hip pain. Follow-up at 7:57 p.m., effective pain zero out of 10. -11/12/25 at 11:12 a.m., Unable to stand today. -11/13/25 at 2:46 p.m., Bruise noted to right upper groin/hip area red/purple to center and yellowing around edges. He denied cause being from any suspicious or inappropriate behavior. Bruise does not appear suspicious. Denies pain. -11/13/25 at 2:49 p.m., Gave 1000 mg Tylenol po as needed for moderate to severe pain. Complained of right	20265		

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20265	Continued from page 5 hip pain and facial grimacing. Follow-up at 4:28 p.m., effective pain rated zero out of 10. -11/14/25 at 12:33 a.m., gave 1000 mg Tylenol PRN for moderate to severe pain. Right hip pain. Follow up at 3:08 a.m., effective pain rated zero out of 10. -11/14/25 at 1:50 p.m., Gave Tylenol. Wiggling around in chair and swearing under his breath when he moved a certain way or when he tried to hold up his feet. Pain rated eight out of 10 using PAIN-AD scale (assesses pain in residents with cognitive impairment). Follow-up at 5:23 p.m., effective pain rated zero out of 10. -11/14/25 at 11:40 p.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow-up at 1:43 a.m., effective pain rated zero out of 10. -11/15/25 at 5:18 a.m., Bruising observed above posterior right knee and extended into upper posterior thigh. No pain with palpitation. -11/15/25 at 9:54 a.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow up at 12:00 p.m., effective pain rated two out of10. -11/15/25 at 5:28 p.m., Gave Tylenol for complaints of increased right hip pain. Follow up at 7:26 p.m., ineffective. Pain rated six out of 10. Stated his pain was the same or worse since Tylenol administration. Facial grimacing. Has a yellowish brise with deep purple red marks across right hip. -11/15/25 at 9:38 p.m., Right hip bruise was yellowing with areas of dark purple. Appeared slight swollen. Tylenol administered at p.m. meal. Checked in with R1 twice and he stated it did not help much at all. Offered ice/heat, refused. Appeared to be in moderate pain. -11/16/25 at 3:58 p.m., Gave Tylenol for complaints of increased right hip pain. R1 grimacing, groaning. Rates pain at eight to nine out of 10. Noted to position self so he was lying on his left hip, offloading pressure on the right. Large ice pack applied. Follow-up at 6:47 p.m., continued to complain of increased right hip pain. Continuing with ice and repositioning. -11/16/25 at 8:39 p.m., R1 had a large amount of bruising noted to posterior right leg and right anterior hip area. Legs are equal in length. Right hip pain with movement and external rotation, no pain at rest. He did not remember hurting himself stated “when you get old you just get fragile, I guess”. Phoned	20265		

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ST WILLIAMS LIVING CENTER	**212 WEST SOO STREET, BOX 30 , PARKERS PRAIRIE, Minnesota, 56361**

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20265	Continued from page 6 daughter and updated, currently on her way to facility to assess if she would like him sent in or not. Per daughter request was sent to ER to have right hip assessed. Provider on-call approved transfer to ER. Left facility via ambulance at 9:20 p.m. -11/17/25 at 12:21 a.m., Returned to facility via ambulance. No signs of pain, no grimacing or verbalization of pain. Received Tylenol at 10:23 p.m. -11/17/25 at 12:08 p.m., daughter visited. Writer evaluated R1's bruising. Deep purple bruising remained to right posterior leg from behind knee to groin area, small scattered red bruising to lateral right thigh and softball sized deep purple bruise to right lower back. Faded bruising to right anterior hip. No c/o pain to back or lower leg. Complained of pain to right outer hip when palpated or pressure placed on area. Unable to lay on right side. No swelling or deformity noted to right hip. Daughter expressed concern that he had fallen and not reported she was unable to figure out how else the bruising occurred. Writer and daughter tried to brainstorm together but unable to determine definitive cause for bruising. He denied anyone hurting him. He will be a Hoyer lift for all transfers as EZ stand transfers are too unsafe. Requested MD [doctor] be contacted for better pain control. -11/17/25 at 12:14 p.m., Fax sent to primary provider (MD) to update on ER visit from last evening and requested pain medication orders. Physical therapy evaluation and plan for treatment dated 11/10/25, identified reason for referral: to evaluate if bed rails are necessary for mobility/transfers, and patient goal: decrease pain. Pain in right hip/deep rated at three out of 10 and skin integrity intact (per notes, had open area along right hip where brief attached). R1 reported increased right hip pain during today's session, limited his ability to complete transfers, and recent decline in functional mobility safety. Required maximum assistance with stand aid to transfer. R1's ER visit dated 11/16/25 at 9:43 p.m., identified presented with concerns about hip pain/bruising. Imaging result on 11/16/25, x-ray of right hip/pelvis. Impression: no definite fracture or dislocation was identified. Diagnoses: contusion (bruise) of right hip. R1's primary provider visit dated 11/19/25, identified the primary driver of the bruising suspected was the	20265		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAMS LIVING CENTER	**212 WEST SOO STREET, BOX 30 , PARKERS PRAIRIE, Minnesota, 56361**

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20265	Continued from page 7 apixaban. Does not appear to be concerning for injury. Denied any staff injury, unable to identify how bruises occurred, and felt safe. Continue to monitor closely. Facility 5-day report submitted to the Minnesota Department of Health (MDH) dated 11/19/25 at 4:55 p.m., identified an incident report was submitted on 11/16/25 at 10:34 p.m., regarding an allegation of unexplained injury of unknown source occurred on 11/16/25 at 8:43 p.m. Bruising was noted to posterior right hip, leg and front of hip. Unknown source of origin. He did not know how bruising occurred, no recollection of any recent falls or events that could have caused significant bruising, has a poor memory, on Eliquis, and required assistance of two staff to transfer in an EZ stand lift. Initial bruising (4 to 5 smaller bruises that resulted in a larger bruise) was noted on 11/11/25. Between 11/15/25 p.m. [evening] shift and 11/16/25 at 0430 he remained in bed due to not needing incontinence cares until 0430. At that time the night NA went to assist with cares and noted the bruise went from the bottom of his buttocks to his knee on the right leg. Night nurse was notified, and bruising charting was initiated. On 11/16/25, prior to midnight the NA's noted old bruising on the right hip lighter in color. On 11/16/25, at approximately 8:30 p.m., registered nurse (RN) checked on R1 due to complaints of pain and found the bruising had expanded, darker in color than what was observed on 11/16/25. Some bruising was noted on upper back. Pain was managed by Tylenol 1000 mg, hot/cold packs and repositioning. Family, director of nursing (DON), and administrator were notified, and he was sent to emergency room (ER) at 9:20 p.m. ER visit indicated no major injury, and diagnosis was hip bruise and constipation. During an observation on 12/12/25 at 1:06 p.m., nursing assistant (NA)-B and NA-A entered R1's room with an EZ total lift machine. R1 sat in WC. Loops from sling lift located underneath him were hooked up to the lift machine bar, lifted off wheelchair and transferred to the bed. Pulled down his pants, skin was observed. NA-A identified where the bruises used to be located on right hip, entire length of backside of right upper thigh, and the outer middle right side of his back. No bruises were seen during this observation. R1 stated, "it hurts," when turned onto his right side. During an interview on 12/12/25 at 1:20 p.m., NA-A stated she identified a bruise on R1's backside of his mid-thigh on 11/13/25, looked like a thumb print	20265		

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20265	Continued from page 8 red/purple and no yellow, looked fresh. She informed the nurse (unsure of which one) on the day shift. She worked again on 11/15/25 and saw big dark purple bruises on his right middle lateral flank round, approximately six inches in diameter, and back of right thigh that covered the entire area from just above his knee to top of his thigh. She had no idea how the bruises occurred. Staff were expected to report a bruise right away to the nurse. During an interview on 12/12/25 at 2:47 p.m., licensed practical nurse (LPN)-B stated R1 did not have the best memory but was able to respond appropriately to questions some of the time. R1 stated no one hurt him and LPN-B trusted what he said. She had worked on 11/13/25 and learned during report he had a bruise on right hip. No documentation had been written in his chart prior to her assessment. R1 had a purple/red bruise with yellowing around the outside of it approximate size of a 50-cent piece. No open areas, asked if R1 was harmed and he replied, "no." LPN-B informed RN-D of the bruise and was informed weekly skin monitoring would be set up to assess the bruise. LPN-B worked on 11/14/25, and medicated R1 with Tylenol for right hip pain. LPN-B did not visually assess the hip. LPN-B returned to work on 11/17/25 and was informed R1 had been sent to ER on 11/16/25. LPN-B assessed the right hip and identified significant dark purple bruising located on right flank and back of right thigh. Staff nurse would be expected to report and start an investigation for an unexplained bruise when identified to rule out if he was harmed by anyone, to keep residents safe. During an interview on 12/12/25 at 2:11 p.m., LPN-A stated she identified LPN-B made the first documentation on 11/13/25, in R1's progress notes regarding his bruise and should have been reported right away. On 11/15/25, he complained of right hip pain, grimacing, staff indicated he was in pain with transfers, which was unusual for him, had a scratch and a light in color bruise on the lateral side of the right hip, and administered Tylenol. Follow-up pain score was two out of 10. R1's bruises could have been considered suspicious and unknown how they occurred. Staff were expected to and should have documented size of bruise, report when identified, and notified provider. He was sent to ER to be evaluated on 11/16/25. LPN-A came back to work on 11/18/25 and she saw a big bruise on R1's right flank side of back approximately 6 inches in diameter, round, the entire back side of the right thigh just above his knee to the top of the thigh, both were dark purple.	20265		

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20265	Continued from page 9 During an interview on 12/15/25 at 10:40 a.m., family member (FM) stated R1's memory and strength were declining rapidly. When she visited R1 today, he was unable to recognize her partner. While she accompanied him in ER on 11/16/25, R1 stated he walked outside down the field road from our farm, tripped on the grass, fell and that was how it happened. He would not be able to remember if he fell due to his dementia. On 11/16/25, in the evening, the facility nurse contacted her and was the first time she was made aware R1 had right hip pain and bruises. FM expected staff to have notified her and the provider of right hip pain and multiple bruises prior to 11/16/25, when they were first seen, and hip pain started. FM would have requested he be sent in and checked out sooner. During an interview on 12/15/25 at 2:09 p.m., medical director /primary provider (MD) stated R1's memory and cognition were poor due to dementia. He was able to answer questions about his bruises, denied anything happened, was believable and credible. He was taking Eliquis, would have not taken much trauma/injury and only a bump could have caused the bruising. MD did not have an explanation as to why R1 had bruises in the areas he did. R1 did not have right hip pain prior to the incident. The staff would have been expected to update him on a weekly visit or sooner. MD was not contacted when R1 was sent to ER on 11/16/25. MD would have expected staff to notify him of any bruises or hip pain right away so that nothing was missed and concerns were evaluated as soon as possible. When MD arrived at the facility on 11/19/25, while rounds were being completed, he was told R1 needed a follow-up visit after the ER visit. That was the first time MD was informed of right hip pain and bruises. Upon assessment R1 had bruises located on the right hip, buttock, and superior (flank) to the right lateral abdominal wall mildly tender upon palpation. Color of the bruises were typical, purplish with some yellow, indicated maturing which made sense if they were identified around 11/13/25. No abuse suspected but unsure as to how he received the bruises. During an interview 12/15/25 at 3:00 p.m., RN-C stated a bruise was documented on 11/13/25, in R1's progress notes located on right hip about four to five inches in diameter. She laid eyes on the bruise on 11/15/25, and verified bruise was located on his right hip area only, denied pain, and was not documented. His cognition was not intact to be reliable with his memory. Based off the documentation the bruise was not suspicious, RN-C did not see an injury occurred. The bruise was from an unknown origin (did not know what caused it) and was	20265		

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20265	Continued from page 10 reportable within two hours to make sure there was not neglect, or an injury caused by someone. The staff nurse should have notified the DON, administrator, family, and provider sooner. The nurse would be expected to notify the provider if he had continued/increased pain not relieved by interventions. A fax should have been sent to provider to see if he wanted to do anything different such as interventions. During an interview on 12/15/25 at 3:42 p.m., floor manager RN-D stated staff would have been expected to notify her when bruise was found and right hip pain without relief from interventions. She was made aware of the bruises and right hip pain on 11/17/25, when assessed with his daughter. R1's cognition was severely impaired, and his memory varied. A licensed practical nurse (LPN)-B documented on 11/13/25, R1 was asked what caused the bruise, and R1 was able to tell staff he was not hurt. The bruise was not measured and should have been. On 11/15/25 at 5:18 a.m., the bruise was found with pain and should have been reported to the state; report was filed late. The investigation should have been initiated right away on 11/15/25, to figure out if he had an injury and which staff worked with him. RN-D was unable to identify what had caused the bruises. R1's bruising with hip pain should have been reported to the provider right away to identify the underlying reason for the pain. During an interview on 12/15/25 at 4:08 p.m., social service director (SSD) stated a resident with a brief interview for mental status (BIMS) rated at a three indicated severe cognitive impairment. R1 would have had difficulty making decisions, short term memory was impacted greatly and the recall after a couple of minutes would have been most likely impossible. R1 responded to questions regarding the bruises but was unable to identify who was involved and was not an accurate historian. Once R1's large bruises were identified they should have been reported to MDH. During an interview on 12/15/25, at 5:15 p.m., DON stated R1 had a severely impaired cognitive memory. DON was if he could have recalled what happened. R1 started having right hip pain on 11/8/25 and was not identified as new. DON found out later R1 was medicated with Tylenol and right hip pain up was up to six, eight, nine or over 10. The nurses reported discomfort in the right hip. The RN should have been notified on 11/13/25, when right hip pain was identified and contacted the provider sooner to make sure there was not anything more serious going such as an injury that would have caused more pain or discomfort. There was more bruising from unknown origin identified on	20265		

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20265	Continued from page 11 11/15/25, staff nurse should have notified DON that day, state report should have been filed, and investigation started to protect the residents from possible abuse/neglect and made sure needs were being met. DON was contacted the evening of 11/16/25, informed about additional bruising and unaware of the increase in right hip pain. Facility policy Change in Condition Monitoring dated 2/1/24, identified how to inform staff on how to set up monitoring for changes in condition. Procedure: if a resident has a change in condition that was considered abnormal for them such as change in skin condition daily monitoring will be set up. The doctor and family will be updated if appropriate. Facility policy Change in Condition Notification dated 2/1/24, identified direction for staff on when to notify the medical doctor (MD). Procedure: if the resident develops a bruise that cannot be explained, or the resident is on coumadin contact the MD to see if labs should be obtained. Anytime the resident experiences a change from baseline and complains of not feeling well complete an assessment, set up monitoring, and update the MD as indicated. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to the physician and representative notification. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	20265		

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F0000	INITIAL COMMENTS On 12/12/25, and 12/15/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H55888062C (2671192). Deficient practice was identified related to incidental findings at F580, F609, 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		01/14/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F0580	F 580 Notify of Changes (Injury/Decline/Room, etc.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident’s family and physician were notified promptly. The physician was updated on the resident’s condition and provided orders for evaluation at Alomere ER. The resident’s daughter accompanied the resident to the hospital. The resident was evaluated for bruising and pain; no hip fracture was identified. Nursing staff implemented pain management interventions to ensure the resident’s pain was adequately addressed.	01/14/2026

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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F0580 SS = D	Continued from page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and representative were notified of increased right hip pain and bruising for 1 of 1 resident (R1) reviewed for injury of unknown origin.	F0580	Continued from page 1 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. A nurse completed skin checks on all residents to ensure no other residents had injuries of unknown origin or unreported changes in condition. No additional residents were identified as having a change in condition. The facility reviewed and updated the Change in Condition Notification policy to ensure it is comprehensive and includes conditions such as new or uncontrolled pain, bruising, and other indicators requiring timely notification. The Daily Shift Report: Multi-Resident Change in Condition Monitoring Log was revised to improve tracking and communication. The Director of Nursing (DON) or RN Manager will audit the log weekly for one month, then every two weeks until sustained compliance is demonstrated. Audit results will be reviewed by the QAPI Committee to ensure corrective actions are effective and to determine whether further revisions are needed. Following QAPI review, the committee will determine the ongoing audit frequency. Education on the updated policy and procedures was provided at a nurses meeting on 1/7/2026. Staff unable to attend will complete the training prior to their next scheduled shift. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or RN Manager will conduct weekly audits of the Multi-Resident Change in Condition Monitoring Log for one month, then every two weeks until compliance is demonstrated. Audit findings will be reviewed by the QAPI Committee to ensure the corrective actions remain effective and to determine whether any additional changes are needed. After review, the QAPI Committee will establish the long-term audit schedule. The date that each deficiency will be corrected.	

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F0580 SS = D	Continued from page 2 Findings include: R1's annual Minimum Data Set (MDS) dated 10/17/25, identified R1 entered facility on 10/31/24, from a skilled nursing facility (SNF). He had minimal difficulty with hearing and impaired vision (sees large print, not regular print in newspaper/books). He was severely cognitively impaired without behaviors. He was dependent for toileting hygiene, required substantial/maximal assistance for all transfers, frequently incontinent of bladder, and occasionally incontinent of bowel. Diagnoses included atrial fibrillation (a common heart arrhythmia where the upper chambers (atria) quiver instead of contracting effectively, leading to an irregular and significantly increasing stroke risk) arthritis, Non-Alzhemier's dementia (a group of neurodegenerative disorders, like vascular dementia that affects cognition, behavior, and function often involving blood flow issues (vascular) or protein deposits (Lewy bodies), anxiety, depression, history of falling), anxiety, and depression. Currently taking an anticoagulant (blood thinner, reduces blood clotting, may bruise easily and take longer for bleeding to stop). R1's orders from 11/15/25 to 11/20/25, identified: -7/21/25, Acetaminophen (Tylenol) oral tablet. Give 1000 milligrams (mg) by mouth (po) every 6 hours as needed for moderate to severe pain. Do not exceed 3000 mg in 24 hours. Hold dates: 11/17/25 to 11/24/25. -7/21/25, Acetaminophen oral tablet. Give 500 mg by mouth every 6 hours as needed for mild pain. Do not exceed 3000 mg in 24 hours. Hold dates: 11/17/25 to 11/24/25. -11/5/25, Apixaban (a blood thinner used to prevent blood clots and stroke) tablet. Give 5mg by mouth two times a day related to paroxysmal Atrial Fibrillation. -11/15/25, bruise posterior right (R) upper leg into thigh. Right hip. Every shift until resolved. Discontinued on 12/17/25. -11/18/25, charting bruising R hip/leg: signs and symptoms (s/s) of improvement, pain, s/s of infection, interventions/treatments every day shift for 14 days. Discontinued on 12/19/25. -11/20/25, charting bruising to R hip/leg and R low back/flank s/s of improvement, pain, s/s of infection,	F0580	Continued from page 2 The deficiency will be corrected by January 14, 2026.	

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F0580 SS = D	Continued from page 3 interventions, and treatments every day shift for 14 days. Discontinued 12/4/25. R1's electronic medication administration record (EMAR) from 11/8/25 through 11/17/25, identified: Tylenol 500 mg was administered three times from 11/8/25 through 11/10/25, for right hip pain ranged from two to four on a scale of zero to 10. Tylenol 1000 mg was administered six times from 11/11/25 through 11/17/25, for right hip pain ranged from three to eight on a scale of zero to10. R1's care plan dated 12/17/25, identified: all transfers (started 10/9/25) sit to stand with assist of two and as needed (PRN) Hoyer lift (full body mechanical lift) for pain or difficulty standing/following directions, resolved on 12/17/25. Transfer (started on 12/17/25) Hoyer lift with two assist using the hourglass large sling for all transfers. Potential for falls related to weakness, history of falls, cognitive impairment with impaired safety awareness, visual deficit/blind in right eye, use of psychotropic medications, and impaired balance. Staff were directed to approach from front or left side, floor mat, hi/low bed, toileting schedule, provide a safe environment, gripper socks, anti-reverse brakes on wheelchair, and call don't fall sign place in room and bathroom. He had knee pain due to arthritis, right artificial knee joint and restless leg syndrome (RLS). Impaired cognition related to short term memory problem, time orientation difficulty, and difficulty hearing. Staff were directed to report changes in cognitive status. R1 was a vulnerable adult related to assistance needed for activities of daily living (ADLS), impaired communication and decision-making skills, and impaired mobility. Staff were directed to listed to his concerns and report any inappropriate or suspicious behaviors to the proper authorities. R1's progress notes from 11/10/24, through 11/17/25, identified: -On 11/10/25 at 4:24 a.m., noted during cares an approximate four centimeter (cm) scabbed scratch area noted on right hip located where the edge of the brief touches his skin. -On 11/10/25 at 7:41 p.m., gave 500 mg Tylenol po every six hours PRN for mild pain. R1 grimacing and with rolling and repositioning. Follow-up at 8:49 p.m., effective pain zero out of 10. -11/10/25 at 11:17 p.m., Weekly skin inspection has	F0580		

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F0580 SS = D	Continued from page 4 multiple scabbed areas on right lower extremity and face. No bruising. -11/11/25 at 5:38 p.m., Gave 1000 mg Tylenol po every six hours PRN for moderate to severe pain. R1 jumpy in wheelchair seat at evening meal. Reporting hip pain. Follow-up at 7:57 p.m., effective pain zero out of 10. -11/12/25 at 11:12 a.m., Unable to stand today. -11/13/25 at 2:46 p.m., Bruise noted to right upper groin/hip area red/purple to center and yellowing around edges. He denied cause being from any suspicious or inappropriate behavior. Bruise does not appear suspicious. Denies pain. -11/13/25 at 2:49 p.m., Gave 1000 mg Tylenol po as needed for moderate to severe pain. Complained of right hip pain and facial grimacing. Follow-up at 4:28 p.m., effective pain rated zero out of 10. -11/14/25 at 12:33 a.m., gave 1000 mg Tylenol PRN for moderate to severe pain. Right hip pain. Follow up at 3:08 a.m., effective pain rated zero out of 10. -11/14/25 at 1:50 p.m., Gave Tylenol. Wiggling around in chair and swearing under his breath when he moved a certain way or when he tried to hold up his feet. Pain rated eight out of 10 using PAIN-AD scale (assesses pain in residents with cognitive impairment). Follow-up at 5:23 p.m., effective pain rated zero out of 10. -11/14/25 at 11:40 p.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow-up at 1:43 a.m., effective pain rated zero out of 10. -11/15/25 at 5:18 a.m., Bruising observed above posterior right knee and extended into upper posterior thigh. No pain with palpitation. -11/15/25 at 9:54 a.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow up at 12:00 p.m., effective pain rated two out of10. -11/15/25 at 5:28 p.m., Gave Tylenol for complaints of increased right hip pain. Follow up at 7:26 p.m., ineffective. Pain rated six out of 10. Stated his pain was the same or worse since Tylenol administration. Facial grimacing. Has a yellowish brise with deep purple red marks across right hip. -11/15/25 at 9:38 p.m., Right hip bruise was yellowing with areas of dark purple. Appeared slight swollen. Tylenol administered at p.m. meal. Checked in with R1	F0580		

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F0580 SS = D	Continued from page 5 twice and he stated it did not help much at all. Offered ice/heat, refused. Appeared to be in moderate pain. -11/16/25 at 3:58 p.m., Gave Tylenol for complaints of increased right hip pain. R1 grimacing, groaning. Rates pain at eight to nine out of 10. Noted to position self so he was lying on his left hip, offloading pressure on the right. Large ice pack applied. Follow-up at 6:47 p.m., continued to complain of increased right hip pain. Continuing with ice and repositioning. -11/16/25 at 8:39 p.m., R1 had a large amount of bruising noted to posterior right leg and right anterior hip area. Legs are equal in length. Right hip pain with movement and external rotation, no pain at rest. He did not remember hurting himself stated “when you get old you just get fragile, I guess”. Phoned daughter and updated, currently on her way to facility to assess if she would like him sent in or not. Per daughter request was sent to ER to have right hip assessed. Provider on-call approved transfer to ER. Left facility via ambulance at 9:20 p.m. -11/17/25 at 12:21 a.m., Returned to facility via ambulance. No signs of pain, no grimacing or verbalization of pain. Received Tylenol at 10:23 p.m. -11/17/25 at 12:08 p.m., daughter visited. Writer evaluated R1’s bruising. Deep purple bruising remained to right posterior leg from behind knee to groin area, small scattered red bruising to lateral right thigh and softball sized deep purple bruise to right lower back. Faded bruising to right anterior hip. No c/o pain to back or lower leg. Complained of pain to right outer hip when palpated or pressure placed on area. Unable to lay on right side. No swelling or deformity noted to right hip. Daughter expressed concern that he had fallen and not reported she was unable to figure out how else the bruising occurred. Writer and daughter tried to brainstorm together but unable to determine definitive cause for bruising. He denied anyone hurting him. He will be a Hoyer lift for all transfers as EZ stand transfers are too unsafe. Requested MD [doctor] be contacted for better pain control. -11/17/25 at 12:14 p.m., Fax sent to primary provider (MD) to update on ER visit from last evening and requested pain medication orders. Physical therapy evaluation and plan for treatment dated 11/10/25, identified reason for referral: to evaluate if bed rails are necessary for mobility/transfers, and patient goal: decrease pain.	F0580		

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F0580 SS = D	Continued from page 6 Pain in right hip/deep rated at three out of 10 and skin integrity intact (per notes, had open area along right hip where brief attached). R1 reported increased right hip pain during today's session, limited his ability to complete transfers, and recent decline in functional mobility safety. Required maximum assistance with stand aid to transfer. R1's ER visit dated 11/16/25 at 9:43 p.m., identified presented with concerns about hip pain/bruising. Imaging result on 11/16/25, x-ray of right hip/pelvis. Impression: no definite fracture or dislocation was identified. Diagnoses: contusion (bruise) of right hip. R1's primary provider visit dated 11/19/25, identified the primary driver of the bruising suspected was the apixaban. Does not appear to be concerning for injury. Denied any staff injury, unable to identify how bruises occurred, and felt safe. Continue to monitor closely. Facility 5-day report submitted to the Minnesota Department of Health (MDH) dated 11/19/25 at 4:55 p.m., identified an incident report was submitted on 11/16/25 at 10:34 p.m., regarding an allegation of unexplained injury of unknown source occurred on 11/16/25 at 8:43 p.m. Bruising was noted to posterior right hip, leg and front of hip. Unknown source of origin. He did not know how bruising occurred, no recollection of any recent falls or events that could have caused significant bruising, has a poor memory, on Eliquis, and required assistance of two staff to transfer in an EZ stand lift. Initial bruising (4 to 5 smaller bruises that resulted in a larger bruise) was noted on 11/11/25. Between 11/15/25 p.m. [evening] shift and 11/16/25 at 0430 he remained in bed due to not needing incontinence cares until 0430. At that time the night NA went to assist with cares and noted the bruise went from the bottom of his buttocks to his knee on the right leg. Night nurse was notified, and bruising charting was initiated. On 11/16/25, prior to midnight the NA's noted old bruising on the right hip lighter in color. On 11/16/25, at approximately 8:30 p.m., registered nurse (RN) checked on R1 due to complaints of pain and found the bruising had expanded, darker in color than what was observed on 11/16/25. Some bruising was noted on upper back. Pain was managed by Tylenol 1000 mg, hot/cold packs and repositioning. Family, director of nursing (DON), and administrator were notified, and he was sent to emergency room (ER) at 9:20 p.m. ER visit indicated no major injury, and diagnosis was hip bruise and constipation.	F0580		

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F0580 SS = D	Continued from page 7 During an observation on 12/12/25 at 1:06 p.m., nursing assistant (NA)-B and NA-A entered R1's room with an EZ total lift machine. R1 sat in WC. Loops from sling lift located underneath him were hooked up to the lift machine bar, lifted off wheelchair and transferred to the bed. Pulled down his pants, skin was observed. NA-A identified where the bruises used to be located on right hip, entire length of backside of right upper thigh, and the outer middle right side of his back. No bruises were seen during this observation. R1 stated, "it hurts," when turned onto his right side. During an interview on 12/12/25 at 1:20 p.m., NA-A stated she identified a bruise on R1's backside of his mid-thigh on 11/13/25, looked like a thumb print red/purple and no yellow, looked fresh. She informed the nurse (unsure of which one) on the day shift. She worked again on 11/15/25 and saw big dark purple bruises on his right middle lateral flank round, approximately six inches in diameter, and back of right thigh that covered the entire area from just above his knee to top of his thigh. She had no idea how the bruises occurred. Staff were expected to report a bruise right away to the nurse. During an interview on 12/12/25 at 2:47 p.m., licensed practical nurse (LPN)-B stated R1 did not have the best memory but was able to respond appropriately to questions some of the time. R1 stated no one hurt him and LPN-B trusted what he said. She had worked on 11/13/25 and learned during report he had a bruise on right hip. No documentation had been written in his chart prior to her assessment. R1 had a purple/red bruise with yellowing around the outside of it approximate size of a 50-cent piece. No open areas, asked if R1 was harmed and he replied, "no." LPN-B informed RN-D of the bruise and was informed weekly skin monitoring would be set up to assess the bruise. LPN-B worked on 11/14/25, and medicated R1 with Tylenol for right hip pain. LPN-B did not visually assess the hip. LPN-B returned to work on 11/17/25 and was informed R1 had been sent to ER on 11/16/25. LPN-B assessed the right hip and identified significant dark purple bruising located on right flank and back of right thigh. Staff nurse would be expected to report and start an investigation for an unexplained bruise when identified to rule out if he was harmed by anyone, to keep residents safe. During an interview on 12/12/25 at 2:11 p.m., LPN-A	F0580		

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F0580 SS = D	Continued from page 8 stated she identified LPN-B made the first documentation on 11/13/25, in R1's progress notes regarding his bruise and should have been reported right away. On 11/15/25, he complained of right hip pain, grimacing, staff indicated he was in pain with transfers, which was unusual for him, had a scratch and a light in color bruise on the lateral side of the right hip, and administered Tylenol. Follow-up pain score was two out of 10. R1's bruises could have been considered suspicious and unknown how they occurred. Staff were expected to and should have documented size of bruise, report when identified, and notified provider. He was sent to ER to be evaluated on 11/16/25. LPN-A came back to work on 11/18/25 and she saw a big bruise on R1's right flank side of back approximately 6 inches in diameter, round, the entire back side of the right thigh just above his knee to the top of the thigh, both were dark purple. During an interview on 12/15/25 at 10:40 a.m., family member (FM) stated R1's memory and strength were declining rapidly. When she visited R1 today, he was unable to recognize her partner. While she accompanied him in ER on 11/16/25, R1 stated he walked outside down the field road from our farm, tripped on the grass, fell and that was how it happened. He would not be able to remember if he fell due to his dementia. On 11/16/25, in the evening, the facility nurse contacted her and was the first time she was made aware R1 had right hip pain and bruises. FM expected staff to have notified her and the provider of right hip pain and multiple bruises prior to 11/16/25, when they were first seen, and hip pain started. FM would have requested he be sent in and checked out sooner. During an interview on 12/15/25 at 2:09 p.m., medical director /primary provider (MD) stated R1's memory and cognition were poor due to dementia. He was able to answer questions about his bruises, denied anything happened, was believable and credible. He was taking Eliquis, would have not taken much trauma/injury and only a bump could have caused the bruising. MD did not have an explanation as to why R1 had bruises in the areas he did. R1 did not have right hip pain prior to the incident. The staff would have been expected to update him on a weekly visit or sooner. MD was not contacted when R1 was sent to ER on 11/16/25. MD would have expected staff to notify him of any bruises or hip pain right away so that nothing was missed and concerns were evaluated as soon as possible. When MD arrived at the facility on 11/19/25, while rounds were being completed, he was told R1 needed a follow-up visit after the ER visit. That was the first time MD was informed of right hip pain and bruises. Upon assessment	F0580		

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F0580 SS = D	Continued from page 9 R1 had bruises located on the right hip, buttock, and superior (flank) to the right lateral abdominal wall mildly tender upon palpation. Color of the bruises were typical, purplish with some yellow, indicated maturing which made sense if they were identified around 11/13/25. No abuse suspected but unsure as to how he received the bruises. During an interview 12/15/25 at 3:00 p.m., RN-C stated a bruise was documented on 11/13/25, in R1's progress notes located on right hip about four to five inches in diameter. She laid eyes on the bruise on 11/15/25, and verified bruise was located on his right hip area only, denied pain, and was not documented. His cognition was not intact to be reliable with his memory. Based off the documentation the bruise was not suspicious, RN-C did not see an injury occurred. The bruise was from an unknown origin (did not know what caused it) and was reportable within two hours to make sure there was not neglect, or an injury caused by someone. The staff nurse should have notified the DON, administrator, family, and provider sooner. The nurse would be expected to notify the provider if he had continued/increased pain not relieved by interventions. A fax should have been sent to provider to see if he wanted to do anything different such as interventions. During an interview on 12/15/25 at 3:42 p.m., floor manager RN-D stated staff would have been expected to notify her when bruise was found and right hip pain without relief from interventions. She was made aware of the bruises and right hip pain on 11/17/25, when assessed with his daughter. R1's cognition was severely impaired, and his memory varied. A licensed practical nurse (LPN)-B documented on 11/13/25, R1 was asked what caused the bruise, and R1 was able to tell staff he was not hurt. The bruise was not measured and should have been. On 11/15/25 at 5:18 a.m., the bruise was found with pain and should have been reported to the state; report was filed late. The investigation should have been initiated right away on 11/15/25, to figure out if he had an injury and which staff worked with him. RN-D was unable to identify what had caused the bruises. R1's bruising with hip pain should have been reported to the provider right away to identify the underlying reason for the pain. During an interview on 12/15/25 at 4:08 p.m., social service director (SSD) stated a resident with a brief interview for mental status (BIMS) rated at a three indicated severe cognitive impairment. R1 would have had difficulty making decisions, short term memory was impacted greatly and the recall after a couple of minutes would have been most likely impossible. R1	F0580		

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F0580 SS = D	Continued from page 10 responded to questions regarding the bruises but was unable to identify who was involved and was not an accurate historian. Once R1's large bruises were identified they should have been reported to MDH. During an interview on 12/15/25, at 5:15 p.m., DON stated R1 had a severely impaired cognitive memory. DON was if he could have recalled what happened. R1 started having right hip pain on 11/8/25 and was not identified as new. DON found out later R1 was medicated with Tylenol and right hip pain up was up to six, eight, nine or over 10. The nurses reported discomfort in the right hip. The RN should have been notified on 11/13/25, when right hip pain was identified and contacted the provider sooner to make sure there was not anything more serious going such as an injury that would have caused more pain or discomfort. There was more bruising from unknown origin identified on 11/15/25, staff nurse should have notified DON that day, state report should have been filed, and investigation started to protect the residents from possible abuse/neglect and made sure needs were being met. DON was contacted the evening of 11/16/25, informed about additional bruising and unaware of the increase in right hip pain. Facility policy Change in Condition Monitoring dated 2/1/24, identified how to inform staff on how to set up monitoring for changes in condition. Procedure: if a resident has a change in condition that was considered abnormal for them such as change in skin condition daily monitoring will be set up. The doctor and family will be updated if appropriate. Facility policy Change in Condition Notification dated 2/1/24, identified direction for staff on when to notify the medical doctor (MD). Procedure: if the resident develops a bruise that cannot be explained, or the resident is on coumadin contact the MD to see if labs should be obtained. Anytime the resident experiences a change from baseline and complains of not feeling well complete an assessment, set up monitoring, and update the MD as indicated.	F0580		
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:	F0609	F609 Reporting of Alleged Violations 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. A report was submitted to OHFC, and a Vulnerable Adult investigation was completed. Appropriate follow up actions were taken based on the investigation findings	01/14/2026

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F0609 SS = D	Continued from page 11 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to report an allegation of potential abuse within 2 hours for 1 of 1 resident (R1) with an injury of unknown origin. Findings include: R1's annual Minimum Data Set (MDS) dated 10/17/25, identified entered facility on 10/31/24, from a skilled nursing facility (SNF). He had minimal difficulty with hearing and impaired vision (sees large print, not regular print in newspaper/books). He was severely cognitively impaired without behaviors. He required substantial/maximal assistance for all transfers. Diagnoses included atrial fibrillation (a common heart arrhythmia where the upper chambers (atria) quiver instead of contracting effectively, leading to an irregular and significantly increasing stroke risk) arthritis, Non-Alzhemier's dementia (a group of neurodegenerative disorders, like vascular dementia that affects cognition, behavior, and function often involving blood flow issues (vascular) or protein deposits (Lewy bodies), anxiety, depression, history of falling), anxiety, and depression. Currently taking an anticoagulant (blood thinner, reduces blood clotting, may bruise easily and take longer for bleeding to	F0609	Continued from page 11 to ensure the resident's safety and well being. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice, and what systemic changes will be implemented to ensure the deficient practice does not recur. A licensed nurse completed skin checks on all residents to ensure no other residents had injuries of unknown origin or unreported changes in condition. No additional concerns were identified. To strengthen staff understanding of reportable events, the facility developed a new reference document titled "Scenarios That Require an Immediate / 2 Hour Report" to accompany the Abuse Neglect and Exploitation Policy. This tool provides guidance to nursing staff on when a VA report must be initiated. A new policy titled "Unexplained Injuries" was also created to provide staff with step by step guidance on identifying, documenting, and reporting unexplained injuries. This policy reinforces timely reporting of alleged violations. Education on the updated policies and procedures was provided during the nurses' meeting on 1/7/2026. Staff who were unable to attend will complete the training prior to their next scheduled shift. A facility wide message was sent to ensure all nurses are aware of the required training and makeup sessions. 3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or RN Manager will conduct weekly audits of reportable incidents and documentation for one month, then every two weeks until sustained compliance is demonstrated. Audit results will be reviewed by the QAPI Committee to ensure corrective actions remain effective and to determine whether additional revisions are needed. Following QAPI review, the committee will establish the long term audit frequency. 4. The date that each deficiency will be corrected. The deficiency will be corrected by January 14, 2026.	

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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
F0609 SS = D	Continued from page 12 stop). R1's orders dated 11/5/25, Apixaban (a blood thinner used to prevent blood clots and stroke) tablet. Give 5mg (milligrams) by mouth two times a day related to paroxysmal Atrial Fibrillation. R1's electronic medication administration record (EMAR) from 11/8/25 through 11/17/25, identified: Tylenol 500 mg was administered three times from 11/8/25 through 1/10/25, for right hip pain ranged from two to four out of 10. Tylenol 1000 mg was administered six times from 11/11/25 through 11/17/25, for right hip pain ranged from three to eight out of 10. R1's care plan dated 12/17/25, identified: all transfers (started 10/9/25) sit to stand with assist of two and as needed (PRN) Hoyer lift for pain or difficulty standing/following directions, resolved on 12/17/25. Transfer (started on 12/17/25) Hoyer lift with 2 assist using the hourglass large sling for all transfers. Potential for falls related to weakness, history of falls, cognitive impairment with impaired safety awareness, visual deficit/blind in right eye, use of psychotropic medications, and impaired balance. Staff were directed to approach from front or left side, floor mat, hi/low bed, toileting schedule, provide a safe environment, gripper socks, anti-reverse brakes on wheelchair, and call don't fall sign place in room and bathroom. He had knee pain due to arthritis, right artificial knee joint and restless leg syndrome (RLS). Impaired cognition related to short term memory problem, time orientation difficulty, and difficulty hearing. Staff were directed to report changes in cognitive status. R1 was a vulnerable adult related to assistance needed for activities of daily living (ADLS), impaired communication and decision-making skills, and impaired mobility. Staff were directed to listen to his concerns and report any inappropriate or suspicious behaviors to the proper authorities. R1's progress notes from 11/10/24, through 11/17/25, identified: -On 11/10/25 at 4:24 a.m., noted during cares an approximate 4 centimeter (cm) scabbed scratch area noted on right hip located where the edge of the brief touches his skin. -On 11/10/25 at 7:41 p.m., gave 500 mg Tylenol po every six hours PRN for mild pain. R1 grimacing and with rolling and repositioning. Follow-up at 8:49 p.m. effective pain zero out of 10.	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245588	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

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F0609 SS = D	Continued from page 13 -11/10/25 at 11:17 p.m., Weekly skin inspection has multiple scabbed area on right lower extremity and face. No bruising. -11/11/25 at 5:38 p.m., Gave 1000 mg Tylenol po (by mouth) every six hours PRN for moderate to severe pain. R1 jumpy in wheelchair seat at evening meal. Reporting hip pain. Follow-up at 7:57 p.m., effective pain zero out of 10. -11/12/25 at 11:12 a.m., Unable to stand today. -11/13/25 at 2:46 p.m., Bruise noted to right upper groin/hip area red/purple to center and yellowing around edges. He denied cause being from any suspicious or inappropriate behavior. Bruise does not appear suspicious. Denies pain. -11/13/25 at 2:49 p.m., Gave 1000 mg Tylenol po as needed for moderate to severe pain. Complained of right hip pain and facial grimacing. Follow-up at 4:28 p.m. effective pain zero out of 10. -11/14/25 at 12:33 a.m., gave 1000 mg Tylenol PRN for moderate to severe pain. Right hip pain. Follow up at 3:08 a.m., effective pain zero out of 10. -11/14/25 at 1:50 p.m., Gave Tylenol. Wiggling around in chair and swearing under his breath when he moved a certain way or when he tried to hold up his feet. Pain rated eight out of 10 using PAIN-AD scale (assesses pain in residents with cognitive impairment). Follow-up at 5:23 p.m., effective pain zero out of 10. -11/14/25 at 11:40 p.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow-up at 1:43 a.m., effective pain zero out of 10. -11/15/25 at 5:18 a.m., Bruising observed above posterior right knee and extended into upper posterior thigh. No pain with palpitation. -11/15/25 at 9:54 a.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow up at 12:00 p.m., effective pain two out of 10. -11/15/25 at 5:28 p.m., Gave Tylenol for complaints of increased right hip pain. Follow up at 7:26 p.m., ineffective. Pain six out of 10. Stated his pain was the same or worse since Tylenol administration. Facial grimacing. Has a yellowish brise with deep purple red marks across right hip.	F0609		

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F0609 SS = D	Continued from page 14 -11/15/25 at 9:38 p.m., Right hip bruise was yellowing with areas of dark purple. Appeared slight swollen. Tylenol administered at p.m. (evening) meal. Checked in with R1 twice and he stated it did not help much at all. Offered ice/heat, refused. Appeared to be in moderate pain. -11/16/25 at 3:58 p.m., Gave Tylenol for complaints of increased right hip pain. R1 grimacing, groaning. Rates pain at eight to nine out of 10. Noted to position self so he was lying on his left hip, offloading pressure on the right. Large ice pack applied. Follow-up at 6:47 p.m., continued to complain of increased right hip pain. Continuing with ice and repositioning. -11/16/25 at 8:39 p.m., R1 had a large amount of bruising noted to posterior right leg and right anterior hip area. Legs are equal in length. Right hip pain with movement and external rotation, no pain at rest. He did not remember hurting himself stated “when you get old you just get fragile, I guess”. Phoned daughter and updated, currently on her way to facility to assess if she would like him sent in or not. Per daughter request was sent to ER to have right hip assessed. Provider on-call approved transfer to ER. Left facility via ambulance at 9:20 p.m. -11/17/25 at 12:21 a.m., Returned to facility via ambulance. No signa of pain, no grimacing or verbalization of pain. Received Tylenol at 10:23 p.m. -11/17/25 at 12:08 p.m., Daughter visited. Writer evaluated R1’s bruising. Deep purple bruising remained to right posterior leg from behind knee to groin area, small scattered red bruising to lateral right thigh and softball sized deep purple bruise to right lower back. Faded bruising to right anterior hip. No c/o pain to back or lower leg. Complained of pain to right outer hip when palpated or pressure placed on area. Unable to lay on right side. No swelling or deformity noted to right hip. Daughter expressed concern that he had fallen and not reported she was unable to figure out how else the bruising occurred. Writer and daughter tried to brainstorm together but unable to determine definitive cause for bruising. He denied anyone hurting him. He will be a Hoyer lift for all transfers as EZ stand transfers are too unsafe. Requested MD be contacted for better pain control. -11/17/25 at 12:14 p.m., Fax sent to primary provider (MD) to update on ER visit from last evening and requested pain medication orders.	F0609		

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F0609 SS = D	Continued from page 15 R1's ER visit dated 11/16/25 at 9:43 p.m., identified presented with concerns about hip pain/bruising. Imaging result on 11/16/25, x-ray of right hip/pelvis. Impression: no definite fracture or dislocation was identified. Diagnoses: contusion (bruise) of right hip. R1's primary provider visit dated 11/19/25, identified the primary driver of the bruising suspected was the apixaban. Does not appear to be concerning for injury. Denied any staff injury, unable to identify how bruises occurred, and felt safe. Continue to monitor closely. Facility 5-day report submitted to the Minnesota Department of Health (MDH) dated 11/19/25 at 4:55 p.m., identified an incident report was submitted on 11/16/25 at 10:34 p.m., regarding an allegation of unexplained injury of unknown source occurred on 11/16/25 at 8:43 p.m. Bruising was noted to posterior right hip, leg and front of hip. Unknown source of origin. He did not know how bruising occurred, no recollection of any recent falls or events that could have caused significant bruising, has a poor memory, on Eliquis, and required assistance of two staff to transfer in an EZ stand lift. Initial bruising (4 to 5 smaller bruises that resulted in a larger bruise) was noted on 11/11/25. Between 11/15/25 p.m., shift and 11/16/25 at 0430 (4:30 a.m.) he remained in bed due to not needing incontinence cares until 0430. At that time the night NA went to assist with cares and noted the bruise went from the bottom of his buttocks to his knee on the right leg. Night nurse was notified, and bruising charting was initiated. On 11/16/25, prior to midnight the NA's noted old bruising on the right hip lighter in color. On 11/16/25, at approximately 8:30 p.m., registered nurse (RN) checked on R1 due to complaints of pain and found the bruising had expanded, darker in color than what was observed on 11/16/25. Some bruising was noted on upper back. Pain was managed by Tylenol 1000 mg hot/cold packs and repositioning. Family, director of nursing (DON), and administrator were notified, and he was sent to emergency room (ER) at 9:20 p.m., ER visit indicated no major injury, and diagnosis was hip bruise and constipation. During an observation on 12/12/25 at 1:06 p.m., nursing assistant (NA)-B and NA-A entered R1's room with an EZ total lift machine. R1 sat in WC. Loops from sling lift located underneath him were hooked up to the lift machine bar, lifted off wheelchair and transferred to the bed. Pulled down his pants, skin was observed. NA-A identified where the bruises used to be located on right hip, entire length of backside of right upper	F0609		

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F0609 SS = D	Continued from page 16 thigh, and the outer middle right side of his back. No bruises were seen during this observation. R1 stated “it hurts” when turned onto his right side. During an interview on 12/12/25 at 1:20 p.m., nursing assistant NA-A stated she identified a bruise on R1’s backside of his mid-thigh on 11/13/25, looked like a thumb print red/purple and no yellow, looked fresh. She informed the nurse (unsure of which one) on the day shift. NA-A worked again on 11/15/25 and saw big dark purple bruises on his right middle lateral flank round, approximately six inches in diameter, and back of right thigh that covered the entire area from just above his knee to top of his thigh. NA-A had no idea how the bruises occurred. Staff were expected to report a bruise right away to the nurse. During an interview on 12/12/25 at 2:47 p.m., LPN-B stated R1 did not have the best memory but was able to respond appropriately to questions some of the time. R1 stated no one hurt him and she trusted what he said. LPN-B worked on 11/13/25, and learned during report he had a bruise on right hip. No documentation had been written in his chart prior to her assessment. R1 had a purple/red bruise with yellowing around the outside of it approximate size of a 50-cent piece. No open areas. LPN-B informed RN-D of the bruise and was informed weekly skin monitoring would be set up to assess the bruise. LPN-B worked on 11/14/25, and administered Tylenol for right hip pain, did not visually assess the hip. LPNB returned to work on 11/17/25, and was informed R1 had been sent to ER on 11/16/25. LPN-B assessed the right hip and identified significant dark purple bruising located on right flank and back of right thigh. LPN-B stated the staff nurse would be expected to report the bruising and investigation started immediately for an unexplained bruise when identified to rule out if he was harmed by anyone to keep residents safe. During an interview on 12/12/25 at 2:11 p.m., licensed practical nurse (LPN)-A stated she identified LPN-B made the first documentation on 11/13/25, in R1’s progress notes regarding his bruise and should have been reported right away. On 11/15/25, R1 complained of right hip pain, grimacing, staff indicated he was in pain with transfers, which was unusual for R1, he also had a scratch and a light in color bruise on the lateral side of the right hip. R1’s bruises could have been considered suspicious and unknown as to how they occurred.	F0609		

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F0609 SS = D	Continued from page 17 During an interview 12/15/25 at 3:00 p.m. RN-C stated a bruise was documented on 11/13/25, in R1's progress notes located on right hip about four to five inches in diameter. RN-C saw the bruise on 11/15/25, and verified was located on his right hip area only, denied pain, and was not documented. R1's cognition was not intact to be reliable with his memory. Based off the documentation the bruise was not suspicious, R1 did not see an injury occurred. The bruise was from an unknown origin (did not know what caused it) and was reportable to the State Agency within two hours to make sure there was not neglect, or an injury caused by someone. RN-C stated the staff nurse should have notified the director of nursing (DON), administrator, family, and provider sooner. During an interview on 12/15/25 at 3:42 p.m. floor manager RN-D stated staff would have been expected to notify her when bruise was found and right hip pain without relief from interventions. RN-D was made aware of the bruises and right hip pain on 11/17/25, when assessed with his daughter. R1's cognition was severely impaired, and his memory varied. Progress notes on 11/13/25, identified R1 was asked what caused the bruise, and he was able to tell staff he was not hurt. On 11/15/25 at 5:18 a.m., the bruise was found with pain and should have been reported to the state; report was filed late. The investigation should have been initiated right away on 11/15/25, to figure out if he had an injury and which staff worked with him. RN-D was unable to identify what had caused the bruises. During an interview on 12/15/25 at 4:08 p.m., social service director (SSD) stated a resident with a brief interview for mental status (BIMS) rated at a three indicated severe cognitive impairment. R1 would have had difficulty making decisions, short term memory was impacted greatly and the recall after a couple of minutes would have been most likely impossible. R1 responded to questions regarding the bruises but was unable to identify who was involved and was not an accurate historian. Once R1's large bruises were identified they should have been reported to MDH. During an interview on 12/15/25, at 5:15 p.m., DON stated R1 had a severely impaired cognitive memory. DON was if he could have recalled what happened. R1 started having right hip pain on 11/8/25 and was not identified as new. DON found out later R1 was medicated with Tylenol and right hip pain up was up to six, eight, nine or over 10. The nurses reported discomfort in the right hip. The RN should have been notified on 11/13/25, when right hip pain was identified and	F0609		

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F0609 SS = D	Continued from page 18 contacted the provider sooner to make sure there was not anything more serious going such as an injury that would have caused more pain or discomfort. There was more bruising from unknown origin identified on 11/15/25, staff nurse should have notified DON that day, state report should have been filed, and investigation started to protect the residents from possible abuse/neglect and made sure needs were being met. DON was contacted the evening of 11/16/25, informed about additional bruising and unaware of the increase in right hip pain. Facility policy Neglect, and Exploitation dated 8/2/25, identified it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The facility will have written procedures that include Reporting of all alleged violation to the Administrator, state agency, adult protective services, and to all other required agencies within specified time frames: 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.	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. This REQUIREMENT is NOT MET as evidenced by:	F0610	F610 Investigate / Prevent / Correct Alleged Violation 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. A licensed nurse completed skin checks on all residents to ensure no other residents had injuries of unknown origin or unreported changes in condition. No additional concerns were identified. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice, and what systemic changes will be implemented to ensure the deficient practice does not recur. A licensed nurse completed skin checks on all residents to ensure no other residents had injuries of unknown origin or unreported changes in condition. No additional concerns were identified. The facility developed a new policy titled “Determining Interview Status of Residents” to guide staff in assessing each resident’s ability to participate in interviews. Interview status will now be added as a Care Plan Focus. Social Services will complete this	01/14/2026

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F0610 SS = D	Continued from page 19 Based on observation, interviews and document review the facility failed to thoroughly investigate an allegation of potential resident abuse for 1 of 1 residents (R1) who was found to have an injury of unknown origin. Findings include: R1's annual Minimum Data Set (MDS) dated 10/17/25, identified entered facility on 10/31/24, from a skilled nursing facility (SNF). He had minimal difficulty with hearing and impaired vision (sees large print, not regular print in newspaper/books). He was severely cognitively impaired without behaviors. He was dependent for toileting hygiene, required substantial/maximal assistance for all transfers, frequently incontinent of bladder, and occasionally incontinent of bowel. Diagnoses included atrial fibrillation (a common heart arrhythmia where the upper chambers (atria) quiver instead of contracting effectively, leading to an irregular and significantly increasing stroke risk) arthritis, Non-Alzhemier's dementia (a group of neurodegenerative disorders, like vascular dementia that affects cognition, behavior, and function often involving blood flow issues (vascular) or protein deposits (Lewy bodies), anxiety, depression, history of falling), anxiety, and depression. Currently taking an anticoagulant (blood thinner, reduces blood clotting, may bruise easily and take longer for bleeding to stop). R1's orders identified on 11/5/25, Apixaban (a blood thinner used to prevent blood clots and stroke) tablet. Give 5mg (milligrams) by mouth two times a day related to paroxysmal Atrial Fibrillation. R1's electronic medication administration record (EMAR) from 11/8/25 through 11/17/25, identified: Tylenol 500 mg was administered three times from 11/8/25 through 1/10/25, for right hip pain ranged from two to four out of 10. Tylenol 1000 mg was administered six times from 11/11/25 through 11/17/25, for right hip pain ranged from three to eight out of 10. R1's care plan dated 12/17/25, identified: all transfers (started 10/9/25) sit to stand with assist of two and as needed (PRN) Hoyer lift for pain or difficulty standing/following directions, resolved on 12/17/25. Transfer (started on 12/17/25) Hoyer lift with 2 assist using the hourglass large sling for all	F0610	Continued from page 19 assessment upon admission, quarterly, and with any significant change. Nursing and Social Services will use this information to ensure investigations are conducted appropriately and all residents are monitored effectively. The VA Investigation Form was updated to ensure complete and consistent documentation, including required interview details, timelines, and specific dates of resident and staff interviews. Education on the updated policies and procedures was provided during the nurses' meeting on 1/7/2026. Staff who were unable to attend will complete the training prior to their next scheduled shift. A facility wide message was sent to ensure all nurses are aware of the required training and makeup sessions. 3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON, Social Services Director, or Administrator will conduct weekly audits of VA investigations to ensure all required interviews are completed appropriately and documented accurately. The individual conducting the audit will vary based on who completed the original investigation. Audits will be completed weekly for one month, then every two weeks until sustained compliance is demonstrated. Audit results will be reviewed by the QAPI Committee to ensure corrective actions remain effective and to determine whether additional revisions are needed. Following QAPI review, the committee will establish the long term audit frequency. 4. The date that each deficiency will be corrected. The deficiency will be corrected by January 14, 2026.	

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F0610 SS = D	Continued from page 20 transfers. Potential for falls related to weakness, history of falls, cognitive impairment with impaired safety awareness, visual deficit/blind in right eye, use of psychotropic medications, and impaired balance. Staff were directed to approach from front or left side, floor mat, hi/low bed, toileting schedule, provide a safe environment, gripper socks, anti-reverse brakes on wheelchair, and call don't fall sign place in room and bathroom. He had knee pain due to arthritis, right artificial knee joint and restless leg syndrome (RLS). Impaired cognition related to short term memory problem, time orientation difficulty, and difficulty hearing. Staff were directed to report changes in cognitive status. R1 was a vulnerable adult related to assistance needed for activities of daily living (ADLS), impaired communication and decision-making skills, and impaired mobility. Staff were directed to listed to his concerns and report any inappropriate or suspicious behaviors to the proper authorities. R1's progress notes from 11/10/24, through 11/17/25, identified: -On 11/10/25 at 4:24 a.m., noted during cares an approximate four centimeter (cm) scabbed scratch area noted on right hip located where the edge of the brief touches his skin. -On 11/10/25 at 7:41 p.m., gave 500 mg Tylenol po every six hours PRN for mild pain. R1 grimacing and with rolling and repositioning. Follow-up at 8:49 p.m., effective pain zero out of 10. -11/10/25 at 11:17 p.m., Weekly skin inspection has multiple scabbed areas on right lower extremity and face. No bruising. -11/11/25 at 5:38 p.m., Gave 1000 mg Tylenol po every six hours PRN for moderate to severe pain. R1 jumpy in wheelchair seat at evening meal. Reporting hip pain. Follow-up at 7:57 p.m., effective pain zero out of 10. -11/12/25 at 11:12 a.m., Unable to stand today. -11/13/25 at 2:46 p.m., Bruise noted to right upper groin/hip area red/purple to center and yellowing around edges. He denied cause being from any suspicious or inappropriate behavior. Bruise does not appear suspicious. Denies pain. -11/13/25 at 2:49 p.m., Gave 1000 mg Tylenol po as needed for moderate to severe pain. Complained of right hip pain and facial grimacing. Follow-up at 4:28 p.m., effective pain rated zero out of 10.	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 21 -11/14/25 at 12:33 a.m., gave 1000 mg Tylenol PRN for moderate to severe pain. Right hip pain. Follow up at 3:08 a.m., effective pain rated zero out of 10. -11/14/25 at 1:50 p.m., Gave Tylenol. Wiggling around in chair and swearing under his breath when he moved a certain way or when he tried to hold up his feet. Pain rated eight out of 10 using PAIN-AD scale (assesses pain in residents with cognitive impairment). Follow-up at 5:23 p.m., effective pain rated zero out of 10. -11/14/25 at 11:40 p.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow-up at 1:43 a.m., effective pain rated zero out of 10. -11/15/25 at 5:18 a.m., Bruising observed above posterior right knee and extended into upper posterior thigh. No pain with palpitation. -11/15/25 at 9:54 a.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow up at 12:00 p.m., effective pain rated two out of10. -11/15/25 at 5:28 p.m., Gave Tylenol for complaints of increased right hip pain. Follow up at 7:26 p.m., ineffective. Pain rated six out of 10. Stated his pain was the same or worse since Tylenol administration. Facial grimacing. Has a yellowish brise with deep purple red marks across right hip. -11/15/25 at 9:38 p.m., Right hip bruise was yellowing with areas of dark purple. Appeared slight swollen. Tylenol administered at p.m. meal. Checked in with R1 twice and he stated it did not help much at all. Offered ice/heat, refused. Appeared to be in moderate pain. -11/16/25 at 3:58 p.m., Gave Tylenol for complaints of increased right hip pain. R1 grimacing, groaning. Rates pain at eight to nine out of 10. Noted to position self so he was lying on his left hip, offloading pressure on the right. Large ice pack applied. Follow-up at 6:47 p.m., continued to complain of increased right hip pain. Continuing with ice and repositioning. -11/16/25 at 8:39 p.m., R1 had a large amount of bruising noted to posterior right leg and right anterior hip area. Legs are equal in length. Right hip pain with movement and external rotation, no pain at rest. He did not remember hurting himself stated “when you get old you just get fragile, I guess”. Phoned daughter and updated, currently on her way to facility to assess if she would like him sent in or not. Per	F0610		

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F0610 SS = D	Continued from page 22 daughter request was sent to ER to have right hip assessed. Provider on-call approved transfer to ER. Left facility via ambulance at 9:20 p.m. -11/17/25 at 12:21 a.m., Returned to facility via ambulance. No signs of pain, no grimacing or verbalization of pain. Received Tylenol at 10:23 p.m. -11/17/25 at 12:08 p.m., daughter visited. Writer evaluated R1's bruising. Deep purple bruising remained to right posterior leg from behind knee to groin area, small scattered red bruising to lateral right thigh and softball sized deep purple bruise to right lower back. Faded bruising to right anterior hip. No c/o pain to back or lower leg. Complained of pain to right outer hip when palpated or pressure placed on area. Unable to lay on right side. No swelling or deformity noted to right hip. Daughter expressed concern that he had fallen and not reported she was unable to figure out how else the bruising occurred. Writer and daughter tried to brainstorm together but unable to determine definitive cause for bruising. He denied anyone hurting him. He will be a Hoyer lift for all transfers as EZ stand transfers are too unsafe. Requested MD [doctor] be contacted for better pain control. -11/17/25 at 12:14 p.m., Fax sent to primary provider (MD) to update on ER visit from last evening and requested pain medication orders. R1's ER visit dated 11/16/25 at 9:43 p.m., identified [R1] presented with concerns about hip pain/bruising. Imaging result on 11/16/25, x-ray of right hip/pelvis. Impression: no definite fracture or dislocation was identified. Diagnoses: contusion (bruise) of right hip. R1's primary provider visit dated 11/19/25, identified the primary driver of the bruising suspected was the apixaban. Does not appear to be concerning for injury. Denied any staff injury, unable to identify how bruises occurred, and felt safe. Continue to monitor closely. Facility 5-day report submitted to the Minnesota Department of Health (MDH) dated 11/19/25 at 4:55 p.m., identified an incident report was submitted on 11/16/25 at 10:34 p.m., regarding an allegation of unexplained injury of unknown source occurred on 11/16/25 at 8:43 p.m. Bruising was noted to posterior right hip, leg and front of hip. Unknown source of origin. He did not know how bruising occurred, no recollection of any recent falls or events that could have caused significant bruising, has a poor memory, on Eliquis, and required	F0610		

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F0610 SS = D	Continued from page 23 assistance of two staff to transfer in an EZ stand lift. Initial bruising (4 to 5 smaller bruises that resulted in a larger bruise) was noted on 11/11/25. Between 11/15/25 p.m. [evening] shift and 11/16/25 at 0430 he remained in bed due to not needing incontinence cares until 0430. At that time the night NA went to assist with cares and noted the bruise went from the bottom of his buttocks to his knee on the right leg. Night nurse was notified, and bruising charting was initiated. On 11/16/25, prior to midnight the NA's noted old bruising on the right hip lighter in color. On 11/16/25, at approximately 8:30 p.m., registered nurse (RN) checked on R1 due to complaints of pain and found the bruising had expanded, darker in color than what was observed on 11/16/25. Some bruising was noted on upper back. Pain was managed by Tylenol 1000 mg, hot/cold packs and repositioning. Family, director of nursing (DON), and administrator were notified, and he was sent to emergency room (ER) at 9:20 p.m. ER visit indicated no major injury, and diagnosis was hip bruise and constipation. During an observation on 12/12/25 at 1:06 p.m., nursing assistant (NA)-B and NA-A entered R1's room with an EZ total lift machine. R1 sat in WC. Loops from sling lift located underneath him were hooked up to the lift machine bar, lifted off wheelchair and transferred to the bed. Pulled down his pants, skin was observed. NA-A identified where the bruises used to be located on right hip, entire length of backside of right upper thigh, and the outer middle right side of his back. No bruises were seen during this observation. R1 stated, "it hurts," when turned onto his right side. During an interview on 12/12/25 at 1:20 p.m., NA-A stated she identified a bruise on R1's backside of his mid-thigh on 11/13/25, looked like a thumb print red/purple and no yellow, looked fresh. She informed the nurse (unsure of which one) on the day shift. She worked again on 11/15/25 and saw big dark purple bruises on his right middle lateral flank round, approximately six inches in diameter, and back of right thigh that covered the entire area from just above his knee to top of his thigh. She had no idea how the bruises occurred. Staff were expected to report a bruise right away to the nurse. During an interview on 12/12/25 at 2:47 p.m., licensed practical nurse (LPN)-B stated R1 did not have the best memory but was able to respond appropriately to questions some of the time. R1 stated no one hurt him	F0610		

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F0610 SS = D	Continued from page 24 and LPN-B trusted what he said. She had worked on 11/13/25 and learned during report he had a bruise on right hip. No documentation had been written in his chart prior to her assessment. R1 had a purple/red bruise with yellowing around the outside of it approximate size of a 50-cent piece. No open areas, asked if R1 was harmed and he replied, "no." LPN-B informed RN-D of the bruise and was informed weekly skin monitoring would be set up to assess the bruise. LPN-B worked on 11/14/25, and medicated R1 with Tylenol for right hip pain. LPN-B did not visually assess the hip. LPN-B returned to work on 11/17/25 and was informed R1 had been sent to ER on 11/16/25. LPN-B assessed the right hip and identified significant dark purple bruising located on right flank and back of right thigh. Staff nurse would be expected to report and start an investigation for an unexplained bruise when identified to rule out if he was harmed by anyone, to keep residents safe. During an interview on 12/15/25 at 2:09 p.m., medical director /primary provider (MD) stated R1's memory and cognition were poor due to dementia. He was able to answer questions about his bruises, denied anything happened, was believable and credible. He was taking Eliquis, would have not taken much trauma/injury and only a bump could have caused the bruising. MD did not have an explanation as to why R1 had bruises in the areas he did. R1 did not have right hip pain prior to the incident. The staff would have been expected to update him on a weekly visit or sooner. MD was not contacted when R1 was sent to ER on 11/16/25. MD would have expected staff to notify him of any bruises or hip pain right away so that nothing was missed and concerns were evaluated as soon as possible. When MD arrived at the facility on 11/19/25, while rounds were being completed, he was told R1 needed a follow-up visit after the ER visit. That was the first time MD was informed of right hip pain and bruises. Upon assessment R1 had bruises located on the right hip, buttock, and superior (flank) to the right lateral abdominal wall mildly tender upon palpation. Color of the bruises were typical, purplish with some yellow, indicated maturing which made sense if they were identified around 11/13/25. No abuse suspected but unsure as to how he received the bruises. During an interview on 12/15/25 at 3:42 p.m., floor manager RN-D stated staff would have been expected to notify her when bruise was found and right hip pain without relief from interventions. She was made aware of the bruises and right hip pain on 11/17/25, when assessed with his daughter. R1's cognition was severely impaired, and his memory varied. A licensed practical	F0610		

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F0610 SS = D	Continued from page 25 nurse (LPN)-B documented on 11/13/25, R1 was asked what caused the bruise, and R1 was able to tell staff he was not hurt. The bruise was not measured and should have been. On 11/15/25 at 5:18 a.m., the bruise was found with pain and should have been reported to the state; report was filed late. The investigation should have been initiated right away on 11/15/25, to figure out if he had an injury and which staff worked with him. RN-D was unable to identify what had caused the bruises. R1's bruising with hip pain should have been reported to the provider right away to identify the underlying reason for the pain. During an interview on 12/15/25 at 4:08 p.m., social service director (SSD) stated a resident with a brief interview for mental status (BIMS) rated at a three indicated severe cognitive impairment. R1 would have had difficulty making decisions, short term memory was impacted greatly and the recall after a couple of minutes would have been most likely impossible. R1 responded to questions regarding the bruises but was unable to identify who was involved and was not an accurate historian. Once R1's large bruises were identified they should have been reported to MDH. During an interview on 12/15/25, at 5:15 p.m., DON stated R1 had a severely impaired cognitive memory. DON was if he could have recalled what happened. R1 started having right hip pain on 11/8/25 and was not identified as new. DON found out later R1 was medicated with Tylenol and right hip pain up was up to six, eight, nine or over 10. The nurses reported discomfort in the right hip. The RN should have been notified on 11/13/25, when right hip pain was identified and contacted the provider sooner to make sure there was not anything more serious going such as an injury that would have caused more pain or discomfort. There was more bruising from unknown origin identified on 11/15/25, staff nurse should have notified DON that day, state report should have been filed, and investigation started to protect the residents from possible abuse/neglect and made sure needs were being met. DON was contacted the evening of 11/16/25, informed about additional bruising and unaware of the increase in right hip pain. Facility policy Abuse, Neglect, and Exploitation dated 8/2/25, identified it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. An immediate investigation is	F0610		

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F0610 SS = D	Continued from page 26 warranted when suspicion or reports of abuse, neglect, or exploitation occur. Written procedures for investigation include identifying and interviewing all involved persons, including alleged victim, alleged perpetrator, witness es and others who might have knowledge of allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation.	F0610		