Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 8, 2026

Administrator
Lifecare Greenbush Manor
19120 200TH STREET
GREENBUSH, MN 56726

RE: CCN: 245616
Cycle Start Date: October 16, 2025

Dear Administrator:

On January 5, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2025

Administrator
Lifecare Greenbush Manor

19120 200TH STREET
GREENBUSH, MN 56726

RE: CCN:245616
Cycle Start Date: December 12, 2025

Dear Administrator:

On December 12, 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, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 12, 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 12, 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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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Electronically delivered

December 12, 2025

Administrator
Lifecare Greenbush Manor
19120 200TH STREET
GREENBUSH, MN 56726

Re: Event ID: 1D9323-H1

Dear Administrator:

The above facility survey was completed on December 12, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Greenbush Manor	**19120 200TH STREET , GREENBUSH, Minnesota, 56726**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/14/25 through 10/16/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey H56165783C (2639755) and H56165784C (2639898).	20000		12/18/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/16/2025**

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245616	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2025

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F0000	INITIAL COMMENTS On 10/14/25 through 10/16/25, 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 complaints were reviewed: H56165783C (2639755) with deficiency issued at F600 H56165784C (2639898). Deficient practice was identified related to incidental finding F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		12/18/2025
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0600	F600 Free from Abuse & Neglect SS=D How corrective action will be accomplished for those residents found to have been affected by the deficient practice. NA was suspended immediately and terminated as a result of investigation findings. How the facility will identify other residents having the potential to be affected by the same deficient	12/18/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245616**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/16/2025**
NAME OF PROVIDER OR SUPPLIER **Lifecare Greenbush Manor**	STREET ADDRESS, CITY, STATE, ZIP CODE **19120 200TH STREET , GREENBUSH, Minnesota, 56726**		

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F0600 SS = D	Continued from page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 3 residents (R1) were free from physical and verbal abuse during cares when a nurse aid (NA) made derogatory statements and provided rough care during activities of daily living (ADL) services which was witnessed by another employee and had other witnessed incidents of verbal abuse that went unreported due to staff feeling intimidated or fearful of retaliation. Findings Include: R1's quarterly Minimum Data Set (MDS) dated 9/15/25, identified diagnoses of non-traumatic brain dysfunction. R1 was dependent upon staff for all cares, repositioning, transfers, and frequently incontinent of bowel and bladder. R1's diagnoses report dated 10/15/15, also identified she was suffering from dementia. R1's care plan dated 9/26/25, identified she had an activities of daily living (ADL) self-care performance deficit related to weakness and memory loss. Staff were directed to provide extensive to total assistance of one to two for personal hygiene and toilet use. She had behavioral symptoms and severe impaired cognition, memory loss related to dementia, asks repetitive questions, lacks safety awareness, can be combative with cares, will holler or sing out loud. Staff were directed to provide opportunity for positive interaction/attention, reassurance regarding her stay, and monitor/document/report changes in behaviors/mood/cognition and any signs/symptoms of depression, anxiety, mood as per facility monitoring protocols. Facility investigation dated 10/13/25, identified on 10/9/25 at 3:00 p.m. NA-B reported she observed NA-A wipe R1 aggressively and rough while providing peri cares. She poked or went deeper than needed and heard NA-A address R1 by stating, "God you fucking stinking [sic]. You're no fucking help". During peri cares NA-B observed R1 grimacing and was asked if she was okay, R1 stated no two times. Resident interviews were completed without concerns. Staff peer reviews were completed and	F0600	Continued from page 1 practice. Staff education provided to staff on abuse and prevention. Education included review of VA policy and focused on immediate reporting. LifeCare employee handbook related to employee conduct including retaliation reviewed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Interview 3 residents or staff per week X 12 weeks to monitor for potential abuse and knowledge of reporting immediately and without fear of retaliation. Report findings to QAPI. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur. Ongoing education. Audit resident and staff interviews. Report findings to QAPI. The date that each deficiency will be corrected. 12/17/25	

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F0600 SS = D	Continued from page 2 identified NA-A provided resident cares appropriately but was not warm and fuzzy in her interactions, always cranky, verbally inappropriate while she provided cares, stated “fucking sticks” in front of the resident, and staff feared retaliation by NA-A due to being confrontational. NA-A denied allegation but was witnessed by one employee. NA-A was suspended immediately and terminated after investigation. Informal education was and is being provided at daily stand-up meeting about the importance of speaking out immediately when you believe something wrong had occurred. Allegations: verified. Review of Daily Nurse Communication Sheets from 10/9/25 through 10/15/25, identified: -10/9/25, 10/13/25, 10/14/25, 10/15/25, and 10/16/25, no documentation regarding R1 and incident -10/10/25 Handwritten note at bottom of page *Reminder – All staff are mandated reporters for vulnerable adults (VA). Review of NA-A’s personnel file disciplinary actions taken: -9/15/25 at 3:00 p.m. Comments made one evening in the dining room in front of residents. This type of behavior was not acceptable and will not be tolerated at this facility. We are here to provide services to them with dignity and respect. Retaliation was against the facility’s policy and will lead to further disciplinary actions if identified or observed. During an observation on 10/14/25 at 1:49 p.m., 2:20 p.m., and 3:56 p.m. R1 laid in a low bed with room lights off, shade pulled down, television on and family member sat next to her bed in a chair. During an observation on 10/14/25 at 4:00 p.m., nursing assistant (NA)-C and NA-D entered R1’s room and she opened her eyes. NA-C introduced herself and informed R1 they were there to complete a check and change and get her repositioned, R1 was observed to smile. NA-D rolled R1 onto left side and NA-C pulled her pants down, removed soiled brief, completed peri cares, applied barrier cream and placed a clean brief underneath her. NA-C explained each step to her while she was rolled R1 onto her right side and pulled up her pants. R1 did not verbally respond. R1 was repositioned onto her right side, pillow placed behind her back and covered with a blanket. The bed mattress had raised sides and was lowered down to the floor. Call light was clipped to her shirt and head of bed elevated to	F0600		

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F0600 SS = D	Continued from page 3 approximately 30 degrees. Interactions were appropriate with no concerns. During an interview on 10/14/25 at 2:00 p.m., family member (FM) stated R1 was defenseless, not coherent much of the time, woke up for short periods of time, smiled, did not talk much, and was unable to tell her what happened. Their sister had called and made her aware there was an allegation a NA was too physical during cares with a witness. During an interview on 10/14/25 at 2:26 p.m. NA-B stated she assisted NA-A with cares on 10/6/25, in the afternoon. R1 laid in bed with a sling lift sheet located underneath her and was incontinent of stool. NA-A stated out loud, R1 “you fucking stink and you’re no help”. R1 was rolled towards her and NA-A cleaned up her bottom. R1 was very stiff, and her extremities were hard to move. She indicated NA-A was aggressive with cares, wiped R1 ruff, hard, and scraped her bottom. R1’s reaction was obvious, she flinched physically, and her face winced like she tasted something bad. NA-A slapped the wipes onto her bottom and appeared to hurt R1 physically by the way she responded. R1 did not deserve to be treated like that. NA-B asked R1 if she was ok and she stated, “no” immediately and when she asked R1 if she was okay, she also stated “no”. When R1 responded quickly to the question twice it was serious, and in the moment appeared painful. Once cares were completed NA-A stormed out of the room, slammed the door, which was a frequent occurrence. NA-B stated she remained with R1, apologized and informed her she would do something about how she was treated. Prior to this incident she had witnessed NA-A in the dining room one day when they served pork chops. While NA-A cut up a resident’s porkchop, which were kind of tough, she stated out loud in front of the resident, “she can choke as much as I care”. NA-A occasionally made comments to NA-B like, “I’m sick of her” (meaning resident) or “I do not want to do her today”. During an interview on 10/14/25 at 2:30 p.m., NA-C stated she had witnessed verbal concerns with NA-A previously, she had a snatchy tone (short with the residents) at times. The NA-A no longer worked at this facility. She had not seen any physical concerns; but did not believe she would not do that in front of the nurse. She had witnessed NA-A inappropriately make comments about a resident directly in front him by stating, “he shit his pants”, and had an attitude and was irritable with resident cares especially with behaviors. The last three to four months NA-A bullied staff and lacked good bedside manners. NA-A had called R1 lazy and unable to do things any more or help with	F0600		

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F0600 SS = D	Continued from page 4 her cares, in front of her. During an interview on 10/15/25 at 2:45 p.m., NA-F stated R1 was assist of one to two for cares and check and change every two to three hours. She was able to respond to a yes or no question verbally or nod her head, depending on the day. Approximately two weeks ago she had a bad shift with NA-A, went after her verbally, fisty, replied with a certain attitude, displayed confidence, bullied, and made her uncomfortable. The past month NA-A showed signs of being annoyed with R1, stated out loud in front of her she was an agger like Sherk and rough handled during cares, yanked her around. She overheard NA-A verbally in a loud voice demanding a resident to stand up, come on, let's go (voice carried). NA-A had verbally stated to her regarding a resident, "I'm fucking done with her you can talk care of her". She reported her concerns to DON the first Thursday of October 2025. NA- A created stress for staff, and afraid of her, she would verbally attack those that reported her. During an interview on 10/15/25 at 2:53 p.m., NA-A stated on 10/9/25, after dinner approximately 1:00 p.m. she assisted NA-B with R1's check and change. Everything went fine, we were laughing and R1 was giggling with us. She had cleaned R1's front peri area along with NA-B. R1 was rolled over onto her side and she cleaned her bottom, no excessive pressure was used. R1 tended to stiffen herself when turned or repositioned and pushed against us, can be frustrating and made it harder at times (especially when the sling was placed underneath her). She had not recalled saying anything offensive to R1or sworn in front of residents. R1 spoke few words and some days she randomly sang out loud. Two to three weeks prior to this day she was pulled into the DON's office and was informed she was reported for saying something inappropriate in the dining room. None of the staff liked her, felt she was being targeted, retaliation, and false aquations were made. She received a call on 10/10/25, asked to come in, unable to, interviewed, later that day was called back and terminated. Last shift worked was on 10/9/25. During an interview on 10/16/25 at 11:25 a.m., care coordinator registered nurse (RN)-B stated on 9/6/25 at approximately 3:00 p.m. NA-B made her aware of the incident with R1 during cares and NA-A, before she finished her explanation of what happened she was taken to the social service office and asked to repeat her story. It was a no brainer, needed to be reported, made her sick to her stomach and we do not talk to our residents like that here. R1 had dementia and this incident did not appear to impact her when she cleaned	F0600		

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Lifecare Greenbush Manor	**19120 200TH STREET , GREENBUSH, Minnesota, 56726**

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F0600 SS = D	Continued from page 5 her bottom, did not see any irritation or emotional or physical harm. During an interview on 10/16/25 at 9:38 a.m. DON stated she was contacted on 10/9/25 at approximately 3:44 p.m. and incident happened at 2:00 p.m. NA-A had made rude comments and inappropriately wiped R1 during cares and said ouch (assumed it was the way she wiped her). NA-A was suspended immediately pending investigation. She had asked staff why they did not come forward sooner with concerns regarding NA-A and she was informed NA-A was intimidating and bullied them. Verbal abuse was verified and hard to determine when she wiped was abuse, however approach was not ok. NA-A was not a person that should have been working with residents in the nursing home and was terminated. Informal education was provided to staff immediately during stand-up and passed along from shift to shift. Mandatory education will be completed for all staff by 10/24/25. During an interview on 10/16/25 at 1:36 p.m., assistant administrator stated a couple of weeks prior to the 10/9/25, on 9/15/25 she was made aware of an incident involving NA-A and a resident in the dining room. NA-A served a resident chicken, NA-B asked if she usually cut up the chicken and NA-A stated she did not care, she could choke on the bone for all she cared. NA-B verbalized fearful of retaliation. NA-A was interviewed and did not deny the incident happened. She was notified of the R1's incident that occurred on 10/9/25 at 3:44 p.m. NA-A had left for the day, was not allowed to work again, and terminated on 10/10/25. Facility policy Venerable Adult-Resident Abuse, Neglect, Mistreatment and Misappropriation of Property dated 2/19/25, identified each resident will be free from abuse, neglect, mistreatment, and misappropriation of property. Abuse can include but is not limited to physical harm, pain, mental anguish, verbal abuse (derogatory terms), sexual abuse, or involuntary seclusion from any source. All residents will be protected from abuse, neglect, and harm while they reside at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. In the event of suspected maltreatment, the needs of the resident will be immediately (upon knowledge) assessed, and the safety of the resident will be ensured. The resident will be assessed for physical appearance, skin injuries, trauma, or changed in resident affect, mood, and behavior. The investigation will consist of at least the following: a root cause analysis of all circumstances surrounding the incident. Ensuring safety and well-being for the vulnerable adult is of utmost	F0600		

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NAME OF PROVIDER OR SUPPLIER **Lifecare Greenbush Manor**	STREET ADDRESS, CITY, STATE, ZIP CODE **19120 200TH STREET , GREENBUSH, Minnesota, 56726**		

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F0600 SS = D	Continued from page 6 priority. Examine, assess and interview the resident immediately upon knowledge to determine any injury. Verbal abuse was defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability.	F0600		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure 1 of 3 residents (R1) who were involved in an allegation of rough care/abuse by staff had and initial and ongoing skin and behavioral tracking to monitor for sign of abuse. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/15/25, identified serve impaired cognition without behaviors and that she was dependent upon staff for all cares, repositioning, transfers, and frequently incontinent of bowel and bladder. Facility investigation dated 10/13/25, identified on 10/9/25 at 3:00 p.m. NA-B reported she observed NA-A wipe R1 aggressively and rough while providing peri	F0610	F610 Investigate/Prevent/Correct Alleged Violation SS=D How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Skin assessment completed for R1. Staff education on assessing resident(s) for injury including physical and emotionally upon discovery of VA. How the facility will identify other residents having the potential to be affected by the same deficient practice. Education provided to license staff to observe and document findings and actions taken. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Education and ongoing education to licensed staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur. Audit future VA's to ensure documentation includes assessing and ongoing assessing is completed. Report findings to QAPI. The date that each deficiency will be corrected.	12/19/2025

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F0610 SS = D	Continued from page 7 cares. She poked or went deeper than needed and heard NA-A address R1 by stating, “God you fucking stinking [sic]. You’re no fucking help”. During peri cares NA-B observed R1 grimacing and was asked if she was okay, R1 stated no two times. Resident interviews were completed without concerns. Staff peer reviews were completed and identified NA-A provided resident cares appropriately but was not warm and fuzzy in her interactions, always cranky, verbally inappropriate while she provided cares, stated “fucking sticks” in front of the resident, and staff feared retaliation by NA-A due to being confrontational. NA-A denied allegation but was witnessed by one employee. NA-A was suspended immediately and terminated after investigation. Informal education was and is being provided at daily stand-up meeting about the importance of speaking out immediately when you believe something wrong had occurred. Allegations: verified. Review of R1’s task history orders for 10/9/25, identified: -Description: Monitor for peri area and buttocks for bruising, injury, or increase complaints of pain related to 10/9/25 incident. -Description: Monitor behavior for signs and symptoms (s/s) of emotional distress related to incident on 10/9/25. Located on the history order sheet - Progress notes last six months: no progress notes found for the above two orders. R1’s behavior tracking log form dated October 2025, identified no documentation entered. R1’s NA documentation monitor behavior symptoms every located in electronic medical record under tasks identified the following options: frequent crying, repeats movement, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate, rejection of care, none of the above observed. Review of NA behavior monitoring documentation from 10/8/25 through 10/15/25 identified: -On 10/9/25, all three shifts documented none of the above observed.	F0610	Continued from page 7 12/17/25	

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F0610 SS = D	Continued from page 8 -On 10/10/25, two shifts documented none of the above observed and one shift failed to document -On 10/11/25, one shift documented none of the above observed and two shifts failed to document -On 10/12/25, all three shifts documented none of the above observed. -On 10/13/25, one shift documented none of the above observed and two shifts failed to document -On 10/14/25, one shift documented none of the above observed and two shifts failed to document -On 10/15/25, two shifts documented none of the above observed and one shift failed to document R1' progress notes from 10/4/25 through 10/11/2, identified: -On 10/4/25 at 10:22 a.m. Weekly body audit: skin pink, dry, and intact with some scattered bruising. No concerns for trimming nails currently. -On 10/7/25 at 1:54 a.m. Typically sleeps well at night, checked for incontinence on routine rounds . . . head of bed (HOB) elevated and bed in low position with floor mattress. -On 10/7/25 at 9:10 p.m. On coumadin, had fall last week, noted faded bruising on left shin 4 centimeters (cm) with yellow outer edges, older bruise and healing and denied pain. -On 10/11/25 at 11:01 a.m. Weekly body audit: received a bath this a.m. skin intact, no new areas of concern noted. She was on coumadin, no new bruising. Current weight 189.7 pounds (lbs.). R1's daily report sheets (handwritten entries)10/7/25 through 10/15/25 reviewed with no documentation of incident information, skins checks or behavior monitoring. Review of Daily Nurse Communication Sheets from 10/9/25 through 10/15/25, identified: -10/9/25, 10/13/25, 10/14/25, 10/15/25, and 10/16/25, no documentation regarding R1 and incident	F0610		

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F0610 SS = D	Continued from page 9	F0610		

-10/10/25 Handwritten note at bottom of page *Reminder – All staff are mandated reporters for vulnerable adults (VA).

10/11/25, and 10/12/25 missing documents

During an interview on 10/15/25 at 11:25 a.m., licensed practical nurse (LPN)-A stated nursing staff were expected to have completed a weekly skin check on every resident and important to check for bruising, pressure ulcers, and open areas. She had heard about an incident related to R1alleging rough handling and verbal abuse. She had not been informed of any additional assessments required for R1 though a daily skin assessment should have been entered into the EMAR/TAR and/or documented in the progress notes so that R1's skin could have been monitored closely. Behavior documentation would have been expected to be completed by the nurse (EMAR/TAR) daily and every shift. The NAs would be expected to document daily every shift under tasks in the electronic record system, check boxes with options.

During an interview on 10/15/25 at 4:45 p.m., registered nurse (RN)-C stated she was aware of a complaint regarding R1 but had no specific details. When there was an allegation of abuse the nurse would be expected to assess and document at least every shift on behavior/mood and skin. Any changes could have indicated an adverse effect of the incident, emotional/physical harm and residents with cognition issues/deficits required an assessment to have looked for non-verbal cues. The behavior tracking would be expected to be completed by the NA every shift using the task log and if left blank she would assume negative behavior but unsure. At the end of the shift, she recapped with the NAs for any updates. R1 was unable to answer questions and generally very calm. No changes had been noticed in her behaviors that she was aware of.

During an interview on 10/16/25 at 9:38 a.m., DON stated she was contacted on 10/9/25 at approximately 3:44 p.m. and incident happened at 2:00 p.m. NA-A had made rude comments and inappropriately wiped R1 during cares and said ouch (assumed it was the way she wiped her). NA-A was suspended immediately pending investigation. We placed monitoring for bruising in R1's electronic medication record (EMAR)/Treatment administration record (TAR). DON verified she was not able to identify in R1's medical record skin monitoring

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F0610 SS = D	Continued from page 10 and indicated it appeared it was missed. No formal assessment was completed and documented after the allegation of physical/verbal abuse. The nurse would have been expected to assess the skin especially the per area for bruising. Would have been important to have a separate entry/assessment to assure the nurses were specifically assessing the areas (peri area/buttocks). From there, DON added she would have expected the nurse to assess this every shift and sign it off, and a progress note would have been expected. There was a daily report book (saved for six months then discarded) the nurse would document appointments, labs, behaviors/falls/illness/family visits. DON reviewed R1's entries on the daily report book and verified no documentation from 10/9/25 through 10/15/25 regarding skin and/or behaviors. The expectation for nursing behavior documentation would have not been any different with an allegation of abuse and was documented by exception only. The NAs were to document any concerns on a tracking form (discarded by the nurse) during their shift but do not always get used and instead communicate with the nurse instead. The NAs were expected to document behaviors under tasks section in the electronic record system, unsure as to how often they should document. During an interview on 10/16/25 at 11:25 a.m., care coordinator RN-B stated on 9/6/25 at approximately 3:00 p.m. NA-B made her aware of the incident with R1 during cares. The expectation would be the nurse on duty to have completed an assessment after the allegation of abuse on10/9/25 and that was not done. A weekly skin assessment was completed on 10/11/25, but that was first time an assessment was documented since the incident. We trust our administration team and if they deemed more skin assessing was needed it would have been added. The nursing staff were expected to document in progress note any time there was a change in condition. After the allegation of abuse, there was no scheduled behavior charting added to be completed by the nurse. We relied on the NAs to bring that to our attention and report it. The nurse would observe the skin when they assist with a transfer and pass medications. She was not asked to add behavior charting to R1's medical record. RN-B stated there was behavior charting, check off list under tasks for the NA's and would be expected to complete it daily every shift. RN-B verified there was not consistent documentation under the behaviors task list by the NAs. During an interview on 10/16/25 at 1:36 p.m., assistant administrator stated she was notified of the R1's	F0610		

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F0610 SS = D	Continued from page 11 incident that occurred on 10/9/25 at 3:44 p.m., NA-A had left for the day, was not allowed to work again, and terminated on 10/10/25. The staff nurse would have been expected to complete an assessment including skin and emotional as soon as the alleged perpetrator was removed and document. Important to assess immediately to collect a baseline identify injuries and extent of them. The care coordinator in this case should have collected the data and completed the initial assessment (must be licensed staff) right away. Behaviors and skin assessments should have been completed and monitored daily every shift for at least the first three days to identify a baseline, worsening condition and physical or emotional changes had occurred. If no changes were identified such as behaviors of abuse and/or skin the order would have been discontinued or extended. She entered R1's orders for nursing to monitor skin and behaviors and had not realized for some reason it did not go onto the TAR. Those assessments were not completed. She would have expected the care coordinator nurse to monitor and review the notes over the weekend and should have been caught at that time. NAs were expected to document under tasks every shift R1's behaviors and if none were identified a check mark should have been place in the last column none observed. The five-day facility investigation report did not identify as initial assessment was completed after the incident and should have to identify the severity of the abuse. Facility policy Venerable Adult-Resident Abuse, Neglect, Mistreatment and Misappropriation of Property dated 2/19/25, identified each resident will be free from abuse, neglect, mistreatment, and misappropriation of property. Abuse can include but is not limited to physical harm, pain, mental anguish, verbal abuse (derogatory terms), sexual abuse, or involuntary seclusion from any source. All residents will be protected from abuse, neglect, and harm while they reside at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. In the event of suspected maltreatment, the needs of the resident will be immediately (upon knowledge) assessed, and the safety of the resident will be ensured. The resident will be assessed for physical appearance, skin injuries, trauma, or changed in resident affect, mood, and behavior. The investigation will consist of at least the following: a root cause analysis of all circumstances surrounding the incident. Ensuring safety and well-being for the vulnerable adult is of utmost priority. Examine, assess and interview the resident immediately upon knowledge to determine any injury.	F0610		

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F0610 SS = D	Continued from page 12 Verbal abuse was defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability.	F0610		