DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2026

Administrator
THE GREEN PRAIRIE REHABILITATION CENTER
800 SECOND AVENUE NORTHWEST
PLAINVIEW, MN 55964

RE: CCN: 245345

Cycle Start Date: August 31, 2026

Dear Administrator:

On August 31, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 1, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 1, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 1, 2026.

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

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 1, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Tina Larsen, Regional Supervisor, Federal Rapid Response
Health Regulation Division

Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 28, 2027 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at

Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions

regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

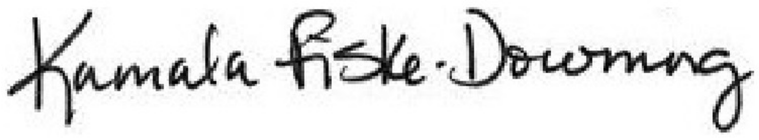
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 17, 2026

Administrator
THE GREEN PRAIRIE REHABILITATION CENTER
800 SECOND AVENUE NORTHWEST
PLAINVIEW, MN 55964

Re: Event ID: 343513-H1

Dear Administrator:

The above facility survey was completed on August 31, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2026

Administrator
THE GREEN PRAIRIE REHABILITATION CENTER
800 SECOND AVENUE NORTHWEST
PLAINVIEW, MN 55964

RE: CCN: 245345
Cycle Start Date: August 31, 2026

Dear Administrator:

On September 17, 2026, we notified you a remedy was imposed. On October 13, 2026 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 9, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 1, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 17, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 1, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 9, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245345	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST , PLAINVIEW, Minnesota, 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 8/31/26, an abbreviated survey was completed by a surveyor from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaints were reviewed: H53453953C (3178032, 3178364) with past non-compliance cited at F689. In addition, a current noncompliance incidental finding was identified and cited at F744. 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		10/09/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe transfer using a mechanical lift was completed for 1 of 1 resident (R1) reviewed. R1 was resistive to care and	F0689	"Past Noncompliance - no plan of correction required"	08/27/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245345	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/31/2026

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F0689 SS = G	Continued from page 1 did not want to get up from the bed, however, two staff members proceeded to place a hoyer sling underneath her and began to transfer her from the bed to a shower chair despite R1 being resistive. R1 became more physically behavioral while in the device (i.e., wiggling around, moving) which caused her shoulder to nudge free from the sling mid-air and resulted in an avoidable fall from the lift. R1 sustained a scalp hematoma (i.e., goose egg) with bleeding, bruising on her left side, increased pain, and mental anguish (i.e., tearfulness) from the event which constituted actual harm. However, the facility took multiple corrective actions starting on 8/27/26, prior to the onsite survey, so these findings are being issued at past noncompliance. Findings include: R1's quarterly Minimum Data Set (MDS), dated 6/25/26, identified R1 had moderate cognitive impairment but no hallucinations or delusions. R1 demonstrated no physical (i.e., hitting, kicking), verbal (i.e., threatening, screaming), other behavioral symptoms, or rejection of care behaviors during the review period. R1 received scheduled pain medication and non-pharmacological interventions for pain, with occasional pain reported during the previous five days. R1 rated the pain as, "01," on the 0 to 10 scale (10 being worst). Further, R1 had no recorded falls since admission/entry/reentry or the previous MDS assessment. R1's MHM (Monarch Healthcare Management) Lift/Mobility Status Form – V3, dated 6/25/26, identified R1 was unable to stand, pivot and walk without at least limited assistance from staff members. R1 had a history of falls recorded but was considered a candidate for using the sit/stand lift (i.e., mechanical stand). The section labeled, "Lift Plan," identified the staff assessed R1 to use a full body lift with assist of two. The type and size of the sling to be used for R1 was recorded as, "Medium Slings." The assessment marked that both the care plan and NA (nursing assistant) care sheets were updated. The evaluation concluded with a section labeled, "Comments," which outlined, "Depending on resident's behaviors, it will determine which lift will be used. Transferring resident to chair or to bed is done with the assist of 2. Either [stand] or Hoyer lift depending on assistance from resident." The completed evaluation lacked evidence of what specific behaviors R1 demonstrated which could impact her transfers. R1's MHM Weekly Skin Inspection V-6, dated 8/19/26, identified R1 received a shower and R1	F0689		08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245345	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/31/2026

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F0689 SS = G	Continued from page 2 allowed a full skin check to be completed. The form recorded R1 had a “discoloration” to her right leg and added, “ … bruise resolved to left elbow.” No further bruising was recorded to R1’s body with this evaluation. The Assignment 4 (NA care sheet), dated 8/26/26, identified R1’s name and basic care instructions to provide care. R1 had a weekly bath/shower scheduled for Wednesday morning and the column labeled, “Transfer,” directed a 2 assist with an EZ Stand (mechanical stand device). However, the column labeled, “Hoyer Sling Size,” identified, “Med [medium].” R1 was to have female caregivers only but the sheet lacked any further information on what, if any, behaviors R1 demonstrated which could impact her transfer status as identified on the previous lift/mobility evaluation (dated 6/25/26). R1’s progress note, dated 8/26/26, identified that at approximately 7:15 a.m., the nurse heard screaming coming from R1’s room. The note recorded, “While entering the room, nurse (writer) stated “if resident is refusing to take a shower at this time, keep her in bed until she is ready,” while saying this, resident was being transferred from bed to shower chair using hoyer lift. Resident began moving in sling while being transferred and fell from hoyer lift.” The nurse assessed R1 and 911 was called. R1 had swelling noted to the back of her head with blood coming from the area, but no other injuries were noted at that time. EMS arrived and R1 was sent to the hospital. Licensed practical nurse (LPN)-A authored the note, and R1 returned from the hospital on the same day at 10: 52 p.m. R1’s ED Notes, dated 8/26/26, identified R1 presented from the care center via EMS who reported the care center staff were transferring R1 using a hoyer lift “and dropped the [patient] about 4 feet.” R1 sustained a head strike but no loss of consciousness. R1 had a “large bump to posterior head with dried blood noted.” R1 was complaining of right upper arm pain and was recorded with, “Bruising and swelling to left thigh, knee, and ankle also noted.” R1 had a series of imaging completed which were negative for fracture, and R1 was discharged back to the care center. R1’s progress note, dated 8/27/26, identified a note completed in conjunction with a nursing order which read, “Monitor for [signs and symptoms] of injury post fall X 72 hours [nursing order].” The staff recorded, “bruising, hematoma.” R1’s SNF Follow-Up/Acute Visit note, dated	F0689		08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245345	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/31/2026

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F0689 SS = G	Continued from page 3 8/27/26, identified R1 was evaluated by the provider at the care center. R1's past medical history was outlined and the note recorded, "She is functionally dependent, requiring assistance with ADLs and uses mobility aids." R1 had chronic right shoulder pain which was managed with Tylenol, lidocaine patches and topical agents. The note then recorded, "On 8/26/2026, she was evaluated for a fall with hypotension and hematoma, managed conservatively, and discharged safely to her facility." R1 endorsed some nausea and dizziness upon exam but no headache. The note recorded, "She is tearful recounting [the] fall. Has some noticeable pain in the left knee and grimaces with flexion and palpation of the knee. Does share that she did receive a hit to her left knee recently with fall. No overlying bruising." The physical exam recorded a nickel-sized abrasion on the scalp and palpable crepitus (medical term for popping, cracking, crunching, or grinding noise and sensation that comes from the knee joint during movement) with range-of-motion to the left knee. The findings for the abrasion and crepitus were both recorded in bold font. An assessment/plan was listed which recorded, "3. Fall, subsequent encounter … Reassuring work up in ED yesterday after fall from hoyer. Tearful from recounting experience as was understandably frightening. Imaging of left knee was obtained in ED which showed severe osteoarthritis which is correlated with crepitus with AROM today on exam. Some nausea reported which could be concussion related to head strike reported with fall from hoyer … - Schedule diclofenac gel 1% (topical cream for pain)." R1's Incident Note, dated 8/29/26, identified R1 had late onset bruising to her bilateral lower extremities mostly on the posterior side of her left leg. The note recorded, "Scattered bruising with pain to the touch." R1 stated the bruises were from the fall and " … hurts only when we have to grab her legs and move them." R1's fall care plan, dated 8/27/26, identified R1 was at risk for falls due to a history of falls and impaired mobility. A goal was listed, "Resident will be safe and free from falls." The plan listed multiple interventions including use of a low bed, following PT and OT instructions for mobility, and no pedals on the wheelchair. The plan also listed several interventions with a recorded initiation (start) date of 8/27/26. These interventions included providing education provided to all staff on how to care for the R1 while having behaviors, using a large-sized hoyer sling, and using a hoyer for all transfers to wheelchair and/or bed.	F0689		08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245345	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/31/2026

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F0689 SS = G	Continued from page 4 On 8/31/26 at 9:50 a.m., R1 was observed lying in her bed asleep. R1 did not wake with verbal interaction. There were no visible hoyer slings in her room or wheelchair, and R1 was covered with blankets. In the hallway outside R1's room, a single Guldmann mechanical lift was present. There were no slings on the device. The device's user manual was zip-tied to it which identified step-by-step instructions on how to use the device and considerations for its use. There was a section labeled, "Important," with several bulleted items including, "Always plan your lift before commencing." Following, at 9:56 a.m., NA-B was interviewed and explained they were shown how to use the device by another NA when they started at the care center but felt they knew how to use it prior from working at other jobs. The nurse then watched them use it and signed them off on it. NA-B demonstrated how to use the device and explained the sling would be placed under the patient and hooked to each of the attachment points on the cradle (two total) using either the green or grey-colored loops. NA-B stated the loop color used did not matter to their knowledge, but they use the green-colored loop usually as it makes the sling have tighter fit around the resident's body. Each resident had their own sling stored in their room, and two NA were present for every transfer using the machine. R1 stated if a resident was behavioral or moving around while trying to lift them in the device, then they should just be put back, and the transfer should not be completed. If the resident started to move mid-transfer, such as in between the bed and destination, then they would likely just get them to the destination "as quickly as possible." NA-B then stated they routinely worked with R1 and recalled R1's fall from the Guldmann mechanical lift on 8/26. NA-B was in the room assisting NA-C with the transfer when it happened. It was R1's shower day and R1 "[was] never happy on her shower days" so it was not unusual for R1 to have some behaviors. R1 refused to help move her feet off the bed for the NA but was not yelling or screaming loudly. NA-B and NA-C proceeded to place the large-sized sling and raise R1 up into the air using the lift. NA-B verified they did not check the sling size before they started the transfer. R1 then suddenly "threw her arm out of the side" of the harness so NA-B turned to quickly get R1's wheelchair but R1 fell onto the floor before they could place it. NA-B stated they didn't feel R1 did not want to get up on that morning, despite not helping with her feet, and the hollering was normal for R1. R1 was not being	F0689		08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245345	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST , PLAINVIEW, Minnesota, 55964

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F0689 SS = G	Continued from page 5 physically combative, or they would not have attempted the transfer. R1 seemed to “fight it more [getting up]” on days when she had a shower scheduled. NA-B stated the fall “happened so fast” and R1 sustained a “goose egg” from it on her head along with some bruising on her left side. The bruising was “pretty bad.” Since the fall, the DON educated NA-B that they should have just left R1 in a “safe spot” since she was behavioral, but NA-B stated, “That is what we were trying to do [get her to the chair].” DON also mentioned they should have likely just left R1 in bed as residents have the right to refuse care or get up. NA-B stated that, in hindsight, they would not change anything from the actions up to the fall and added, “Everything we did was right.” NA-B then acknowledged the care sheet directed to use a medium sized sling which is not what they used that morning when R1 fell. This was just an error “in the heat of the moment” so they used the sling which had been in the room. The DON discovered the wrong sling after the fall and then reprimanded and educated them and NA-C on it. However, when R1 returned from the hospital, she (R1) was re-measured and found to require a large-sized sling, so while they didn’t follow the care sheet on 8/26, they technically used the right sling size in hindsight. NA-B stated they were unsure who or how often the residents are re-measured for sling size at the center. NA-B then stated they would make sure to check for the correct sling size, in hindsight, with hoyer lift transfers. When interviewed on 8/31/26 at 10:28 a.m., NA-C stated they had worked at the care center for about four months now, and recalled they never really were given much, if any, training on how to use the lift devices adding, “Nobody really talked about it.” NA-C stated they had learned how to use it while in school and “went about that,” adding further, “I just went with the flow.” NA-C did not recall any nurses ever checking them off on using the device. NA-C stated a resident’s sling size would be listed on the care plan and their care sheet but was unsure who decided on which size to use. The green-colored loops on the sling were used “usually” unless it was a larger person being transferred. The NA staff use the loops “with what works best for us” as the loops to use are not listed on the care plans. NA-C stated it was “common sense” to use the green loops. NA-C then recalled the incident with R1 on 8/26/26, and verified they were in the room assisting with the transfer with NA-B present. NA-C stated they started to provide care while R1 was still in bed and R1 had been starting to hit out at them and trying to pull her night gown back down as they were changing her. It was like R1 didn’t want help	F0689		08/27/2026

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F0689 SS = G	Continued from page 6 or to do what they were trying to get done. NA-C stated they were told in training that if R1 was refusing to get up to then use the hoyer lift and not the mechanical stand adding that is why they used that device on 8/26/26. The large-sized sling was placed under R1 and NA-C verified they never checked the size prior to placing it. They checked the care plan (which called for a medium-sized) but that was after the fall happened. NA-C stated they just “went off the assumption” it was the correct sling as it had been in R1’s room. R1 was then raised up from the bed in the sling using the mechanical lift when R1 started “wiggling around.” This happened “as soon as she [R1] didn’t feel her bed” below her. NA-C pulled the lift away from the bed and then turned counterclockwise to position R1 and the device in the middle of the room. NA-B was on the opposite side getting the wheelchair ready when suddenly R1 “slipped out” of the sling and onto the floor. NA-C stated they had never been told prior to stop a transfer if someone is physically behavioral. NA-C also stated the lift device itself never malfunctioned to cause the fall, rather it was caused by R1 moving “side to side” while in the air trying to get out of it. During the transfer, the nurse opened R1’s doorway and saw R1 in the air while conversing with NA-B about something. The nurse never said anything about leaving R1 in bed if refusing and reiterated documentation saying that “is not true.” NA-B stated that since the incident, the DON had provided re-education to them and others about transferring and checking the sling size prior. NA-C stated R1 would not have fallen out of the sling if she had not been moving around adding, “No, not at all.” NA-C stated they were made to “sign some papers” the following day by the DON about not following the nurses’ instructions to leave R1 in bed but reiterated that was not true. NA-C stated that since the incident, R1 seemed “a lot more sensitive” and easily triggered and upset by small things, such as her hair not getting done. R1 seemed, in general, to be “more anxious” since the fall happened. When interviewed on 8/31/26 at 12:25 p.m., the director of therapy (DOR) stated the therapy department were not the people who measured for sling size or ever adjusted care plans with that information. R1 had been a stand-pivot transfer previously but lately needed more help. Therapy had re-evaluated R1 after she returned from the ER on 8/26/26 and deemed her to remain now a “total hoyer” for all transfers. DOR stated if a patient started to move and wiggle during a transfer, then the appropriate action would be “stop the situation” and not keep going. To keep going while the patient	F0689		08/27/2026

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F0689 SS = G	Continued from page 7 is moving would be “putting yourself [caregiver] and the patient in danger in my opinion." Further, DOR stated “any movement” of a person in a lift, but also depending on how aggressive it was happening, could impact the safety of the person being transferred. When interviewed on 8/31/26 at 12:36 p.m., licensed practical nurse (LPN)-A stated they worked for an outside agency but picked up at the care center often for shifts. LPN-A recalled R1’s fall on 8/26/26 and stated she heard screaming coming from R1’s room through the closed door. LPN-A opened the door and saw R1 being transferred “in the air” using the mechanical lift by NA-B and NA-C. LPN-A asked what was happening as R1 was “clearly upset,” and then directed NA-B and NA-C to leave R1 in bed if she didn’t want to get up or take a shower. The NA replied they were then going to be behind in work and would get in trouble by management. Then, as that comment was said aloud, R2 shifted her weight and moved then fell onto the floor. LPN-A immediately assessed R1 and found her to have a “golf ball sized lump” on her head with some bleeding. R1 was crying and “really upset” and didn’t want anyone to touch her. LPN-A stated they finally got R1 sent to the hospital with EMS. LPN-A explained that the staff usually used a mechanical stand on R1 to help her transfer, and they were unsure why the aides elected to use a lift that day instead. LPN-A stated they did not do any education with staff on how to use the devices, rather that was the DON who did that. LPN-A verified the device itself did not break or malfunction to cause the fall, rather it was the NAs not stopping the transfer sooner and leaving R1 in bed like she had wanted. LPN-A stated, “This [fall] would have been avoided.” R1 was observed on 8/31/26 at 1:03 p.m. seated upright in her wheelchair while in her room playing with a puzzle on a card table. R1 had visible bruising on her hand and an interview was attempted. R1 was unable to recall how long she’d lived at the care center and mostly responded with, “Yea,” to questions. R1 was asked if she had any recent falls and again just responded aloud, “Yea.” R1 did not articulate any details about the fall, how it happened, or how she felt now about it when asked. On 8/31/26 at 1:25 p.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed. DON explained lift use was trained to staff upon hire and then annually thereafter. The training included a show of the device, then a return demonstration to either a nurse or the DON/ADON. DON verified there had been no education to staff	F0689		08/27/2026

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F0689 SS = G	Continued from page 8 about behaviors of residents while in the device (i.e., start moving around, attempting to get out) prior to R1's fall on 8/26/26. The IDT discussed R1's fall and felt it happened due to R1's behavior. They had "never thought" to educate staff on how to handle transfers while behavioral prior as something like that had not happened. There was also not a formal process to ensure residents would be routinely identified and re-measured for sling size prior to the fall, however, that would now be redone annually or with a significant change in status. DON verified NA-B and NA-C both had training on the use of the lifts prior to operating them and would provide the information (see below). DON then recalled R1's fall on 8/26/26. The ADON received a call from the nurse who then updated the DON. The DON arrived onsite while R1 was being sent to the hospital. NA-B and NA-C were removed from the floor and immediately provided re-education on transfers with behavioral residents and using the care planned sling size. A VA report was then completed and submitted. The education provided to NA-B and NA-C was then started to be sent to all staff members and tracked via email responses. DON verified that upon remeasure, R1 needed a large-sized sling so the care plan was adjusted. A call was also placed to the lift company to help answer some questions to ensure the right lift sling was used. They also completed a whole house audit of residents who used the hoyer to ensure their care plans were correct and the sling was right. The DON stated the fall happened because R1 started moving around while in the air and the staff "should have lowered her back down or put her back in bed." The fall was likely avoidable and would not have happened if they had done that. DON verified R1 obtained a "goose egg" and some bleeding from the fall along with some bruising on her left side. Further, DON reiterated they immediately started education with the staff. NA-B and NA-C's Facility Training Policy Acknowledged form(s), dated 4/30/26 and 7/15/25 respectively, identified they had been provided training on the mechanical lifts and transferring of patients. These forms were signed by the staff members and a nurse. On 8/31/26 at 2:47 p.m., a telephone interview was completed with the lift company representative (LCR)-A provided by the DON. He stated he was unsure of the details about R1's fall or the situation and said to contact corporate but was unsure of their contact information. He responded, "I don't want to get involved with this."	F0689		08/27/2026

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F0689 SS = G	Continued from page 9 The provided Safe Resident Handling Program policy, dated 3/2020, identified procedures to ensure both the residents and staff members involved remained safe and free of injury with transfers and handling. Manual lifting would be minimized. Each resident would be assessed for safe patient handling needs using the MHM Lift/Mobility Status Form “and for each relevant activity in the care delivery process.” The information would then be in the care plan. Training to nurses and other employees would then be provided to demonstrate proper application and use of the handling equipment. The past noncompliance harm-level findings were corrected on 8/27/26, after the facility started and took multiple corrective actions. This included auditing all residents to ensure the correct lift sling size was care planned and available for use; updating R1’s NA care sheet with current information; starting re-education with all staff members to ensure appropriate use of the mechanical lift; and re-assessing R1 for their transfer status to ensure safety. These actions were verified as completed during the onsite investigation and no other residents had sustained a fall from the lift in the care center.	F0689		08/27/2026
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed, develop or implement interventions to reduce distress and behaviors on bath days for 1 of 3 residents (R1) reviewed. R1 displayed signs of dementia with obvious cognitive impairment and was identified by the staff to have increased behaviors on her bath/shower days but the medical record lacked evidence this had been evaluated by the interdisciplinary team (IDT) to determine if additional interventions were needed. Findings include: R1’s quarterly Minimum Data Set (MDS), dated 6/25/26, identified R1 had moderate cognitive impairment and no symptoms of delirium. R1	F0744	R1’s care plan was reviewed, and interventions were implemented to reduce distress and behaviors on bath days. Green Prairie Rehabilitation Center does ensure that a resident that is experiencing behaviors is assessed and will have an appropriate care plan in place with appropriate interventions to reduce behaviors on shower/bath days. Policies and procedures regarding behavior monitoring have been reviewed and continue to be appropriate. All residents will have target behavior monitoring orders in place were reviewed and reflect any changes needed. All residents with target behavior monitoring orders in place have been reviewed, and care plans have been updated as needed to reflect any resident specific behaviors related to showers and baths. Immediate verbal staff education was received on 08/31/2026 on how to appropriately care for a resident that is having behaviors during transfers. All nursing staff will be educated on how to appropriately recognize and report behaviors, identify potential triggers, what to do when a	10/09/2026

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F0744 SS = D	Continued from page 10 demonstrated no delusions, hallucinations, other behavior symptoms (i.e., physical, verbal, other), or any rejection of care behavior during the review period. R1's medical diagnoses included other neurological conditions, cerebral palsy, seizure disorder or epilepsy, and depression. R1's most recent MHM (Monarch Healthcare Management) Target Behavior Form – V6, dated 6/25/26, identified R1 consumed anti-depressant medication and had no recent changes to doses. The section labeled, "Charted Behaviors," identified staff dictation which read, "Resident has had increased behaviors such as yelling out when puzzle pieces fall on the floor or she doesn't like a certain staff member. Much of her behaviors are yelling out loud." There were no additional causative factors listed only dictation, "See above [prior statement]." The non-pharmacological interventions written included redirection, food/fluids, and repositioning. The recommendations just recorded, "Continue to use the non-pharmacological interventions." IDT reviewed the care plan and no changes were made, IDT also reviewed R1's target behavior monitoring orders and no changes were made. R1's Assignment 4 (care sheet), dated 8/26/26, identified R1 was scheduled for a Wednesday morning (AM) bath/shower. The column labeled, "Special Needs," just directed to use female caregivers only. R1's progress notes, dated 6/1/26 to 8/31/26, identified multiple notes about observed behaviors which staff recorded under the order for monitoring target behavior. These included: On 6/3/26, R1 was "anxious/yelling out" before her shower that morning. Reassurance was given. R1 was upset about her puzzle piece. On 6/17/26, R1 was "verbally aggressive" with her shower that morning. On 7/22/26, R1 was combative with care that morning. The note recorded, " … attempted to hit staff while helping her get ready for her shower. Resident was redirectable." On 8/5/26, R1 was again combative and yelling at staff while preparing for her shower. R1 was difficult to redirect but seemed calmer with redirection and reapproach. On 8/26/26, R1 was refusing to take a shower according to the nurse. R1 was being transferred	F0744	Continued from page 10 resident becomes resistive or distressed, documentation expectations and when the IDT will need to reassess interventions by the compliance date at the next staff meeting. Behavior monitoring orders have been placed in the POC system for staff to document on any behaviors that may occur before, during and after showers or baths. IDT will review the monitoring for patterns/triggers and determine whether the interventions are effective or need to be changed. Audits will be done on residents with known behaviors/resistance to care to determine if they have behaviors associated with bathing, showering, transfers, or other care activities. If behaviors are identified, IDT will assure that the behaviors/triggers have been assessed and appropriate interventions are reflected in the care plan and be sure that staff are able to follow the resident specific interventions and will be discussed with the IDT team during our monthly IDT target behavior meeting. DON or designee will audit compliance operation weekly X 4 weeks, monthly X 3 months, then quarterly thereafter. Audit results will be reviewed by the QAPI committee for further recommendations. Audit form: DON/ADON/SW	10/09/2026

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F0744 SS = D	Continued from page 11 using a mechanical lift and began to move around while being moved and fell onto the floor. R1 sustained a head strike and some bleeding. R1 was sent to the hospital for evaluation. R1's Follow Up Question Report, dated July 2026, identified R1's nursing assistant (NA) charting responses for the month. This included to chart what behavior happened, how many times on that shift, approaches attempted, and any trend. The charting recorded R1 as being resistive or refusing care on 7/1/26 (Wed), 7/7/26 (Wed), and 7/29/26 (Wed). In total, six (6) days had recorded behavior happen and of these, three (3) happened on R1's scheduled bath/shower day. R1's Follow Up Question Report, dated August 2026, identified the NA charting responses for the month. The same behavior questions were listed as July 2026, and the charting recorded R1 with only two behavioral episodes. On 8/5/26 (Wed), R1 was recorded as resisting care or refusing. On 8/26/26 (Wed), R1 was again recorded as resisting care or refusing. When interviewed on 8/31/26 at 9:56 a.m., NA-B stated they had worked with R1 multiple times and R1 had recently fallen due to "behaviors" while in the mechanical lift. NA-B recalled being there when R1 fell and stated it happened on R1's shower day then adding, "She is never very happy on her shower days." NA-B explained R1 was "just not a happy camper" on her shower days and could be, at times, very combative and yell at the staff while they help her. NA-B questioned if maybe R1 just didn't want to get up early but then stated R1 seemed "to fight it more [care]" on days when she knows a shower is scheduled. It could be the water or something else and NA-B added, "I'm just not totally sure." NA-B stated maybe an evening shift (i.e., PM) shower would help more as then R1 didn't have to get up so early. When interviewed on 8/31/26 at 10:28 a.m., NA-C stated they also had worked with R1 prior to her fall on 8/26/26. R1 liked her routines and would "get mad" if something was amiss with it each day. NA-C stated they had also noticed R1 to be generally more behavioral in the morning when a shower was scheduled. NA-C stated they thought it was waking up R1 earlier than usual to do it that may be upsetting her but was not sure. NA-C stated having a PM shower maybe better since R1 could then go immediately to bed adding, "I think that would be so much better with her." NA-C stated it had "always been like this" with R1 on her	F0744		10/09/2026

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F0744 SS = D	Continued from page 12 scheduled shower days and her having more behaviors it seemed. On 8/31/26 at 1:03 p.m., R1 was observed seated in her wheelchair in her room, R1 was playing with a puzzle on a table and appeared clean and without odor present. An interview was attempted but R1 only responded to most questions with, “Yea,” and did not give a meaningful response. R1’s cognition care plan, dated 11/2020, identified R1 had potential for impaired cognition due to her medical diagnoses and communication deficit. R1 was able to communicate her needs and feelings when asked. The plan added, “Resident is compliant with cares, medications, and treatments.” The plan directed to allow R1 time to communicate her needs/wants, document changes in orientation, and provide/maintain a consistent environment. The last time these interventions or that section was revised was 11/9/2020. The mood and behavior care plan, dated 9/2024, identified R1 as having an alteration in mood and behavior related to her change in level of independent and medical history. R1 had adjusted to placement at the center and was able to communicate her needs and feelings when asked. The plan here again outlined, “Resident is compliant with cares, medications, and treatments.” R1 disliked certain staff members. The plan listed interventions which included turning on the Vikings or Twins, being alert to changes with her mood/behavior, and monitoring her target behaviors per protocol. The last time these interventions were revised was recorded as 9/20/2024. However, the care plan lacked any interventions specific to R1’s shower/bath event or day despite the care center staff noticing increased resistance to cares and more behaviors on those days and/or possibly with that event. R1’s medical record was reviewed and lacked evidence the IDT had comprehensively assessed and determined what, if any, causative factors for R1’s increased behaviors on the scheduled bathing days; nor evidence what, if any, interventions were considered or implemented on those days despite the NA charting showing obvious behaviors on multiple scheduled bath/shower days and the direct care staff seeing/feeling like R1 had increased behaviors on those days. On 8/31/26 at 1:25 p.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed. DON acknowledged R1 had sustained a fall from the mechanical lift after becoming behavioral and moving around in the sling	F0744		10/09/2026

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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
F0744 SS = D	Continued from page 13 mid-transfer (see F689) and expressed the aides should have allowed R1 to refuse the care and not continued with the transfer when R1 was seeming to resist it. DON explained that behaviors were recorded in the point-of-care (POC) charting by the aides and told to notify the nurse when they happen so the nurses can better assess the situation. The nurses were also able to do behavior charting in their progress notes. DON stated they felt R1's behaviors had escalated since people of color were employed at the care center and R1 had it explained multiple times that everyone was there to help her and be kind. The nurse was responsible for assessing any behaviors and they would record that in the EMR system. DON stated they thought R1 used to be a scheduled PM bath, but it was moved to days (AM) as R1 also had behaviors on the PM but was unsure offhand when this was or what happened. R1 had been scheduled for a twice-a-week bath, too, but was reduced to one weekly for the behaviors. Following, at 3:06 p.m., DON had reviewed R1's medical record and reiterated nobody had reported any concerns with R1 having increased behaviors on her scheduled bathing day recently to them or the ADON. If concerns are seen, then they should be reported. DON stated they had just spoken with their regional nurse and didn't feel not bathing R1 in the shower or bath was an option. They were going to discuss what options they had further. DON stated the MDS nurse and the social services designee (SSD) were responsible to review the target behaviors being charted/tracked with the MDS cycle and could complete their assessments of them and update the care plans, if needed. A facility policy for behavior assessment and management was requested; however, none was received.	F0744		10/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/31/2026**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/31/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H53453953C (3178032, 3178364) MDH documents 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	20000		10/09/2026

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 **08/31/2026**

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20000	Continued from page 1 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		10/09/2026