



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

Administrator
WAVERLY GARDENS
5919 CENTERVILLE ROAD
NORTH OAKS, MN 55127

RE: CCN: 245613

Cycle Start Date: May 29, 2026

Dear Administrator:

On June 17, 2026, we notified you a remedy was imposed. On July 7, 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 July 2, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 2, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 29, 2026. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered

August 13, 2026

Administrator
WAVERLY GARDENS
5919 CENTERVILLE ROAD
NORTH OAKS, MN 55127

Re: Reinspection Results
Event ID: 2330E4-H2

Dear Administrator:

On July 7, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 29, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

June 17, 2026

Administrator

Waverly Gardens

5919 CENTERVILLE ROAD

NORTH OAKS, MN 55127

RE: CCN: 836967000

Cycle Start Date: May 29, 2026

Dear Administrator:

On May 29, 2026, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 28, 2026, the situation of immediate jeopardy to potential health and safety cited at F600 - Free from Abuse and Neglect was removed. However, continued non-compliance remains at the lower scope and severity of D.

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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 2, 2026.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 2, 2026 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 2, 2026 (42 CFR 488.417 (b)).

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.

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 May 29, 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Waverly Gardens is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 29, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may

request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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 "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor, Rapid Response

St. Cloud A District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: Nikki.Harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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 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 November 29, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered

June 17, 2026

Administrator

Waverly Gardens

5919 CENTERVILLE ROAD

NORTH OAKS, MN 55127

Re: State Nursing Home Licensing Orders

Event ID: 2330E4-H1

Dear Administrator:

The above facility survey was completed on May 29, 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245613		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/29/2026	
NAME OF PROVIDER OR SUPPLIER Waverly Gardens				STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD , NORTH OAKS, Minnesota, 55127			
(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 5/22/26, 5/26/26, through 5/29/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H56132528C (3018557, 3018766) with a deficiency issued at F600. As a result of the investigation, deficiencies was issued at F609, F610, F710. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to ensure R1 was free from abuse during cares on 5/16/26, when licensed practical nurse (LPN) performed manual removal of impacted feces from the rectum without consent reviewed for abuse. The IJ began on 5/16/26, and the immediacy was removed on 5/28/26 at 2:50 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted on 5/28/26. 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			07/02/2026
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and			F0600	“This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of		07/02/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245613		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/29/2026	
NAME OF PROVIDER OR SUPPLIER Waverly Gardens				STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD , NORTH OAKS, Minnesota, 55127			
(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
F0600 SS = SQC-J	Continued from page 1 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure 1 of 3 residents (R1) reviewed for abuse, was free from abuse during cares on 5/16/26, when licensed practical nurse (LPN)-A performed a manual removal of impacted feces from the rectum without consent and continued after R1 asked LPN-A to stop. The immediate jeopardy began on 5/16/26, when the facility failed to ensure R1 was free from abuse during cares when licensed practical nurse (LPN)-A performed a manual removal of impacted feces from the rectum without consent and continued after R1 requested he stop. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 5/27/26 at 5:00 p.m. The immediate jeopardy was removed on 5/28/26, but noncompliance remained at the lower scope and severity level D (isolated, scope and severity level) which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission Minimum Data Set (MDS) dated 5/26/26, identified R1 was admitted to the facility on 5/13/26, from the hospital. R1 had moderately impaired cognition and no behaviors. R1 had functional limitations in range of motion (ROM) in upper and lower extremities on one side. R1 required substantial/maximal assistance with personal hygiene, was dependent on staff for all transfers, repositioning in bed, toileting hygiene, and lower body dressing. R1			F0600	Continued from page 1 noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F600 Free from Abuse and Neglect It was noted on page 23/49 it states that the immediate jeopardy began on 3/16/26 and was removed on 5/28/26. Please note that immediate jeopardy began on 5/16/26 and ended on 5/28/26. Immediate Corrective Action: R1 remains a resident of the facility. R1 continues to be seen by Associated Clinic of Psychology to address ongoing psychosocial support. The facility also has assessed and will continue to assess R1 for psychosocial impact. R1 continues to receive daily skilled therapy and is progressing well towards her goals to discharge towards a lesser level of care. LPN-A remains out on administrative leave pending the facilities conclusion of their internal investigation. The Vulnerable Adult Policy dated 2025 remains effective. The facility also requested the Chief Medical Office to review the Policy "Impaction Removal" and "Bowel Management Program Policy" and both of these policies are current and remain effective. The facility standing house orders were reviewed and signed last January 26, 2026, and are based on the Minnesota Alliance of Geriatric Inspired Clinicians. Corrective Action as it Applies to Other Residents: All residents were interviewed by facility staff on 5/27/26 with no concerns regarding abuse or neglect identified. Facility has a grievance process which is used as a method to collect concerns and there have been no situations brought forward regarding abuse or neglect identified since survey exit. Reoccurrence will be Prevented By: Education was initially provided as part of the abatement plan Facility continues to provide education as needed. The facility will ensure residents are free from abuse and neglect by conducting interviews		07/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245613		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/29/2026	
NAME OF PROVIDER OR SUPPLIER Waverly Gardens				STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD , NORTH OAKS, Minnesota, 55127			
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F0600 SS = SQC-J	Continued from page 2 was frequently incontinent of bladder and occasionally incontinent of bowel with constipation. R1's diagnoses included: stroke, atrial fibrillation, hemiplegia or hemiparesis (weakness or paralysis on one side of the body), adjustment disorder, mixed anxiety and depressed mood. R1's care plan dated 6/14/26, identified: Limited physical mobility and unable to ambulate. Staff were directed to transfer R1 with assist of two with a stand lift and support right arm, unable to hold (Should this be fold) her hand but able to bend elbow slight. R1 was at risk for abuse and/or neglect. Staff were directed to follow the facility Vulnerable Adult (VA) policy. Keep her safe and refer to resident services as needed (PRN). R1's physician orders identified: May use house standing orders. Order date: 5/13/26. Hydroxyzine HCL (hydrochloride) (given for anxiety) 25 milligrams (mg) every four hours by mouth (po) as needed (PRN) for anxiety or insomnia. Senna (laxative used to relieve constipation) 8.6 mg give two tablets po every 24 hours as needed for constipation times two daily (no stool in the last day). Start dated 5/13/26. Polyethylene Glycol (MiraLAX) (laxative) 3350 oral powder 17 gm (Grams)/scoop po one time a day for constipation. Order date: 5/15/26. Discontinue date: 5/21/26. Behavioral Expression: every shift for clinical monitoring for seven days. Start dated 5/19/26. End dated 5/26/26. Buddy Cares at all times. Nurses and aides, every shift. Start date: 5/19/26. R1's electronic medication administration (EMAR) reviewed 5/15/26 through			F0600	Continued from page 2 with 10% of the resident census weekly for any concerns related to F600 for 4 weeks and these will be processed through the facility QAPI to determine ongoing frequency. Facility will also complete random audits all staff on varied s hifts weekly x4 weeks to ensure they understand residents' rights to be free from abuse and neglect and immediate reporting; results of these audits will be processed through QAPI for ongoing need and frequency. The facility administrator will be responsible for oversight. Date of compliance: July 2, 2026.		07/02/2026

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F0600 SS = SQC-J	Continued from page 3 5/22/26, identified: Polyethylene Glycol 3350 oral powder 17 gm/scoop one time a day po for constipation for three days. Administered 5/16/26, 5/17/26, and 5/18/26. Bisacodyl rectal suppository 10 mg insert rectally every 24 hours as needed for constipation, no stool in the last three days. Administered on 5/16/26 at 7:26 p.m. Hydroxyzine HCL give 25 mg po every four hours PRN for anxiety or insomnia. Administered on 5/21/26 at 9:02 p.m. Hydroxyzine Pamoate capsule 50 mg every four hours PRN po for anxiety or insomnia. Administered on 5/13/26, 5/15/26, and 5/17/26. Senna 8.6 mg give two tablets po every 24 hours PRN for constipation times two daily as needed (no stool in last day). Administered on 5/16/26 at 3:02 p.m. Behavior Expression: refer to progress note template for assessment and documentation requirements every shift for clinical monitoring for seven days all three shifts and Buddy cares at all times (nurses and aides) every shift. Start date: 5/19/26 at 3:00 p.m. Check marks noted on 5/19/26, evening and night shift, 5/20/26 and 5/21/26, for all three shifts, and 5/22/26, for day shift. Polyethylene Glycol (MiraLAX) (laxative) 3350 oral powder 17 gm/scoop po one time a day for constipation. Administered on 5/22/26. R1's nursing assistant (NA) bowel movement (BM) documentation reviewed 5/14/26 through 5/17/26, identified: 5/14/26, no BM 5/15/26, no BM			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 4 5/16/26 at 4:42 a.m. no BM and 9:42 p.m., large BM. 5/17/26 at 4:19 a.m.,12:40 p.m., and 7:58 p.m., medium BMs. R1's NA Target Behavior documentation reviewed 5/14/26 through 5/27/26, target behaviors 1. Crying/sad and 2. Anxiety/Agitation occurred. Intervention attempted. Intervention effective/ineffective. Documentation identified: Target behaviors were documented as did not occur or not applicable from 5/14/26 through 5/18/26, 5/20/26, and 5/27/26 (7 days). 5/19/26 at 1:38 p.m., anxiety/agitation, other, intervention ineffective. 5/21/26 at 10:59 p.m., anxiety/agitation, crying/sad, reassure, intervention effective. 5/22/26 at 2:50 p.m., anxiety/agitation, crying/sad, conversation, intervention ineffective. 5/23/26 at 5:36 a.m., anxiety/agitation, other, intervention effective. 5/24/26 at 11:08 p.m., anxiety/agitation, reassure, intervention effective. 5/25/26 at 8:55 p.m., anxiety/agitation, reassure, intervention effective. 5/26/26 at 9:55 p.m., anxiety/agitation, reassure, intervention effective. Provider initial visit/assessment to establish a plan of care dated 5/14/26 at 5:16 p.m., R1 was hospitalized on 4/18/26 through 4/22/26 for acute ischemic stroke. While at a transitional care unit (TCU) occupational therapy (OT) was working with R1, and had a very large stool (bowel movement) (BM) after some prolonged constipation, dizziness leaving the bathroom, syncope (fainting or passing			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 5 out), most likely a vasovagal event (the vagus nerve was stimulated typically from straining or discomfort during defecation leading to a sudden drop in heart rate and blood pressure which may result in fainting), loss consciousness, and pulselessness (lack of flow of circulation). A code blue (a medical emergency that required resuscitation) was called and R1 received 15 compressions with return of spontaneous circulation. R1's progress notes from 5/16/26 through 5/22/26, identified: 5/16/26 at 11:22 p.m., R1's daughter complained her mother had no bowel movements for the last three days. Senna was given per orders, rectal check was done and hard stool noted, suppository administered without results. Manual evacuation of stool was performed with removal of large amounts of stool. R1 expressed discomfort during the removal but was relieved at the end. 5/17/26 at 12:16 p.m., Alert and orientated to self with some confusion, increased anxiety observed upon rising this morning. Assist of two with stand lift transfer. 5/17/26 at 12:41 p.m., Family expressed concerns to staff regarding bowel habits, digital removal, policies regarding procedure. Family concerned that digital removal was painful, and she [R1] called family distressed after procedure was performed. Family expressed dissatisfaction with nurse who performed procedure. 5/17/26 at 11:56 p.m., Family wished to stay the night, staff prepared air mattress and bedding for family. Family changed mind later and went home to prepare for early morning appointment. Staff reported they would call family if any concerns arose during the night 5/18/26 at 1:00 p.m., Writer entered R1's room and daughter was present and brought up some concerns that she had been having. Writer reassured R1 and daughter that she would bring concerns to superiors. Writer immediately brought concerns to supervisor and director of nursing (DON) upon leaving room.			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 6 5/19/26 at 5:50 a.m., Overnight staff reported went to change R1, but she refused cares stating she was dry. Staff stated they just needed to change her brief, was a little wet from overnight, R1 was not pleased with that but let them. 5/19/26 at 7:16 a.m., R1’s daughter called writer and reported her mother called crying and needed help immediately. Writer went into R1’s room and she observed her sitting on bedside on the verge of tears. R1 stated “I haven’t slept since 5:00 a.m., because I do not know why people have to come in here and change people at 5:00 a.m. when they are supposed to be sleeping. Writer apologized, reassured her care plan will be updated. R1 stated “I am sorry to bother you with my complaints, but I am in pain.” Writer offered medication, accepted, and administered. 5/19/26 at 2:36 p.m., R1 alert, oriented to self, family, place with forgetfulness and confusion within her baseline. R1 refused therapy this morning due to fatigue per resident, slept in per request and cares were done as allowed by R1. 5/19/26 at 4:07 p.m., Email message sent to Pastor, daughter requested a visit for R1, thought it benefit her mom. 5/21/26 at 10:58 a.m., Pastor visit made. 5/21/26 at 4:30 p.m., DON checked in on R1. Daughter and ex-husband were both in R1’s room. Daughter inquired about the possibility of rectal bleeding following recent stool removal procedure, expressed concern related to potential rectal tearing. DON informed daughter if any tissue injury had occurred symptoms would likely have presented by this time and no observed or reported signs/symptoms identified. 5/22/26 at 2:21 p.m., R1 refused toileting, bed bath, and scheduled weekly shower, requested to be able to go back to sleep, stated not now, later, and reapproached with no success. R1’s Bowel, Bladder, and Skin Risk Assessment dated 5/17/26, identified areas affecting elimination patterns: decreased mobility, chair bound, and poor fluid intake. Bowel movement frequency was			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 7 identified as: more than three days since admission and constipation. PRN or routine bowel medications: senna PRN and MiraLAX daily. Suspected type of incontinence (due to) decreased mental awareness, decreased loss of mobility or personal unwillingness. Ability of skin and underlying tissue to tolerate exposure to pressure: no new skin integrity issues reported or observed. R1’s Body Audit completed on 5/22/26 at 6:25 p.m., by registered nurse (RN)-C identified current alterations in skin integrity: other type of alternations. Scattered bruising on belly and near both elbows/antecubital spaces. R1 had an old/healing scratch mark on her left shin, daughter said she thought it was from the lift machine in the hospital. All other areas of skin are clean, dry and intact. R1’s Body Audit completed on 5/27/26 at 9:11 p.m., by DON identified overall skin is clean, dry and intact. All bruises are in the healing stage, and the scratch continues to heal without issues. The peri-anal area was assessed and unremarkable. The anus is clean, intact, without visible cuts, tears, or lumps and is normal in size and shape. Psychology visit dated 5/22/26, identified R1, recently had an incident during caretaking where she felt violated by a staff member. It had been reported and investigated appropriately by the facility/regulatory officials. Appointment was made to follow up to evaluate distress and provide additional support. R1’s mental status exam identified oriented to general situation, short term memory mildly impaired, thought process linear, goal directed, and thought blocking (sudden interruptions in a person's thought process often associated with various mental health conditions), depressed and anxious mood, and quality of mood: anxious and dysphoric (“hard to bear” characterized by feelings of sadness, irritability, restlessness, and general discomfort). R1’s symptoms identified: moderate depressed mood and low self-worthlessness/guilt moderate, and mild crying spells. Regarding the recent incident, R1 stated she remained emotionally impacted but felt she continued to process and gained some emotional distance from it. R1 reported she felt increasingly supported and reassured by the facility response and identified several individuals she can reach out to if needed. She currently felt safe, heard and comfortable with the environment. Treatment recommendations: paired-care approaches, as she had identified this as reassuring and emotionally regulating for both herself and staff and			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 8 trauma-informed and emotionally validating approaches emphasizing predictability, reassurance, and collaborative communication (knocking before entering, announcing presence with name and role, extra attention to explaining cares, going slow and allowing her input). During an interview on 5/22/26 at 11:38 a.m., NA-F stated she saw R1 cry on 5/18/26. R1 stated the nurse abused her on 5/16/26, he placed his finger in her, and she begged him to stop. R1 told NA-F, he was smiling when she looked at him and every time she talked about it, she cried. Monday was a very difficult day for R1. When R1 cried on 5/18/26, it was different that day versus days prior to the incident since admission to the facility, R1 had more emotion and seemed completely upset with what happened to her. R1’s daughter informed NA-F the incident happened on 5/16/26 around 6:00 p.m. A male nurse (LPN-A) administered a rectal suppository. R1 told NA-F, at approximately 8:30 p.m., LPN-A put his finger her rectum to pull out the BM and hurt R1. R1 stated she just wanted him to stop, it was so painful. NA-F reported this incident right away to the DON on 5/18/26. NA-F stated when R1 requested the nurse to stop he should have stopped. LPN-A seemed to always smile. When NA-F asked LPN-A why he smiled all the time he told her why should I be angry? NA-F stated LPN-A had the kindest expression and did not think he would intentionally hurt anyone. NA-F stated she had not received education regarding abuse since this incident. During an interview on 5/22/26 at 12:37 p.m., R1 stated she had no concerns about staff until 5/16/26, when she was constipated and unable to have a BM. R1 felt the nurse was in a hurry, and one or two other female staff were in the room with him. The nurse inserted his finger into her anus, started to circle it around and informed her he had to do that to make the stool come out. R1 stated the male nurse kept circling his finger, “Over and over,” and she started to cry and begged him to stop. LPN-A told R1, “We need to get it out of here, just relax.” R1 told LPN-A, “Oh please stop you are hurting me.” When R1 looked at LPN-A, “He smiled at me and I felt he was laughing at me.” R1 stated she begged him to stop, it made her vulnerable, embarrassed, and felt he was making a mockery for her. “You can ask the other staff when I begged him to stop, they were standing right there.”			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 9 During a follow-up interview on 5/22/26 at 4:55 p.m., R1 stated the nurse kept digging with his finger, “It felt like it was in the vaginal area but hard to say for sure, he was doing it so fast. It was very painful. I told him he was hurting me. He grinned at me. It was awful. It made me feel like a piece of dirt.” R1 stated she tried to let it go but it continued to bother her and felt it was horribly demeaning. R1 stated she cried when it came to mind. R1 was sad that someone could treat her that way. R1 stated she wondered what the repercussions were for the nurse, “Will he be upset and come back and hurt me? Does he expect me to be submissive and let him hurt me? It was very unprofessional. I do not want to believe he treated other people like that but if he came back to work, would he retaliate?” R1 stated it was perplexing for her. During an interview on 5/22/26 at 1:45 p.m., NA-D stated R1 had some difficulty with memory. Since admission on 5/13/26 through today, R1 had increased behaviors such as refused therapy, refused to participate in activities of daily living (ADLs), and did not want to get up until 12:00 p.m. today. R1 did not say why she refused these things, but nothing seemed to be working for her. NA-D thought R1 seemed sad with her stroke and talked about how it impacted her. NA-D had not worked with LPN-A. Last time she had received education on abuse was one month ago. During an interview on 5/22/26 at 2:04 p.m., NA-E stated today had been a hard day for R1, she refused breakfast, only ate four bites of toast, and refused her shower. R1 seemed to not focus or pay attention when NA-E talked with her and overwhelmed with many staff in the room at one time. Yesterday, R1 informed NA-E at the end of the day, a nurse assisted her with constipation and how she had not liked his approach. NA-E stated she planned on reporting it to the DON but forgot and told her today instead. NA-E received abuse education one month ago. Staff were expected to approach R1 with two staff now and she was unaware of why. During an interview on 5/22/26 at 2:42 p.m., LPN-D stated on 5/18/26 at approximately 1:00 p.m., she entered R1’s room and R1’s daughter reported she had concerns about the care her mother received. Daughter indicated specifically the name of the nurse [LPN-A] administered a rectal suppository, dug out stool from R1’s rectum with possible			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 10 vaginal penetration, and R1 experienced quite a bit of pain. LPN-D informed R1 and daughter she would bring this information immediately to her supervisor. LPN-D left R1's room, went directly to DON and reported the incident. LPN-D stated she was unaware of who was responsible for completing the assessment on R1 after an allegation of abuse. LPN-D did not complete an assessment. LPN-D stated the nurse would be expected to listen to the resident if they indicated they were in pain, stop what they were doing, and contact provider if needed. LPN-D had not received education on abuse since orientation in 1/2026. During an interview on 5/22/26 at 3:15 p.m., LPN-C stated a suppository and/or manual stool removal can be uncomfortable but should not be painful. When a resident asked a nurse to stop, the nurse should stop. Pain tolerance was different for everyone. If the resident complained of pain, the nurse should stop, respect the resident, find a different way to get the results, and contact a provider for further orders. Any allegation of abuse should have been reported immediately to the supervisor. Staff involved in the allegation should be removed from work to protect the residents. A physical assessment, including the area of concern, should be completed right away to provide a clear picture of what may have happened. The assessment should also include a behavior assessment with changes from baseline noted and documented. If a resident was scared, they would be more anxious and possibly crying. LPN-C verified documentation of a physical or behavior assessment was not identified in R1's medical record. R1's care plan was changed with direction for two staff go into R1's together for all needs and cares. This was done to make sure R1 was safe. LPN-C stated they had not received any additional education on abuse or removal of impaction of stool since 5/16/26, following the incident. During an interview on 4/22/26 at 4:15 p.m., NA-A stated R1 had a change in her behavior since the incident on 5/16/26. On 5/16/26, R1 was having trouble with a BM that wouldn't come out and requested to go to the bathroom every 15 minutes. NA-A asked LPN-A to take a look at R1. LPN-A offered a suppository, R1 agreed. NA-A was in R1's room when LPN-A gave R1 a suppository, NA-A felt it went well. R1 did not have any results from the suppository. LPN-A offered to remove the			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 11 BM. NA-A was unsure if R1 gave consent but remembered LPN-A explained to R1 what he was going to do. R1 was transferred into the bathroom with a stand lift. LPN-A attempted to scoop the BM out of R1’s rectal area with a gloved hand. NA-A was unable to see specifically where LPN-A's hands were placed. NA-A heard R1 state, “Stop, stop, stop.” while she cried. NA-A asked LPN-A, “Are you done yet, she doesn’t want to do this anymore, can we be done?” LPN-A did not respond right away then stated he was almost done and continued to remove hard stool for one to two minutes. R1 screamed out while crying, asking LPN-A, “Stop! Please stop!” LPN-A continued for another minute to remove stool manually with his hand. R1 was lowered down onto the toilet. NA-A could see in R1’s face, she was shaken up. R1 stated, “That was the most terrible thing I have ever went through.” NA-A stated it was scary. R1 stopped crying around 7:30 p.m. NA-A stated she saw manual bowel removal done before but had never seen a resident have this much pain or discomfort during the procedure. NA-A did not see any blood. NA-A stated she should have reported this incident to the supervisor. NA-A's feeling about this was not good, and thought LPN-A knew what he was doing. Today, R1 refused her bath, didn’t want to get out of bed, was anxious, and cried a few times. R1 had anxiety prior to this incident but it seemed to be really sinking in for her now and that was why she had increased anxiety, refused to shower, get out of bed, and did not eat much. NA-A stated she should have told another nurse when it happened, she was in shock at the time. NA-A stated R1 told NA-A today, LPN-A had placed his finger in her vagina, R1 had not said this on 5/16/26. NA-A was interviewed on 5/18/26 and again on 5/22/26 by DON and received education on VA reporting. NA-A did not notice anything different with R1’s skin the day of the incident. During an interview on 5/26/26 at 2:15 p.m., R1’s primary provider nurse practitioner (NP) stated R1 had concerns with constipation while in the hospital with a Vaso Vagal response. NP stated she had seen R1 on 5/16/26 and noted R1 had not had a BM since admission. 5/16/26 was R1’s fourth day without a BM. NP stated standing orders for constipation should have been initiated prior to 5/16/26. The nurse would have been expected to follow the protocol, listen to bowel sounds, note if R1 was eating, drinking, and document findings. Once the standing orders are			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 12 implemented, senna should have been given as ordered, waited 24 hours, if no BM then administered a suppository, then a fleets enema. The nurse was expected to not do all the steps one after another. If the resident is doing ok, the nurse is expected to follow orders. The nurse would be expected to complete assessments to guide them on the next step taken. When a resident does not have bowel sounds it could be a bad sign, and an x-ray may be needed. If additional orders are needed, the on-call provider should have been contacted. NP stated she had never given orders for manual removal of stool, and the standing order indicated rectal checks. There was no standing order for bowel impaction and was unsure if an order was needed for disimpaction. The nurse would be expected to check for the presence of stool. This may have resulted in disimpaction of stools due to stimulation, without the need for manual removal. The rectal check could have felt invasive, painful and uncomfortable. A resident may cry and complain of pain during manual removal of hard stool; the nurse should have listened to the resident and stopped. The NP stated three minutes seemed like a long time in general for manual removal of stool. The nurse would be expected to assist with stool coming out but if the resident is distressed and in pain, the nurse would be expected stop as soon as they can. There are risks with manual removal of stool such as bleeding, pain, or a rectal tear, depending on how big and hard the stool was. The NP verified there was no documentation in R1's medical record to indicate the on-call provider was contacted on 5/16/26. The NP stated she was made aware of the incident on 5/17/26. It would have been helpful for her or the on-call provider to know about R1's constipation due to this specific situation. If R1 was that constipated, a provider could have provided further direction regarding what to do next. A physical exam would not have been needed after the incident as would not have shown. R1 did not have vaginal or rectal bleeding that NP was aware of. NP stated she was not aware of changes in behaviors with R1. R1 seemed calm, cooperative, was anxious and did not like to be alone due to previous deaths in family, and more depressed over the stroke situation. During an interview on 5/26/26 at 3:03 p.m., RN-D stated nurses are expected to follow the facility standing orders for constipation, administer the medications as ordered, and allow time for medications to work. A physical assessment			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 13 should have been completed which included listening for bowel sounds and examine the abdomen (hard, soft, or distended). The assessment should have been completed at least every shift if the resident had no BM for three days. The assessment results were used to determine how the resident was responding. The provider should be contacted if additional orders were needed. RN-D stated manual stool removal was an invasive procedure, could be traumatizing to the resident, and could have had a history in which it would not be appropriate, therefore an order would have been needed. Manual stool removal would have been uncomfortable but should not have been painful. R1 should have been positioned on her left side in a Sims position (due to the anatomy/ position of the intestine helps promote evacuation of the stool) and made comfortable. This process should not have been completed while R1 stood up. RN-D stated, “Given the population we work with, it would have placed the resident at risk for a fall, being uncomfortable, and the nurse would have been unable to see what they are doing, which increased the risk for harm to the resident such as rectal tear and/or bleeding. If a resident stated they were in pain and requested the nurse to stop, the nurse would be expected to stop immediately. This type of situation could have caused harm to the resident, it was a sign something wasn’t going well, and there was a need to come up with a different intervention and/or plan.” On 5/17/26 at 3:45 p.m., R1’s family voiced concern to her about digital removal of stool, pain, and dissatisfaction with how the nurse performed the procedure. RN-D stated she listened to the daughter and looked at the standing orders. RN-D now realized she should have asked more questions and reported the daughter’s concerns to the supervisor right away. RN-D completed a neurological assessment on 5/17/26, assisted R1 to the bathroom, but did not assess her skin on her bottom or rectal area. RN-D stated she documented in R1’s progress notes, the concerns the family had but should have taken action to keep R1 safe, assess and follow up in case the procedure caused harm. RN-D stated it could have been abuse and caused harm. RN-D stated she was not interviewed and had not received abuse education since the incident. During an interview on 5/26/26 at 4:04 p.m., LPN-A stated the facility protocol for constipation and/or impacted stool included the night nurse was responsible to check in the computer and see how many days each resident had gone without a			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 14 BM. After three days without a BM, the night nurse entered the standing orders for Senna twice a day to be administered on day four. The nurse completed rectal check on day five and administered a suppository. If no results from the suppository, then the nurse administered an enema. LPN-A stated, usually after the suppository, stool can be felt. If the resident had poor cognition, then LPN-A would contact the on-call provider and ask for orders. LPN-A stated when a resident indicated they were constipated; the nurse was expected to give the resident options and ask what they would prefer. LPN-A stated that was how he completed the assessment. LPN-A would document results of the assessment in the medical record so that other staff can see what has been done so far. On 5/16/26, R1 agreed to manual removal of the stool. LPN-A stated it was his first time taking care of R1, he did not know how long it had been since R1 had a stool and was unaware if she had a history of constipation other than what her daughter told him. R1’s daughter approached LPN-A and indicated she had not had a stool for five days and requested something be given. LPN-A stated R1 had already received MiraLAX, so LPN-A administered senna. One hour later, R1’s daughter informed LPN-A, R1 had not had a bowel movement yet. Twenty minutes later, while R1 laid in bed, he completed a rectal check, placed his finger R1’s in rectum, felt stool, and administered a suppository. R1’s daughter left the facility at 6:30 p.m. Approximately 40 minutes later, R1 requested to go to the bathroom and NA-A asked him if he could help R1. While R1 stood in bathroom by the toilet, LPN-A placed gloves on and asked R1 if she could push stool out, R1 stated, “No.” LPN-A informed R1 h e planned on pulling it out. R1 told LPN-A, “It’s hurting me.” LPN-A informed R1, “It’s going to hurt because it’s hard.” LPN-A placed his finger inside her rectal area and pushed on the hard stool with his finger. LPN-A stated he did not swirl his finger around, nor did he enter the vaginal area, and NA-A was there as a witness. R1 told LPN-A, “It’s hurting me,” but was not crying. LPN-A did not remember R1 asking him to stop, “If she had, I would have stopped and reported to the nurse practitioner. The stool was giving her [R1] pain, not me. I just needed to get it out, it was so hard, and she was very uncomfortable. There was quite a big piece of stool that came out.” LPN-A stated a physical assessment of R1’s abdomen was not completed, “The stool was just hanging there. I am unsure how long the removal took. [NA-A] did not ask me to			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 15 stop.” LPN-A stated in his nursing career he usually took the resident to the bathroom; he never manually removed stool while laying down. In nursing school, LPN-A was not taught to use a certain position, only how to get the stool out. LPN-A stated it was his process to manually remove R1’s stool in the bathroom, he made a nursing judgement to get it out. LPN-A did not feel he could go back and call the provider, “I helped [R1], and documented what I did.” LPN-A stated the manual removal of R1’s stool was not completed according to the facility policy/protocol. The enema was not administered, R1’s provider was not updated for further directions. LPN-A stated, following the protocol would have been important to him as a nurse, “They would have helped the resident, and then they couldn’t say, ‘You did not call the provider.” LPN-A stated he did not typically follow facility protocol for constipation, however he would next time. LPN- A stated facility protocol included directions to administer the enema, call the provider if there were not results, and send resident to emergency room if ordered. LPN-A stated he was a smiling person; he was not smiling during the time he assisted R1 with stool removal and was not sure why R1 reported that. He returned to work on 5/18/126 at 2:30 p.m., assigned to the same area he had worked on 5/16/26, worked until almost 5:00 p.m. when approached, was told something happened on Saturday and sent home. LPN-A stated he was placed on leave, had not worked since, and interviewed regarding the incident for the first time on 5/19/26. During an interview on 5/27/26 at 8:15 a.m., DON stated staff were expected follow the facility process/policy/protocol for constipation. The nurse would be expected to complete initial and ongoing physical assessments which included listening to bowel sounds, checking for abdominal tenderness, distention, nausea, review BM log, and document findings. DON stated R1 was impacted with stool when she came to their facility, staff were not informed R1 had not had a BM when admitted to the facility. R1 had a vaso vagal episode in the hospital that was determined it was due to bearing down during a BM. When a resident failed to have a BM for three days, nurses were expected to have completed a rectal check to determine impaction. Once impaction was confirmed, nurses were expected to follow the protocol and start with administration of senna. DON stated LPN-A would have been expected to complete basic abdominal assessment and document. LPN-A should have			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 16 followed the facility protocol and administered an enema prior to manual removal of the stool. When family voiced concerns related to a resident's bowel pattern, the nurse would have been expected to provide education, explain what and why he was doing to lower anxiety, bring trust and provide a clear picture of the next steps so that they would have been aware of what to expect. LPN-A administered two senna (takes up to 24 hours to work), on the same day a suppository was administered (takes more than a few hours and up to 12 hours to have results depending on the severity of the constipation). LPN-A then tried to remove the stool manually. LPN-A would have been expected to follow standing orders, should have administered the enema, and been gentler. If there were doubts and/or concerns, LPN-A would have been expected to contact a provider, the DON, or nurse manager for direction/further orders. The DON stated during LPN-A's interview he identified R1 told him to stop during the manual removal of stool. R1 was given a break and sat down on toilet a few times. The LPN-A told the DON, the stool was right there, he never placed his finger in the vaginal area but continued with manually removing the stool. The DON stated this was an invasive procedure; there was potential to cause harm to R1 especially when standing. R1 was potentially at a higher risk of a rectal tear and should have been assessed and monitored after the incident. Staff were expected to assess and monitor R1's abdomen, peri/anal area, and bowel sounds by 5/17/26, to make sure there were not any issues such as skin integrity and alterations in the peri/anal area. The enema was not given and could have loosened the stool, decreased the pain, discomfort, and emotional trauma R1 went through and prevented possible tearing, affecting the integrity of the sphincter. The DON stated the LPN-A would have been expected to lay R1 down on her side in bed, a good visual field was needed. Lying in bed would have been more comfortable for R1 and allow rest in between attempts to pull out stool. The DON stated if a resident requested staff to stop, it would never be appropriate to not stop. The LPN-A should have given the R1 a break, explain what was happening, and proceeded only if R1 agreed to try again. R1 had the right to say no/stop and LPN-A should have stopped. DON stated NA-A was a witness to the incident and would have been expected to share concerns with her and/or another nurse as soon as possible after it happened. Bottom line was to make sure residents were safe and felt safe with the care			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 17 they received. The DON stated she was not made aware of the incident until 5/18/26 (three days later) between 1:00 p.m. and 1: 30 p.m. when R1’s family voiced concerns to LPN-D. The DON was not aware of R1’s progress notes written on 5/17/26 (one day after incident) until now, when family voiced concerns about digital removal of stool, painful, and dissatisfaction with nurse who performed procedure. That progress note identified the same concern as discussed by family with RN-D on 5/18/26, and the DON would have wanted to follow up right away and collected more details. The DON stated the LPN-D was not interviewed by the DON. The DON stated it was hard to tell if R1 displayed any behavioral changes after the incident due to recent medical issues and a tremendous amount of change in a short amount of time (stroke, sleep apnea, history of depression, anxiety, uprooted from Arizona). R1 was negatively impacted and affected by this incident identified during her interview she stated it caused her worry, fear and she was afraid LPN-A would come back. During an interview on 5/27/26 at 9:46 a.m., NA-B stated she worked the evening shift on 5/16/26. R1 had constipation issues for approximately three or four days. This was her first day working with R1. NA-B stated earlier in shift R1 was uncomfortable and stressed out, she had assisted with R1’s transfer to and from bathroom, but unable to go. She returned to R1’s room that evening, she passed LPN-A in R1’s doorway. LPN-A had just completed digital removal and scooped the BM out. NA-B assisted R1 off the toilet with the stand lift. R1 was crying, very emotional, and asked her are you ok, she stated “no”. R1 did not complain of pain prior to this incident. LPN-A was the only nurse NA-B had worked with, he was kind of on the quiet end, did not really have conversations with others, seemed like he did a good job but would tell us what to do and expected it to be done right away. NA-B stated in the past she had to beg him to help when she required assistance with a lift transfer and other staff were not available, and he would state oh am I a NA now? NA-B stated if a resident told a nurse to stop, they should have stopped, the resident had the right to choose what was done to them. NA-B stated we are required to have two staff in room to care for R1, to have a witness if something should happen to protect her. NA-B stated she had not received any education on Abuse since this incident. During an interview on 5/27/26 at 11:00 a.m., a family member (FM) stated R1 led a very normal life			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 18 prior to her stroke and had no issues with constipation until after the stroke. R1 was admitted on 5/13/26, FM talked with R1’s provider on 5/14/26, regarding constipation issues she had at the hospital and last BM was on 5/12/26. On 5/16/26, FM arrived at facility, R1 complained of constipation. FM informed LPN-A R1 needed to poop and needed his help, she was told he was busy. Later that day she requested MiraLAX and senna for R1, these were given. R1 told FM she was placed on the toilet, could feel hard stool but was unable to get it out. FM stated while she was in the R1’s room, the staff placed her back into the recliner, R1 stated stool was trying to get out yelled, “ouch, ouch, ouch!” when assisted to the chair. Staff lifted her back up and the pain stopped. FM asked what else can be done and LPN-A appeared frustrated, upset, and stated loudly, “Put her on the bed.” LPN-A administered a suppository at approximately 7:30 p.m. At 8:00 p.m. R1 stated, “I think I have to poop,” to FM. NA-A answered the call light and indicated she would take her to the bathroom. FM informed NA-A she needed to leave. At 8:39 p.m. R1 called FM crying and sounded scared, “Help me, he hurt me, he hurt me he hurt me. He had his fingers in my vagina and anus hanging from the lift machine. I had tears coming down my cheeks and said you’re hurting me, and he wouldn’t stop. I turned around and saw him grinning at me.” FM asked R1 if she wanted her to come back to facility, R1 told FM, “I just want to know if I’m safe from him.” FM reassured R1. The following morning (5/17/26) FM arrived at facility and talked to RN-D, explained what happened the previous evening and RN-D replied she would have to ask her supervisor about the incident. RN-D checked documentation, verified R1 had stool removed, and told FM, “The nurse should not have manually removed stool without an order.” FM stated on Monday (5/17/26), she brought the incident up again to LPN-D. LPN-D went into R1's room and talked to her about what happened on 5/16/26 and indicated she planned on going directly to the DON and report this. At approximately 2:00 p.m., the DON was in R1’s room, spent over one hour taking notes while she visited with her. R1 had the same story every time. The DON told FM this would be reported to the state of Minnesota, was very serious, and the nurse would be placed on administrative leave for at least one week while an investigation was completed. The DON opened the door and R1 saw LPN-A outside her door and stated, “He’s here!” The FM stated R1’s behavior has changed since the incident, she’s afraid he [LPN-A] will come back.			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 19 R1 continued to be affected by this incident, refusing cares, toileting, getting out of bed, and not wanting to eat much. FM stated the incident on 5/16/26 with LPN-A was psychologically traumatizing to her and the family both. “She [R1] talks about the incident all the time, at least three times a day. Yesterday was the first day she [R1] had not mentioned it. She [R1] was afraid he [LPN-A] would come back and go to her window and either smother or suffocate her. The psychological and emotional piece is very real and huge with her. This was a wrench that had been thrown into an already difficult situation since she had her stroke. We are worried that after the investigation is over, will he be coming back to work? He can never be around my mother again.” The FM stated she was gone only 40 minutes on 5/16/26, and R1 called her screaming, crying, and sounded scared. During an interview on 5/27/26 at 4:30 p.m., RN-C confirmed he completed R1's body audit on 5/22/26 at 6:25 p.m. The audit included a full skin check of abdomen/arms/shin, how often she was wet, bowel and bladder function, and if R1 was at risk for skin breakdown. RN-C stated he did not assess R1's rectal area. During an interview on 5/28/26 at 10:46 a.m., medical director (MD) stated staff would be expected to follow the facility protocol/policy for constipation. The protocol was designed to guide staff to utilize critical thinking. MD stated she was unaware of whether an order was necessary to manually remove impacted stool. A general order would be tough to write, too much gray area. MD stated R1 should have been placed /laid in left lateral decubitus (left-side Sim's position) during process to manually removal stool. Standing up would not be the optimal position and would increase the risk of mucosal injury in the anal/rectal area. When staff became aware of R1's and/or family's concern of abuse she would have expected them to report it right away. The MD stated she would have expected staff to have listened to R1 when she asked them to stop and informed the staff the procedure was causing pain. MD stated the nurse should have paused, taken a break, stepped back, looked at what was happening, reassessed, and done the right thing. Facility policy Impaction Removal dated 9/2015, identified: Purpose: To remove impacted feces from the rectum.			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 20 Procedure: 1. Explain procedure and provide privacy. 2. Removed pillow and lower head of bed 3. Assist resident to left side, with knee flexed. 4. Place protective plastic, sheeting beneath buttocks. 5. Drape resident for privacy exposing only buttocks. 6. Put on glove and lubricate index finger. 7. Gently insert index finger into rectum as far as possible. 8. Remove fecal material gently. 9. If resident complains of pain and/or bleeding occurs, discontinue procedure and notify attending physician. 10. If bleeding occurs, observe universal precautions or other infectious control standards as approved by appropriate facility committee. 11. When all fecal material has been removed, wash, and dry rectal area and assist resident to comfortable position with call light within reach. Facility Bowel Management Program Policy dated 11/2019, identified purpose: To ensure the residents experience adequate bowel elimination. Procedure for ongoing management of resident bowel status: 1. Medical record will be reviewed by nursing daily for presence of a bowel elimination alert indicating a potential concern. 2. Licensed nurse will evaluate for the appropriate intervention by visualizing the resident and must be documented in medical record. The nurse will proceed with the intervention and document. 3. If the resident has not had a bowel movement for 3 days, nursing will administer Senna per standing orders (or specific order for that resident). 4. The nurse will notify staff if residents have received Senna.			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 21 5. The nursing staff will report and record bowel movement results to the licensed nurse. If there are positive results to the intervention this will be documented as a follow-up to the use of the PRN medications. 6. If no results within 24 hours the licensed nurse will complete a GI assessment of the resident for presence of bowel sounds, vital signs and abdominal distention, and document assessment. 7. If assessment does not identify irregularities, perform rectal check to determine if there is presence of stool in the lower rectum. If positive administer Bisacodyl suppository per standing orders (or specific order for that resident). 8. If no results from suppository administer Fleets enema per standing orders. Note: do not use in residents with renal failure. 9. Nursing will monitor and record results as indicated. 10. If no results perform a second GI assessment (bowel sounds, palpate abdomen, ect), review medications and report to primary provider. Facility Standing Orders for Skilled Nursing Facilities dated 1/26/26, at 12:22 p.m., identified: Constipation (perform steps sequentially) Consider rectal check to determine if impaction is present. Encourage 2,000 milliliters (ml) daily fluid intact unless contraindicated. Consult nutrition services for dietary recommendations. Sennoside 8.6 milligrams (mg) take 2 tablets by mouth (po) two times a day (bid) if no bowel movement in 3 days. If no results, perform rectal check to determine if impaction is present. If no results within 24 hours, give Bisacodyl			F0600			07/02/2026

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F0600 SS = SQC-J	Continued from page 22 suppository 10 mg per rectal (PR) daily as needed (prn). Fleets enema PR every 3 days PRN if no results from suppository (note: do not use in patients with renal failure). Monitor and record results from treatment. Addendum to VA Education dated 5/27/26, identified objectives: staff will demonstrate understanding of resident right to refusal or cares and staff will demonstrate understanding of VA reporting expectations. 1. When a resident says no to care or procedures, what do you do? - Nurses: stop, reassess resident for procedure, if still indicates pain or discomfort update provider, obtain guidance for next intervention. -NA's: Stop, report to nurse/supervisor immediately. -Other staff: Report to nurse/supervisor immediately. 2. When you observe another staff member being asked to stop cares by a resident, what do you do? -Ask other staff member to stop cares or activity. -Endure Resident is safe. -Report to supervisor per VA reporting process. The immediate jeopardy that began on 3/16/26, was removed on 5/28/26 at when the facility completed R1's skin, bowel and bladder and psychosocial/trauma assessments, referral and visit completed with psychologist, and plan of care updated. They completed interviews with all residents to ensure they felt safe and random staff interviews regarding nursing practice, no concerns identified. Facility staff education was provided on reporting VA and how to follow the facility bowel protocol and removal of impacted bowel policy.			F0600			07/02/2026

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F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse to the State Agency (SA) within two hours for 1 of 1 resident (R1) who was witnessed being abused by a staff member. Findings include: Facility Vulnerable Adult (VA) Maltreatment Report filed with State Agency (SA) dated 5/18/26 at 5:36 p.m., identified estimated date and time of most recent occurrence was 5/16/26 at 8:00 p.m. in resident bathroom. Description of incident: Allegation of sexual contact by daughter today on 5/18/26. VA complained of rectal pain before, during, and after administration of bowel evacuation regime. Daughter stated VA called her crying around 8:30 p.m. on 5/16/26 stated "he hurt me! He hurt me! He put his fingers in my rectum and vagina." VA interviewed in room today 5/18/26 and she wept, "I looked back at him while he was behind me and was smiling at me while he hurt me, digging around in my anus." Allegation: sexual			F0609	"This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F609 Reporting of Alleged Violations Immediate Corrective Action: R1 remains a resident of the facility. R1 continues to be seen by Associated Clinic of Psychology to address ongoing psychosocial support. The facility also has assessed and will continue to assess R1 for psychosocial impact. R1 continues to receive daily skilled therapy and is progressing well towards her goals to discharge towards a lesser level of care. LPN-A remains out on administrative leave pending the facilities conclusion of their internal investigation. The Vulnerable Adult Policy dated 2025 remains effective. The facility also requested the Chief Medical Office to review the Policy "Impaction Removal" and "Bowel Management Program Policy" and both of these policies are current and remain effective. The facility standing house orders were reviewed and signed last January 26, 2026, and are based on the Minnesota Alliance of Geriatric Inspired Clinicians. Corrective Action as it Applies to Other Residents: All residents were interviewed by facility staff on 5/27/26 with no concerns regarding abuse or neglect identified. Facility has a grievance process which is used as a method to collect concerns and there have been no situations brought forward regarding abuse or neglect identified since survey exit. Reoccurrence will be Prevented By: Education was provided to all staff on the importance of reporting all suspected abuse to supervisor immediately to allow for immediate reporting as part of the abatement plan. These communication expectations have also been documented on facility communication board for ease of information access. All care center staff have re-educated on timely reporting of abuse to supervisors and no further		07/02/2026

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F0609 SS = D	Continued from page 24 abuse. Facility 5-day report dated 5/22/26 at 8:13 p.m., identified on 5/18/26, R1’s daughter reported an allegation of inappropriate sexual contact involving facility staff. R1 had a history of constipation and rectal pain due to bowel management interventions. R1 complained of pain following administration of a rectal suppository during manual removal of stool and documented by a nurse on 5/16/26 prior to allegation made on 5/18/26. On 5/16/26 at approximately 8:30 p.m. R1 called daughter in a distressed stated crying and stating, “he hurt me, he hurt me and put his fingers in my rectum and vagina.” On 5/18/26, R1 was interviewed in presence of daughter and appeared tearful and stated “I looked back at alleged perpetrator while he was behind me and he was smiling while he is hurting me, digging around in my anus. At the time the allegation was disclosed on 5/18/26, R1 appeared tearful, covered her mouth and stated, “I don’t want to get him or anyone into trouble, or anyone to lose their job, but he hurt me.” R1 had received a rectal suppository and reported pain during insertion without results and later assisted to the bathroom by nursing assistant NA-A and licensed practical nurse LPN-A. R1 stated during this time LPN-A placed his fingers in her rectum and vagina and she kept saying “you’re hurting me, you’re hurting me.” NA-A stated she observed R1 stood in a stand lift while LPN-A performed manual stool removal from her rectum. During that process R1 had significant discomfort, tearful, appeared shaken and stated “stop” but LPN-A continued attempting to remove the stool. NA-A stated she asked LPN-A if we could be done now and did not stop and procedure took approximately two to three minutes. When done R1 stated “glad it’s one it was terrible.” LPN-A stated manual removal of stool was done with a gloved hand and R1 appeared uncomfortable during the process, did not insert his finger as the hard stool was right there, hard as a rock, difficult to remove, and just needed to pull it out. LPN-A did not pause when R1 was in pain during removal of the stool because it was coming in pieces. When R1 said stop he stopped three times, told her if it was going to hurt, she tried to push it out, and he was finally able to pull it out. LPN-A stated was aware of the of the facility policy on removal of impactions and if there was pain to stop and pause the procedure. R1’s Minimum Data Set (MDS) dated 5/26/26, identified she was admitted to the facility on 5/13/26, from the hospital. R1 had moderately impaired cognition and no behaviors. R1 had functional limitations in range of motion (ROM) in			F0609	Continued from page 24 cases of late reporting have been identified. Further staff audits have been completed using internal and external auditors to vet the staff understanding and no further issues have been identified. Facility continues to provide education with all new staff upon hire, and all staff meetings and as needed. Furthermore, the facility continues to ensure residents are free from abuse and neglect by conducting interviews with 10% of the resident census weekly for any concerns related to F600 for 4 weeks and these will be processed through the facility QAPI to determine ongoing frequency. Facility will also complete random audit all varied shifts weekly x4 weeks to ensure they understand residents' rights to be free from abuse and neglect and immediate reporting; results of these audits will be processed through QAPI for ongoing need and frequency. The facility administrator will be responsible for oversight.		07/02/2026

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F0609 SS = D	Continued from page 25 upper and lower extremity on one side. She required substantial/maximal assistance with personal hygiene and lying to sit on bed, dependent for all transfers, repositioning in bed, toileting hygiene, and lower body dressing, and used a manual wheelchair for mobility. R1 was frequently incontinent of bladder and occasionally incontinent of bowel with constipation. R1’s diagnoses included: stroke, atrial fibrillation, hemiplegia or hemiparesis (weakness or paralysis on one side of the body), adjustment disorder with mixed anxiety and depressed mood. R1’s care plan dated 5/14/26, identified: -R1 was at risk for abuse and/or neglect. Staff were directed to follow the facility Vulnerable Adult (VA) policy. Keep her safe and refer to resident services as needed (PRN). R1’s physician orders identified: - Behavioral Expression: every shift for clinical monitoring for seven days. Start dated 5/19/26. End dated 5/26/26. -Buddy Cares at all times. Nurses and aides, every shift. Start date: 5/19/26. R1’s nursing assistant (NA) BM documentation from 5/14/26 through 5/17/26, identified: -5/14/26, no BM -5/15/26, no BM -5/16/26 at 4:42 a.m. no BM and 9:42 p.m., large BM. -5/17/26 at 4:19 a.m.,12:40 p.m., and 7:58 p.m., medium BMs. R1’s NA Target Behavior documentation from 5/14/26 through 5/26/26, target behaviors 1. Crying/sad and 2. Anxiety/Agitation occurred. Intervention attempted. Intervention effective/ineffective. -5/19/26 at 1:38 p.m., anxiety/agitation, other, no. -5/21/26 at 10:59 p.m., anxiety/agitation, crying/sad, reassure, yes. -5/22/26 at 2:50 p.m., anxiety/agitation, crying/sad, conversation, no.			F0609			07/02/2026

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F0609 SS = D	Continued from page 26 -5/23/26 at 5:36 a.m., anxiety/agitation, other, yes. -5/24/26 at 11:08 p.m., anxiety/agitation, reassure, yes. -5/25/26 at 8:55 p.m., anxiety/agitation, reassure, yes. -5/26/26 at 9:55 p.m., anxiety/agitation, reassure, yes. Target behaviors were documented as did not occur or not applicable from 5/14/26 through 5/18/26, 5/20/26, and 5/27/26 (7 days). R1's progress notes from 5/16/26 through 5/22/26, identified: -5/16/26 at 11:22 p.m., R1's daughter complained her mother had no bowel movements for the last three days. Senna was given per orders, rectal check was done and hard stool noted, suppository administered without results. Manual evacuation of stool was performed with removal of large amounts of stool. R1 expressed discomfort during the removal but relieved at the end. -5/17/26 at 12:16 p.m., Alert and orientated to self with some confusion, increased anxiety observed upon rising this morning. Assist of two with stand lift transfer. -5/17/26 at 12:41 p.m., Family expressed concerns to staff regarding bowel habits, digital removal, policies regarding procedure. Family concerned that digital removal was painful, and she called family distressed after procedure was performed. Family expressed dissatisfaction with nurse who performed procedure. -5/17/26 at 11:56 p.m. Family wished to stay the night, staff prepared air mattress and bedding for family. Family changed mind later and went home to prepare for early morning appointment. Staff reported they would call family if any concerns arose during the night -5/18/26 at 1:00 p.m. Writer entered R1's room and daughter was present and brought up some concerns that she had been having. Writer reassured R1 and daughter that she would bring concerns to superiors. Writer immediately brought concerns to supervisor and director of nursing (DON) upon leaving room. -5/19/26 at 5:50 am. Overnight staff reported went			F0609			07/02/2026

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F0609 SS = D	Continued from page 27 to change R1, but she refused cares stating she was dry. Staff stated they just needed to change her brief, was a little wet from overnight, R1 was not pleased with that but let them. -5/19/26 at 7:16 a.m., R1's daughter called writer and reported her mother called crying and needed help immediately. Writer went into R1's room and she observed her sitting on bedside on the verge of tears. R1 stated "I haven't slept since 5:00 a.m., because do not know why people have to come in here and change people at 5:00 am when they supposed to be sleeping. Writer apologized, reassured her care plan will be updated. R1 stated "I am sorry to bother you with my complaints, but I am in pain." Writer offered medication, accepted, and administered. -5/19/26 at 2:36 p.m. R1 alert oriented to self, family, place with forgetfulness and confusion within her baseline. R1 refused therapy this morning due to fatigue per resident, slept in per request and cares were done as allowed by R1. -5/19/26 at 4:07 p.m., Email message sent to Pastor, daughter requested a visit for R1, thought it benefit her mom. -5/21/26 at 10:58 a.m. Pastor visit made. -5/21/26 at 4:30 p.m. DON checked in on R1. Daughter and ex-husband were both in R1's room. Daughter inquired about the possibility of rectal bleeding following recent stool removal procedure, expressed concern related to potential rectal tearing. DON informed daughter if any tissue injury had occurred symptoms would likely have presented by this time and no observed or reported signs/symptoms identified. -5/22/26 at 2:21 p.m., R1 refused toileting, bed bath, and scheduled weekly shower, requested to be able to go back to sleep, stated not now, later, and reapproached with no success. Psychology visit dated 5/22/26, identified R1, recently had an incident during caretaking where she felt violated by a staff member. It had been reported and investigated appropriately by the facility/regulatory officials. Appointment was made to follow up to evaluate distress and provide additional support. R1's mental status exam identified oriented to general situation, short term memory mildly impaired, through process linear, goal directed, and thought blocking (sudden interruptions in a person's thought process often			F0609			07/02/2026

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F0609 SS = D	Continued from page 28 associated with various mental health conditions), depressed and anxious mood, and quality of mood: anxious and dysphoric (means “hard to bear” characterized by feelings of sadness, irritability, restlessness, and general discomfort). R1's symptoms identified: moderate depressed mood and low self-worthlessness/guilt moderate, and mild crying spells. Regarding the recent incident, R1 stated she remained emotionally impacted but felt she continued to process and gained some emotional distance from it. R1 reported she felt increasingly supported and reassured by the facility response and identified several individuals she can reach out to if needed. She currently felt safe, heard and comfortable with the environment. Treatment recommendations: paired-care approaches, as she had identified this as reassuring and emotionally regulating for both herself and staff and trauma-informed and emotionally validating approaches emphasizing predictability, reassurance, and collaborative communication (knocking before entering, announcing presence with name and role, extra attention to explaining cares, going slow and allowing her input). During an interview on 5/22/26 at 11:38 a.m. NA-F stated she saw R1 cry on 5/18/26. R1 stated the nurse abused her on 5/16/26, he placed his finger in her, and she begged him to stop. R1 told her he was smiling when she looked at him and every time she talked about it, she cried, Monday was a very difficult day for R1. When R1 cried on 5/18/26, it was different that day versus days prior to the incident since admission to the facility, she had more emotion and seemed completely upset with what happened to her. R1's daughter informed her the incident happened on 5/16/26 around 6:00 p.m. when a male nurse LPN-A administered a rectal suppository. At approximately 8:30 p.m., LPN-A placed his finger in to pull out the BM and hurt R1. R1 stated she just wanted him to stop, it was so painful. NA-F reported this incident right away to the DON on 5/18/26. NA-F stated when R1 requested the nurse to stop he should have stopped. During an interview on 5/22/26 at 12:37 p.m., R1 stated she had no concerns about staff until 5/16/26, when she was constipated and unable to have a BM. There was a male nurse, she felt he was in a hurry, and one or two other female staff were in the room with him. The nurse inserted his finger into my anus, started to circle it around and informed her he had to do that to make the stool come out. R1 stated the male nurse kept circling his finger over and over and she started to cry with tears and begged him to stop. He stated we need to get it out			F0609			07/02/2026

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F0609 SS = D	Continued from page 29 of here, just relax. She told him “Oh please stop you are hurting me” and turned around, he smiled at her and felt like he laughed at her. She begged him to stop, it made her vulnerable, embarrassed, and felt he was making a mockery for her. R1 stated you can ask the other staff when she begged him to stop, they were standing right there. During a follow-up interview on 5/22/26 at 4:55 p.m. R1 stated the nurse kept digging with his finger, felt like it was in the vaginal area but hard to say for sure, he was doing it so fast, very painful, felt like she was going through the roof told him you are hurting me, he grinned at her, it was awful, and made her feel like a piece of dirt. R1 stated she tried to let it go but still bothered her and felt it was horribly demeaning. R1 stated she cried and when it came to mind, she became sad that someone could treat her that way. Observation during the interview identified R1 became teary eyed. R1 stated she wondered what the repercussion were for the nurse, would he be upset and come back and hurt her? Did he expect her to be submissive and let him hurt her, it was very unprofessional. She did not want to believe he treated other people like that but if he came back to work, would he retaliate? R1 stated she did not know him, but you never know, and he seemed humiliated afterwards, but did he think it was the right way to act? It was perplexing for her. During an interview on 5/22/26 at 2:04 p.m. NA-E stated today had been a hard day for R1, she refused breakfast, offered toast, accepted and ate only 4 bits, refused shower, accepted a bed bath instead but was unable to complete a bed bath before end of day, and passed it onto the next shift. R1 seemed a bit more absent when she conversed with her and overwhelmed with many staff in the room at one time. Yesterday, R1 informed her at the end of the day something about a nurse assisting her with constipation and how she had not liked his approach. NA-E stated she planned on reporting it to the DON but forgot and told her today instead. Staff were expected to approach R1 with two staff now and she was unaware of why. During an interview on 5/22/26 at 2:42 p.m., LPN-D stated on 5/18/26 at approximately 1:00 p.m. she entered R1’s and daughter indicated she had concerns about the care her mother received. Daughter indicated specifically the name of the nurse [LPN-A] administered a rectal suppository, dug out stool from her rectum with possible vaginal penetration, and R1 experienced quite a bit of pain. LPN-D informed R1 and daughter she would bring this information immediately to her supervisor.			F0609			07/02/2026

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F0609 SS = D	Continued from page 30 LPN-N left R1’s room, went directly to DON and reported the incident. The nurse would be expected to listen to the resident if they indicated they were in pain, stop what they are doing, and contact provider if needed. During an interview on 5/22/26 at 3:15 p.m. LPN-C stated a suppository and/or manual stool removal could have been uncomfortable but not painful. When a resident asked a nurse to stop, stop and go by what they said. Pain tolerance was different for everyone, if painful stop, respect the resident, find a different way to get the results, and contact a provider for further orders. Any allegation of abuse should have been reported immediately to the supervisor, removal of staff involved to protect the residents, and a physical assessment including the area of concern, should have been completed right away to provide a clear picture of what may have happened, if anything, and make sure it did not happen again During an interview on 4/22/26 at 4:15 p.m. NA-A stated R1 had a change in her behaviors since the incident on 5/16/26. Today (4/22/26) she had refused her bath, didn’t want to get out of bed, anxious, and cried a few times. On 5/16/26, R1 had a BM that wouldn’t come out and had to go to the bathroom every 15 minutes, tried to get her comfortable in any way we could, then she started to cry. The past week she was constipated and on Friday (5/14/26) NA-A asked another nurse if he could look at it and not be sure if that happened. On 5/16/26, she asked LPN-A to look at R1 and when he did state yes there is a problem here, offered a suppository, R1 agreed, and suppository was given and went well. R1 did not have any results from the suppository and aske LPN-A what can he do, and he stated maybe we can take it out. Unsure if R1 gave consent but remembered LPN-A explained to R1 what he was going to do. R1 was transferred into the bathroom with a stand lift and LPN-A stood by the wall, looking down at R1’s buttocks. LPN-A placed gloved on and attempted to scoop the BM out of her rectal area. NA-A was unable to see where his hands were placed. R1 stated “stop, stop, stop, while she cried. NA-A asked LPN-A “are you done yet, she doesn’t want to do this anymore, can we be done? “ LPN-A did not respond right away then stated he was almost done and continued to remove hard compacted stool for one to two minutes. R1 screamed out while crying to LPN-A stop please stop and LPN-A continued for one more minute to remove stool manually with his hand. R1 was lowered down onto the toilet and was shook up,			F0609			07/02/2026

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F0609 SS = D	Continued from page 31 could see it in her face, and she stated that was the most terrible thing I have ever went through. NA-A stated it was scary, and she felt bad seeing R1 being treated like that and her crying stopped around 7:30 p.m. NA-A stated she had seen this done before but never did the resident have this much pain or discomfort. NA-A did not see any blood. NA-A stated she should have most likely reported this to the supervisor, her feeling about this was not good, and thought LPN-A knew what he was doing. R1 had anxiety prior to this incident but really sinking in for her now and that was why she had increased anxiety, refused to shower, get out of bed, and did not eat much. NA-A stated she should have told another nurse when it happened, she was in shock and getting the gravity of the situation. NA-A stated today R1 stated LPN-A had placed his finger in her vagina, that was not said on 5/16/26. NA-A stated last time she worked with LPN-A on 5/18/26, he left the facility in the middle of this shift. During an interview on 5/26/26 at 2:15 p.m., primary provider nurse practitioner (NP) stated R1 had concerns with constipation while in the hospital with a Vaso Vagal response. NP stated she had seen R1 on 5/16/26, had not had a BM since admission, which was the fourth day, and standing orders should have been initiated for constipation. The nurse would have been expected to follow the protocol when R1 had not had a BM in three days, concerns with constipation, listed to bowel sounds, note if she was eating, drinking, and document findings. The rectal check could have felt invasive, painful and uncomfortable. A resident may cry and complain of pain during manual removal of hard stool; the nurse should have listened to the resident to guide him and stopped. Three minutes seemed like a long time in general for something like that to be done, manual removal of stool. The staff would be expected to assist with stool coming out but if the resident is distressed and in pain stop as soon as they can. There are risks with manual removal of stool such as bleeding, pain, or a rectal tear depending on how big and hard the stool was. NP verified there was no documentation in R1's medical record the on-call provider was contacted on 5/16/26. NP stated she was made aware of the incident on 5/17/26. It would have been helpful for her or the on-call provider to know about R1's constipation due to this specific situation, the family is really involved and if she was that constipated a provider could have provided further direction as to what to do next so that something could be done about it. R1 was cognitively impaired and unable to describe anything to her.		F0609			07/02/2026	

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F0609 SS = D	Continued from page 32 During an interview on 5/26/26 at 3:03 p.m. RN-D stated staff nurse would be expected to follow the facility standing orders for constipation, administer the medications as ordered, and allow them to work. RN-D stated manual stool removal was an invasive procedure, can be traumatizing to the resident, and could have had a history in which it would not be appropriate, therefore an order would have been needed. This process should not have been completed while the resident stood up, given the population we work with, it would have placed the resident at risk for a fall, uncomfortable, and the nurse would have been unable to see what they are doing, which increased the risk for harm to the resident such as rectal tear and/or bleeding. If a resident stated they were in pain and requested the nurse to stop, the nurse would be expected to stop immediately. That type of situation would have caused harm to the resident, it was a sign something wasn't going well, and there was a need to come up with a different intervention and/or plan. On 5/17/26 at 3:45 p.m. R1's family voiced concern to her about digital removal of stool, pain, and dissatisfaction with how the nurse performed procedure. RN-D stated she listened to the daughter and looked at the standing orders and now realized she should have asked more questions and reported this to the supervisor right away. RN-D completed a neurological assessment that day, assisted R1 to the bathroom, did not assess her skin on her boom or rectal area. RN-D documented in R1's progress notes the concerns the family had that day, should have taken action to keep her safe, assess and follow up in case it could have caused harm or just being uncomfortable due to digital removal of stool. RN-D stated she did not put it all together at the time and could have been abuse and caused harm. During an interview on 5/26/26 at 4:04 p.m., LPN-A stated R1's daughter approached him and indicated she had not had a stool for five days and requested something be given. LPN-A stated R1 had already received MiraLAX, he administered Senna, one hour later daughter informed him she had not gone yet. Twenty minutes later while R1 laid in bed, he completed a rectal check, placed his finger in the rectal area, felt stool, and administered the suppository. R1's daughter left the facility at 6:30 p.m. Approximately 40 minutes later, R1 requested to go to the bathroom and NA-A asked him if he could help R1. While R1 stood in bathroom by the toilet, LPN-A placed gloves on and asked R1 if the stool could be pushed out and she stated no, informed her he planned on pulling it out. R1 stated it's hurting me, and he informed her it's going to hurt because it's hard. LPN-A placed his finger inside			F0609			07/02/2026

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F0609 SS = D	Continued from page 33 her rectal area and pushed on the hard stool with his finger. LPN-A stated he did not swirl his finger around, nor did he enter the vaginal area, and NA-A was there as a witness. R1 stated it's hurting me, was not crying, did not remember her asking him to stop, but if she had, he would have stopped and reported to the NP. The stool was giving R1 pain, not him, just needed to get the stool out, it was so hard, and she was very uncomfortable. There was quite a big piece of stool that came out. LPN-A stated a physical assessment of R1's abdomen was not completed; the stool was just hanging there. and unsure how long the removal took. The NA-A did not ask him to stop. LPN-A stated in his nursing career he usually took the resident to the bathroom, never manually removed stool while laying down. In nursing school, they did not teach us to use a certain position only just how to get the stool out. LPN-A stated, it was his process to manually remove R1's stool in the bathroom, he made a nursing judgement to get it out, could not go back and call the provider, helped R1, and documented what he did. LPN-A stated the manual removal of R1's stool was not completed according to the facility policy/protocol, that was not his practice or how he did things. LPN-A stated next time he would follow the facility protocol, administer the enema per order not given, call provider if there were no results, and send them to emergency room. Those steps would have been important to him as a nurse, helped the resident, and then they couldn't say "you did not call the provider." LPN-A stated he was a smiling person, and he was not smiling during the time he assisted R1 with stool removal, not sure why R1 said that. LPN-A stated he provided report to the oncoming shift at approximaely 12:00 a.m. and went home. He returned to work on 5/18/126 at 2:30 p.m., was assigned to the same area he had worked on 5/16/26, worked until almost 5:00 p.m. when approached, was told something happened on Saturday and sent home. LPN-A stated he was placed on leave, had not worked since, and interviewed regarding the incident for the first time on 5/19/26. During an interview on 5/27/26 at 8:15 a.m., DON stated staff were expected follow the facility process/policy/protocol for constipation. DON stated R1 was impacted with stool when she came to their facility, staff were not informed. During LPN-A's interview he identified R1 stated stop during the manual removal of stool, she was given a break, sat down on toilet a few times, stool was right there, never placed his finger in the rectal area, and continued with manually removing the stool. DON stated this was an invasive procedure,			F0609			07/02/2026

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F0609 SS = D	Continued from page 34 depending on the size of the stool, there was potential to cause harm to R1 especially when standing there was potentially a higher risk of a rectal tear and should have been assessed and monitored after the incident. Staff were expected to assess and monitor R1's abdomen, bottom area, bowel sounds by 5/17/26, to make sure there were not any issues such as skin integrity and alterations in the peri/anal area. DON stated in this type of environment, impaction of stool can occur, and the provider should have been updated when the steps in the policy had not worked prior to the manual removal of stool to provide direction to what the nurse should have done next. DON stated if resident states stop it would never be appropriate to not stop. LPN-A should have given the R1 a break, explain what is happening, and proceed only if she said yes and try again. R1 had the right to say no/stop and LPN-A should have stopped. R1 reported she told LPN-A to stop, NA-A stated can we be done now, LPN-A stated it's almost out and did not stop per NA-A's and R1's requests. DON stated NA-A was a witness to the incident and would have been expected to share concerns with her and/or another nurse as soon after it happened. DON was unsure if that happened and would have been important for the safety and well-being of the resident, started investigation to determine what the complaint was, clarified it had occurred and prevented it from occurring again. Bottom line was the allegation of abuse should have been reported within two hours of the allegation to make sure residents were safe and felt safe with the care they were receiving. DON stated she was not made aware of the incident until 5/18/26 (3 days later) between 1:00 p.m. and 1: 30 p.m. when R1's family voiced concerns to LPN-D. DON was not aware of R1's progress notes written on 5/17/26 (1 day after incident) until now, when family voiced concerns about digital removal of stool, painful, and dissatisfaction with nurse who performed procedure. That progress note identified the same concern as discussed by family with nurse on 5/18/26, and she would have wanted to follow up right away and collected more details. DON stated LPN-D was not interviewed. DON stated it was hard to tell if R1 displayed any behavioral changes after the incident due to recent medical issues and a tremendous about of change in a short amount of time (stroke, sleep apnea, history of depression, anxiety, uprooted from Arizona). R1 was negatively impacted and affected by this incident identified during her interview she stated it caused her worry, fear and she was afraid LPN-A would come back. During an interview on 5/27/26 at 9:46 a.m., NA-B			F0609			07/02/2026

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F0609 SS = D	Continued from page 35 stated she worked the evening shift on 5/16/26. R1 had constipation issues for approximately three or four days. This was her first day working with R1. NA-B stated earlier in shift R1 was uncomfortable and stressed out, she had assisted with R1's transfer to and from bathroom, but unable to go. She returned to R1's room that evening, she passed LPN-A in R1's doorway. LPN-A had just completed digital removal and scooped the BM out. NA-B assisted R1 off the toilet with the stand lift. R1 was crying, very emotional, and asked her are you ok, she stated "no". R1 did not complain of pain prior to this incident. LPN-A was the only nurse NA-B had worked with, he was kind of on the quiet end, did not really have conversations with others, seemed like he did a good job but would tell us what to do and expected it to be done right away. NA-B stated in the past she had to beg him to help when she required assistance with a lift transfer and other staff were not available, and he would state oh am I a NA now? NA-B stated if a resident told a nurse to stop, they should have stopped, the resident had the right to choose what was done to them. NA-B since 5/19/26, we have been required to have two staff in room to care for R1, to have a witness if something should happen to protect her. During an interview on 5/27/26 at 11:00 a.m., a family member (FM) stated she informed LPN-A R1 needed to poop and needed his help, she was told he was busy. LPN-A appeared frustrated, upset, and stated loudly, placed R1 on the bed and administered a suppository at approximately 7:30 p.m. At 8:00 p.m. R1 stated I think I have to poop. NA-A answered the call light and indicated she would take her to the bathroom. FM informed NA she needed to leave and went home to rest. At 8:39 p.m. R1 called her crying and sounded scared stating help me, he hurt me, he hurt me, he hurt me; he had his fingers in my vagina and anus hanging from the lift machine, tears coming down my checks and said you're hurting me, and he wouldn't stop, turned around, and saw him grinning at me. FM asked R1 if she wanted her to come back to facility and she stated just want to know if I'm safe from him, reassurance was given. The following morning (5/17/26) FM arrived at facility and talked to RN-D, explained what happened with my mother the previous evening and RN-D replied she would have to ask her supervisor about the incident, checked documentation, verified R1 had stool removed, and stated the nurse should have not manually removed stool without order. R1 talked about this incident all day over and over again and had not realized the day before the extent and how awful this incident had been for her. FM stated on Monday (5/17/26),			F0609			07/02/2026

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F0609 SS = D	Continued from page 36 she brought the incident up again to LPN-D. This nurse went into R1's room and talked to her about what happened on 5/16/26, and indicated she planned on going directly to the DON and report this. At approximately 2:00 p.m., the DON was in R1's room, spent over one hour taking notes while she visited with her. R1 had the same story every time. DON stated this would be reported to the state of Minnesota, was very serious, and the nurse would be placed on administrative leave for at least one week while an investigation would be completed. DON opened the door and R1 saw LPN-A outside her door and stated, "he's here!" The DON stated yes, he had picked up a shift and we are handling it. A Ramsey count investigator entered the room and R1 stated are you here to arrest me? The investigator asked if we wanted to press charges and R1 stated I don't think so. R1's behavior had changed since the incident, she's afraid he will come back. R1 continued to be affected by this incident, refused cares, toileting, getting out of bed, and not wanting to eat much. FM stated she had asked DON if R1 had a rectal tear and she stated we would have known by know if she had one, no. The incident on 5/16/26 with the male nurse LPN-A had been psychologically traumatizing to her and the family both. R1 talked about the incident all the time, at least three times a day, and yesterday was the first day she had not mentioned it. R1 was afraid LPN-A would come back and go to her window, smother /suffocate her, the psychological and emotional piece is very real and huge with her. This was a wrench that had been thrown into an already difficult situation since she had her stroke. We are worried that after the investigation is over, he will be coming back to work. LPN-A can never be around her mother again. R1 was perfectly fine 6 weeks ago. FM stated she was gone only 40 minutes on 5/16/26, and R1 called her screaming, crying, and sounded scared stating "help me, he hurt me, he hurt me with his fingers in her vagina and anus" and wouldn't stop. R1 stated just want to know if I'm safe from him and reassurance was given. During an interview on 5/28/26 at 10:46 a.m. medical director (MD) stated when the staff became aware of R1's and/or family's concern of abuse she would have expected them to report it right away if they felt comfortable with that, some staff do not feel empowered to come forward. MD stated she would have expected staff to have listened to R1 when she asked them to stop and informed the staff you're hurting me. MD stated the nurse should have paused, taken a break, stepped back, looked at what was happening, reassessed, and do the right thing.			F0609			07/02/2026

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F0609 SS = D	Continued from page 37 During an interview on 5/28/26 at 1:24 p.m., administrator stated an incident should be reported as soon as anyone realized abuse was alleged or a staff heard that the resident felt unsafe, in this case, felt violated or hurt. This incident was reported on 5/18/26, by a staff nurse to the DON, after the daughter had mentioned something had happened, bothered her mother, and used words such as the nurse raped by mom. Once we went through interviews and heard the resident's statement, the resident stated stop and she was in pain, at that point if we had known about that information, it should have been reported sooner just wasn't brought to her attention. Staff would have been expected to tell someone, especially a witness to the incident, because the resident expressed discomfort with the situation and if reported sooner, we could have intervened sooner. We pulled a report for the interdisciplinary team (IDT) and identified a progress note dated 5/17/26, usually don't read the progress notes unless it was brought to her attention, and the RN should have sent us a note, and we would have investigated it. The staff nurse on 5/16/26, should have reported family had concerns. Facility policy Vulnerable Adult Abuse Prevention Plan dated October 2025 identified each resident has the right to be free from abuse including but not limited to verbal, sexual, physical, and mental abuse, injuries of unknown origin, corporal punishment, misappropriation of resident property, mistreatment, neglect or involuntary seclusion. Any form of resident abuse will not be tolerated. Physical abuse was defined as the use of force that may result in bodily injury, physical pain, or impairment. Sexual abuse was defined as sexual contact that results from threat, force, or the inability of the person to give consent, and involving a range of activities, including but not limited to, assault, rape, or sexual harassment. Pursuant to state and federal regulations Pursuant to state and federal regulations, it is the policy of Presbyterian Homes & Services to require the reporting of the maltreatment of adult residents, who are rendered vulnerable by reason of physical or mental disability, are relying on the institution for provision of care and are deemed to be unable or unwilling to report such treatment of their own accord. The VA protection Act requires that mandated reporters make an immediate report when there is reason to believe a vulnerable adult is or has been maltreated, or they have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained. All reports should be made promptly. If the event that caused the allegation involves abuse or results in serious bodily injury the report must be made no later than			F0609			07/02/2026

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F0609 SS = D	Continued from page 38 2 hours after the allegation is made. Any person employed at Presbyterian Homes and Services, including contractors, and persons who are volunteering in the facility are responsible for reporting suspected or known cases of resident maltreatment to their immediate supervisor who will notify the administrator and/or appropriate designee. All cases of maltreatment or potential maltreatment must be reported immediately to an employee's supervisor (or designee) who will then report it immediately to the Administrator who will contact the Clinical Administrator if needed. Reporting to the administrator will be in person or via phone. Care should be taken immediately to remove the resident from immediate danger.			F0609			07/02/2026
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 interviews and document review the facility failed to thoroughly investigate an allegation of staff to resident abuse and protect residents during the investigation for 1 of 1 residents (R1) who reported abuse. Findings include: R1's Minimum Data Set (MDS) dated 5/26/26, identified she was admitted to the facility on 5/13/26, from the hospital. R1 had moderately			F0610	“This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F610 Investigate/Prevent/Correct Alleged Violation Immediate Corrective Action: R1 remains a resident of the facility. R1 continues to be seen by Associated Clinic of Psychology for ongoing psychosocial support. The facility also has assessed and will continue to assess R1 for psychosocial impact. R1 continues to receive daily skilled therapy and is progressing well towards her goals to discharge towards a lesser level of care. LPN-A remains out on administrative leave pending the facilities conclusion of their internal investigation. The Vulnerable Adult Policy dated 2025 remains effective. Corrective Action as it Applies to Other Residents: All residents were interviewed by facility staff on 5/27/26 with no concerns regarding abuse or neglect identified. Facility has a grievance process and there have been no concerns regarding abuse or neglect identified since survey exit.		07/02/2026

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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
F0610 SS = D	Continued from page 39 impaired cognition and no behaviors. R1 had functional limitations in range of motion (ROM) in upper and lower extremities on one side. R1 required substantial/maximal assistance with personal hygiene and lying to sit on bed, was dependent on staff for all transfers, repositioning in bed, toileting hygiene, and lower body dressing. R1 used a manual wheelchair for mobility. R1 was frequently incontinent of bladder and occasionally incontinent of bowel with constipation. R1's diagnoses included stroke, atrial fibrillation, hemiplegia or hemiparesis (weakness or paralysis on one side of the body), adjustment disorder with mixed anxiety and depressed mood. R1's care plan dated 5/14/26, identified: R1 was at risk for abuse and/or neglect. Staff were directed to follow the facility Vulnerable Adult (VA) policy. Keep her safe and refer to resident services as needed (PRN). R1's physician orders identified: Behavioral Expression: every shift for clinical monitoring for seven days. Start dated 5/19/26. End dated 5/26/26. Buddy Cares at all times. Nurses and aides, every shift. Start date: 5/19/26. R1's NA Target Behavior documentation reviewed 5/14/26 through 5/27/26, target behaviors 1. Crying/sad and 2. Anxiety/Agitation occurred. Intervention attempted. Intervention effective/ineffective. Documentation identified: Target behaviors were documented as did not occur or not applicable from 5/14/26 through 5/18/26, 5/20/26, and 5/27/26 (7 days). 5/19/26 at 1:38 p.m., anxiety/agitation, other, intervention ineffective. 5/21/26 at 10:59 p.m., anxiety/agitation, crying/sad, reassure, intervention effective. 5/22/26 at 2:50 p.m., anxiety/agitation, crying/sad, conversation, intervention ineffective. 5/23/26 at 5:36 a.m., anxiety/agitation, other, intervention effective. 5/24/26 at 11:08 p.m., anxiety/agitation, reassure, intervention effective.			F0610	Continued from page 39 Reoccurrence will be Prevented By: Re-education to Facility leadership has been initiated on the Vulnerable abuse investigation process to ensure completely investigations are complete. This education includes the facility's investigation process, including timely initiation and completion of investigations, documentation requirements, maintenance of investigation files, reporting requirements, and oversight responsibilities to ensure resident safety. 100% of investigations completed will be audited for compliance for 4 weeks through QAPI for ongoing frequency. The facility administrator will be responsible for oversight.		07/02/2026

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F0610 SS = D	Continued from page 40 5/25/26 at 8:55 p.m., anxiety/agitation, reassure, intervention effective. 5/26/26 at 9:55 p.m., anxiety/agitation, reassure, intervention effective. R1's progress notes from 5/16/26 through 5/22/26, identified: 5/16/26 at 11:22 p.m., R1's daughter complained her mother had no bowel movements for the last three days. Senna was given per orders, rectal check was done and hard stool noted, suppository administered without results. Manual evacuation of stool was performed with removal of large amounts of stool. R1 expressed discomfort during the removal but relieved at the end. 5/17/26 at 12:16 p.m., Alert and orientated to self with some confusion, increased anxiety observed upon rising this morning. Assist of two with stand lift transfer. 5/17/26 at 12:41 p.m., Family expressed concerns to staff regarding bowel habits, digital removal, policies regarding procedure. Family concerned that digital removal was painful, and she called family distressed after procedure was performed. Family expressed dissatisfaction with nurse who performed procedure. 5/18/26 at 1:00 p.m. Writer entered R1's room and daughter was present and brought up some concerns that she had been having. Writer reassured R1 and daughter that she would bring concerns to superiors. Writer immediately brought concerns to supervisor and director of nursing (DON) upon leaving room. 5/19/26 at 7:16 a.m., R1's daughter called writer and reported her mother called crying and needed help immediately. Writer went into R1's room and she observed her sitting on bedside on the verge of tears. R1 stated "I haven't slept since 5:00 a.m., because do not know why people have to come in here and change people at 5:00 am when they supposed to be sleeping. Writer apologized, reassured her care plan will be updated. R1 stated "I am sorry to bother you with my complaints, but I am in pain." Writer offered medication, accepted, and administered. 5/19/26 at 2:36 p.m. R1 alert oriented to self, family, place with forgetfulness and confusion within her baseline. R1 refused therapy this morning due to fatigue per resident, slept in per request and cares			F0610			07/02/2026

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F0610 SS = D	Continued from page 41 were done as allowed by R1. 5/19/26 at 4:07 p.m., Email message sent to Pastor, daughter requested a visit for R1, thought it benefit her mom. 5/21/26 at 10:58 a.m. Pastor visit made. 5/21/26 at 4:30 p.m. DON checked in on R1. Daughter and ex-husband were both in R1's room. Daughter inquired about the possibility of rectal bleeding following recent stool removal procedure, expressed concern related to potential rectal tearing. DON informed daughter if any tissue injury had occurred symptoms would likely have presented by this time and no observed or reported signs/symptoms identified. 5/22/26 at 2:21 p.m., R1 refused toileting, bed bath, and scheduled weekly shower, requested to be able to go back to sleep, stated not now, later, and reapproached with no success. R1's Body Audit completed on 5/22/26 at 6:25 p.m., by registered nurse (RN)-C identified current alterations in skin integrity: other type of alternations. Scattered bruising on belly and near both elbows/antecubital spaces. R1 had an old/healing scratch mark on her left shin, daughter said she thought it was from the lift machine in the hospital. All other areas of skin are clean, dry and intact. The Body Audit did not include an assessment of R1's peri-rectal area. R1's Body Audit completed on 5/27/26 at 9:11 p.m., by DON identified overall skin is clean, dry and intact. All bruises are in the healing stage, and the scratch continues to heal without issues. The peri-anal area was assessed and unremarkable. The anus is clean, intact, without visible cutes, tears, or lumps and is normal in size and shape. Facility Vulnerable Adult (VA) Maltreatment Report filed with State Agency (SA) dated 5/18/26 at 5:36 p.m., identified estimated date and time of most recent occurrence was 5/16/26 at 8:00 p.m., in resident bathroom. Description of incident: Allegation of sexual contact by daughter today on 5/18/26. VA complained of rectal pain before, during, and after administration of bowel evacuation regime. Daughter stated VA called her crying around 8:30 p.m. on 5/16/26 stated "he hurt me! He hurt me! He put his fingers in my rectum and vagina." VA interviewed in room today 5/18/26, she wept, "I looked back at him while he was behind me and was smiling at me while he hurt me, digging around in			F0610			07/02/2026

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F0610 SS = D	Continued from page 42 my anus.” Allegation: sexual abuse. Facility internal investigation documents identified on 5/18/26, R1’s daughter reported an allegation of inappropriate sexual contact involving facility staff. R1’s constipation was identified as a current problem on 5/15/26. R1 complained of rectal pain prior to and during administration of a bowel evacuation regimen (rectal suppository and manual stool removal). This information was documented by the nurse on 5/16/26. On 5/18/26, alleged perpetrator nurse was interviewed and again for clarification on 5/22/26. Additionally, (undated) two NA’s (one witnessed incident) were interviewed. On 5/22/26, interviews were completed with six residents out of 60. Questions asked: do you feel safe here, have you ever witnessed any abuse here, has anybody intentionally hurt you, and if you had a problem with someone here who would you report it to? No concerns noted. LPN-A’s time card identified work history from 5/16/26 through 5/23/26: -On 5/16/26 started work at 6:30 a.m., break taken from 10:30 a.m. to 11:00 a.m., worked 11:00 a.m. to 3:00 p.m. -On 5/16/26 started work at 3:00 p.m., break taken from 7:00 p.m. to 7:30 p.m., worked 7:30 p.m. to 12:00 a.m. -On 5/18/26 started work at 2:30 p.m., worked until 5:15 p.m. Unpaid administrative leave taken from 5:15 p.m. through 11:00p.m. During an interview on 5/22/26 at 11:38 a.m. NA-F stated on 5/18/26, R1’s daughter informed her the incident happened on 5/16/26 at approximately 8:30 p.m., LPN-A placed his finger in to pull out the BM and hurt R1. R1 stated she just wanted him to stop, it was so painful. NA-F reported this incident right away to the DON on 5/18/26. NA-F stated when R1 requested the nurse to stop he should have stopped. NA-F stated LPN-A arrived at work on 5/18/26 at 7:00 a.m. and at 10:00 a.m. the DON talked to him, and he left the building. NA-F stated she had not received any education regarding abuse since incident on 5/16/26. During an interview on 5/22/26 at 12:37 p.m., R1 stated she had no concerns about staff until 5/16/26, when she was constipated and unable to have a BM. R1 felt the nurse was in a hurry, and one or two other female staff were in the room with him. The nurse inserted his finger into her anus,			F0610			07/02/2026

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F0610 SS = D	Continued from page 43 started to circle it around and informed her he had to do that to make the stool come out. R1 stated the male nurse kept circling his finger, “Over and over,” and she started to cry and begged him to stop. LPN-A told R1, “We need to get it out of here, just relax.” R1 told LPN-A, “Oh please stop you are hurting me.” When R1 looked at LPN-A, “He smiled at me and I felt he was laughing at me.” R1 stated she begged him to stop, it made her vulnerable, embarrassed, and felt he was making a mockery for her. “You can ask the other staff when I begged him to stop, they were standing right there.” During a follow-up interview on 5/22/26 at 4:55 p.m., R1 stated the nurse kept digging with his finger, “It felt like it was in the vaginal area but hard to say for sure, he was doing it so fast. It was very painful. I told him he was hurting me. He grinned at me. It was awful. It made me feel like a piece of dirt.” R1 stated she tried to let it go but it continued to bother her and felt it was horribly demeaning. R1 stated she cried when it came to mind. R1 was sad that someone could treat her that way. R1 stated she wondered what the repercussions were for the nurse, “Will he be upset and come back and hurt me? Does he expect me to be submissive and let him hurt me? It was very unprofessional. I do not want to believe he treated other people like that but if he came back to work, would he retaliate?” R1 stated it was perplexing for her. During an interview on 5/22/26 at 2:04 p.m. NA-E stated today had been a hard day for R1, she refused breakfast, offered toast, accepted and ate only 4 bits, refused shower, accepted a bed bath instead but was unable to complete a bed bath before end of day, and passed it onto the next shift. Yesterday, 5/21/26, R1 informed her at the end of the day something about a nurse assisting her with constipation and how she had not liked his approach. NA-E stated she planned on reporting it to the DON but forgot and told her today instead. NA-E received abuse education one month ago. Staff were expected to approach R1 with two staff now and she was unaware of why. During an interview on 5/22/26 at 2:42 p.m., LPN-D stated on 5/18/26 at approximately 1:00 p.m., she entered R1’s room and R1’s daughter reported she had concerns about the care her mother received. Daughter indicated specifically the name of the nurse [LPN-A] administered a rectal suppository, dug out stool from R1’s rectum with possible			F0610			07/02/2026

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F0610 SS = D	Continued from page 44 vaginal penetration, and R1 experienced quite a bit of pain. LPN-D informed R1 and daughter she would bring this information immediately to her supervisor. LPN-D left R1's room, went directly to DON and reported the incident. LPN-D stated she was unaware of who was responsible for completing the assessment on R1 after an allegation of abuse. LPN-D did not complete an assessment. LPN-D stated the nurse would be expected to listen to the resident if they indicated they were in pain, stop what they were doing, and contact provider if needed. LPN-D had not received education on abuse since orientation in 1/2026. During an interview on 5/22/26 at 3:15 p.m., the LPN-C any allegation of abuse should have been reported immediately to the supervisor, removal of staff involved to protect the residents, and a physical assessment including the area of concern, should have been completed right away to provide a clear picture of what may of happened, and to make sure it did not happen again. The assessment should have included a behavioral assessment and any changes noted and documented from baseline. If a resident was scared, they would be more anxious and possibly crying. The LPN-C verified documentation of a physical or behavioral assessment was not identified in R1's medical record. On 5/22/26, a change in R1's care plan was noted, two staff were expected to go into R1's together for everything to make sure R1 was safe. The LPN-C stated she had not received any additional education on abuse or impaction of stool since the incident. During an interview on 5/27/26 at 8:15 a.m., the DON stated NA-A was a witness to the R1's incident and would have been expected to share concerns with her and/or another nurse as soon as possible after it happened on 5/16/26. The DON was unsure if that happened and would have been important for the safety and well-being of the residents, to start an investigation to determine what the complaint was, to determine if it had occurred and prevent it from occurring again. "The bottom line was to make sure residents were safe and felt safe with the care they were receiving." The DON stated she was not made aware of the incident until 5/18/26 between 1:00 p.m. and 1: 30 p.m., when R1's family voiced concerns to the LPN-D. The DON was not aware of R1's progress notes written on 5/17/26, when family voiced concerns about digital removal of stool, painful, and dissatisfaction with nurse who performed procedure. The DON was notified of the progress note written on 5/17/26, today. The			F0610			07/02/2026

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F0610 SS = D	Continued from page 45 progress note identified the same concern as discussed by family with the LPN-D on 5/18/26, and she would have wanted to follow up right away and collected more details. DON stated LPN-D was not interviewed. DON stated it was hard to tell if R1 displayed any behavioral changes after the incident due to recent medical issues and a tremendous amount change in a short amount of time (stroke, sleep apnea, history of depression, anxiety, uprooted from Arizona). The DON stated she initiated an investigation as soon as she was aware of the situation on 5/18/26 on 1:20 p.m. No physical exam was completed at that time, there was an emotional component as mentioned in report and interviews. R1 was negatively impacted and affected by this incident which was identified during R1's interview. R1 told the DON stated it caused her [R1] worry, fear and she was afraid LPN-A would come back. LPN-A was placed on administrative leave on 5/18/26. The DON stated, "We are still investigating and waiting for the outcome of your [State Agency] investigation. To have her [R1] that scared, see him [LPN-A] working here again and have no outcome of what was determined would not have been appropriate." The DON stated LPN-A worked at the facility as a trained medication assistant (TMA) and NA since 2018, he worked as a LPN since 3/1/25. LPN-A worked on both units, had potential contact with all residents in the facility, and worked all three shifts (a.m., p.m., nights), but mostly a.m. and p.m. shifts. On 5/22/26, six residents (determined by administrator) out of 60 were interviewed. The DON stated all residents who were able to be interviewed should have been. "For those residents who we were not able to interview, we should have contacted family and asked if they had any concerns. We needed to assure all the residents were safe, nothing had happened to them to mitigate any harm." During an interview on 5/27/26 at 4:30 p.m., the RN-C confirmed he completed R1's body audit on 5/22/26 at 6:25 p.m. The body audit included a full skin check of abdomen/arms/shin, how often R1 was wet, her bowel and bladder function, and if at risk for skin breakdown. The RN-C stated he did not assess R1's rectal area. Follow-up information provided on 5/28/26 at 12:17 p.m., the DON verified via email she had completed R1's Body Audit on 5/27/26 at 9:11 p.m., and assessed the peri-anal area, no concerns. During an interview on 5/28/26 at 1:24 p.m., the administrator stated staff education would have been expected to be started sooner, usually before submission of the five day report to the State			F0610			07/02/2026

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F0610 SS = D	Continued from page 46 Agency (SA) and may take a day or two to be completed after investigating. Staff education was important to make sure the facility was in compliance right away and staff knew what was expected of them, also to ensure the safety of all residents. Resident interviews usually started before the five day was submitted to the SA to identify any concerns and should included in the report. The resident interviews were started on 5/22/26. These interviews should have been done sooner to ensure no concerns or patterns were identified and to protect all residents from abuse. The administrator stated she had determined a certain percentage of residents, 10 to 20%, were interviewed. If a pattern was identified, all residents would have been interviewed. "We did not interview those residents who were unable to be interviewed and we did not looked for signs of distress. If noted, the nurse would have charted those findings and concerns would have been brought to our attention. It would have been a good idea to audit those residents unable to speak for themselves to identify if there were any concerns. Other staff were not made aware of the incident." Facility policy Vulnerable Adult Abuse Prevention Plan dated 10/2025, identified all cases of maltreatment or potential maltreatment must be reported immediately to an employee's supervisor who will then report immediately to the administrator. Care should be taken immediately to remove the resident from immediate danger and intervene in any situation to protect residents. Remove any individual from the facility if necessary for the protection of residents or staff, including but not limited to employees, visitors, contractors, and family members. Call local law enforcement for assistance for the protection of residents or staff. The following action must be taken in cases of suspected sexual assault/rape: immediately put suspected perpetrator on administrative leave pending investigation. Assess the resident for possible injuries immediately. The administrator or designee will complete a full review of the investigation documentation before investigation is signed off on and filed to identify trends or patterns in individuals involved, or system issues. Review of each occurrence will be made to determine if policies, procedures or facility systems need to be modified to prevent further occurrences. Take necessary corrective action with employee (after consulting with Human Resources) and document results. Implement follow-up education/training with appropriate personnel. Complete investigation form and staff interviews for your investigation. Notify medical director of allegation and investigation			F0610			07/02/2026

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F0610 SS = D	Continued from page 47 proceedings. Notify appropriate board for substantiated cases of abuse/neglect (nurse aide registry, board of nursing). Follow-up action plan: complete an action plan for follow-up after the investigation: update care plan, staff assignment sheets, update physician and discuss whether any new MD orders needed, and follow-up with resident and resident's designated representative for resolution.		F0610			07/02/2026	
F0710 SS = A	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure admission orders were approved in writing by a physician for 1 of 1 resident (R2) reviewed for admission orders. Findings include: R2's entry Minimum Data Set dated 5/13/26, indicated admission on 5/13/26. R2's hospital transfer orders dated 5/13/26, provided by the facility as evidence of admission orders, indicated R2 was expected to discharge to the facility on 5/13/26, and were signed by a physician's assistant (PA) on 5/11/26 at 6:54 a.m. During an interview on 5/28/26 at 3:21 p.m., the administrator acknowledged R2's hospital transfer orders were signed by a PA, and not a physician. An email dated 5/28/26 at 4:12 p.m., from the administrator to the surveyor indicated the		F0710			07/02/2026	

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F0710 SS = A	Continued from page 48 administrator spoke to the facility regional director of clinical services who indicated the facility had admission orders from R2's Discharge Summary dated 5/14/26, signed by a nurse practitioner (NP), which should be used instead of the hospital transfer order as evidence of admission orders. R2's Discharge Summary dated 5/7/26 at 4:41 p.m., and signed 5/14/26 at 9:58 a.m., provided by the facility as evidence of admission orders, indicated the admission orders were signed by a NP. During a follow-up interview on 5/28/26 at 5:01 p.m., the administrator acknowledged R2's hospital Discharge Summary with orders for R2 to admit to the facility were signed by a NP, and not a physician. The Physician Services policy dated 11/2019, indicated it is the policy that a physician will approve written orders for admission to the community.			F0710			07/02/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/29/2026	
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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	
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 5/22/26, 5/26/26, through 5/29/26. A complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed H56132528C (3018557, 3018766). with a licensing order issued at 1285		20000			07/02/2026	

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		07/02/2026	
21285	Admission Orders and Physician Evaluations CFR(s): MN Rule 4658.0710 Subp. 2 Subp. 2. Admission orders. A nursing home must have physician orders for a resident's admission and immediate care at the time of admission. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure admission orders were approved in writing by a physician for 1 of 1 resident (R2)	21285	F710 Resident’s Care Supervised by a Physician Immediate Corrective Action: R2 has been discharged from facility. Corrective Action as it Applies to Other Residents: All resident admission orders will be audited to ensure a physician has approved admission to this skilled nursing facility. Reoccurrence will be Prevented By: Admissions	07/02/2026	

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21285	Continued from page 2 reviewed for admission orders. Findings include: R2's entry Minimum Data Set dated 5/13/26, indicated admission on 5/13/26. R2's hospital transfer orders dated 5/13/26, provided by the facility as evidence of admission orders, indicated R2 was expected to discharge to the facility on 5/13/26, and were signed by a physician's assistant (PA) on 5/11/26 at 6:54 a.m. During an interview on 5/28/26 at 3:21 p.m., the administrator acknowledged R2's hospital transfer orders were signed by a PA, and not a physician. An email dated 5/28/26 at 4:12 p.m., from the administrator to the surveyor indicated the administrator spoke to the facility regional director of clinical services who indicated the facility had admission orders from R2's Discharge Summary dated 5/14/26, signed by a nurse practitioner (NP), which should be used instead of the hospital transfer order as evidence of admission orders. R2's Discharge Summary dated 5/7/26 at 4:41 p.m., and signed 5/14/26 at 9:58 a.m., provided by the facility as evidence of admission orders, indicated the admission orders were signed by a NP. During a follow-up interview on 5/28/26 at 5:01 p.m., the administrator acknowledged R2's hospital Discharge Summary with orders for R2 to admit to the facility were signed by a NP, and not a physician. The Physician Services policy dated 11/2019, indicated it is the policy that a physician will approve written orders for admission to the community. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure a physician must personally approve in writing a recommendation that an individual be admitted to a facility. The director of nursing or designee, should conduct measurable audits of admission orders to ensure that facility processes are followed. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21285	Continued from page 2 Nurse and HUC/designee will be educated on the requirement for having a MD sign all admission orders. The facility will audit all admissions and returns from the hospital weekly X 4 weeks to ensure compliance, and the results of these audits will be brought through the facility QAPI process to determine ongoing frequency. The facility administrator will be responsible for oversight. Date of compliance: July 2, 2026		07/02/2026