STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on the Lake LLC	1020 Lark Street Alexandria, MN 56308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to protect 1 of 3 residents (R1) reviewed for abuse, from mental abuse when nursing assistant (NA)-A ridiculed, yelled with intent to intimidate, and threatened R1 with physical abuse, to be sent to a locked unit, and for staff to be unwilling to provide cares to R1 in the future. R1's actual response and the use of the reasonable person concept identified serious psychosocial harm to R1 when she exhibited crying and combative behavior above baseline, fear/anxiety manifested as combativeness, resistance to care and social interaction, and self-isolation. The IJ began on 3/11/26 at 8:30 p.m., when NA-A was witnessed to make derogatory aggressive toned statements in the presence of R1 and two other staff. NA-A was not removed from shift and continued to work with R1 and other vulnerable residents despite an internal report being made. The administrator and director of nursing (DON) were notified of the IJ on 3/26/26 at 2:45 p.m. The facility implemented corrective action by 3/13/26 prior to the start of the survey and therefore is issued as past non-compliance. Findings Include: R1's admission Minimum Data Set (MDS) dated [DATE], identified admission to facility on 2/26/26, from home/community. R1 had severely impaired cognition, feeling down, depressed, or hopeless (two-to-six days out of seven), and no behaviors noted. R1 required partial/moderate assistance with oral/personal hygiene, shower/bathe, substantial/maximal assistance with upper body dressing, roll left and right in bed, sitting to lying position, lying to sitting on side of bed, was dependent with toileting hygiene, lower body dressing, sit to stand, all transfers, was unable to walk, and used a manual wheelchair for mobility. R1 was frequently incontinent of bowel and bladder. R1's diagnoses included non-traumatic brain dysfunction, arthritis, muscle weakness, Alzheimer's disease, dementia, anxiety, depression, and psychotic disorder. R1's medications include antipsychotic, antianxiety, and antidepressant.R1's St. Louis University Mental Status (SLUMS) (an assessment designed to evaluate various cognitive functions, including memory, attention, and problem-solving skills) dated 3/3/26, identified a score of 4 out of 31 [sic] - dementia (25-30 normal cognition, 20-24 mild neurocognitive disorder, and 1-19 points dementia).R1's care plan dated 3/16/26, identified the following areas of concerns and interventions to address each area:Alteration in behavior as evidenced by (AEB) wandering, yelling in room for help, yelling in hallway, combative with staff, throwing belongings, calling staff names related to psychotic disorder, anxiety, Alzheimer's disease, dementia and chronic pain. Interventions included to call family or granddaughter to assist with compliance of medications and calming R1 down, be alert to mood and behavior changes, approach in a calm voice making eye contact and using therapeutic touch. Behaviors were to be documented. Additional interventions included to validate feelings/provide emotional support, administer medications as ordered, re-direct by offering food/fluids/toileting/repositioning, Alteration in cognition and psychosocial wellbeing. Interventions included to allow her time to communicate her needs/wants, provide and maintain consistent environment, provide cues, reorientation/supervision as needed, monitor and respond to unmet needs, and monitor mood state.Alteration in mood and behavior related to psychotic disorder with delusions. Interventions included to monitor and document mood state/behaviors upon occurrence.R1 was a (continued on next page)

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 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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F 0600 Level of Harm - Actual harm Residents Affected - Many	vulnerable adult while she resided in facility. Interventions included to monitor for signs of emotional distress or mood and behavior changes, continue to follow the facility vulnerable adult and abuse reporting policy. In addition, the local Ombudsman, Adult Protection, Police and/or state/financial agencies were to be notified of any suspected abuse or financial exploitation as needed.Facility investigation 5-day report dated 3/16/26 at 3:10 p.m., indicated on 3/11/26 at 8:30 p.m., NA-A and NA-B assisted R1 with evening cares. R1 was crying, and had ended a phone call with her son when NA-A stated, you need to stop crying, you are acting like a two-year-old. NA-B reported NA-A seemed frustrated and sounded stern. NA-A placed R1's arms on the EZ stand (mechanical device used to lift and lower a resident), R1 swatted out at NA-A. NA-A stated if you hit me again, I am going to hit you back. This statement confirmed by NA-A, who stated she made the comment not thinking but would never hit a resident. Staff assistance was requested over the walkies. NA-C entered R1's room and heard NA-A yell at R1 in a loud toned voice, stop crying, they are going to put you in a locked unit. NA-C felt NA-A was not joking. NA-A left R1's room briefly to assist another resident and returned approximately five minutes later. R1 continued to cry and was distraught. NA-A stated to R1, nobody will want to keep working with you, nobody wants to work with a crybaby.R1's physician orders included:-Monitor for signs and symptoms of emotional distress and place a note in chart three times a day until 3/26/26 at 11:59 p.m. Order date: 3/12/26. Start date: 3/12/26. -Monitor for bruising on upper body every shift. Order date: 3/12/26. Start date: 3/12/26. -Target behavior monitoring: 1. Restlessness, 2. Increase in complaints, 3. Refusing care, 4. Self-isolation, 5. Crying, 6. Not sleeping at night, 7. Wandering into other resident rooms. Non-pharmacological, Document number of those interventions used: 0: N/A, 1. redirection, 2. Ambulate, 3. offer activity, 4. Ambulate, 5. Reposition, 6. Toileting, 7. Provide 1:1, 8. Offer food/fluids, 9. Offer pain relief two times a day. If target behavior observed. Select chart other and enter findings including effectiveness of interventions in the nursing progress notes. Order date: 3/12/26. Start date: 3/12/26. -Sending to ER for evaluation of symptoms of combativeness and emotional distress. Order date: 3/14/26.-Risperidone (used to treat agitation, aggression, and psychosis during dementia) oral tablet 0.25 milligrams (mg) give 0.25 mg by mouth (po) at bedtime for dementia with aggressive behavior. Start date: 3/14/26. Discontinue date: 3/16/26.- Risperidone oral tablet 0.25 mg give po at bedtime related to psychotic disorder with delusions due to known physiological condition. Start date: 3/16/26. Hold date: 3/18/26, through 3/24/26. Discontinue date: 3/24/26.-Alprazolam (anti-anxiety) oral tablet 0.25 milligram (mg) po as needed (PRN) for anxiety related to anxiety disorder for 14 days, three times a day (t.i.d.), morning, noon and evening. Order date: 2/26/26. Start date 2/26/26, and renewed order on 3/14/26. Start date: 3/14/26. End date: 3/28/26.- Quetiapine (Seroquel) Fumarate (antipsychotic) oral tablet give 50 mg po three times a day (8:00 a.m., 2:00 p.m., 8:00 p.m.) related to dementia with other behavioral disturbance disorder with delusions due to psychological condition. Start date: 2/26/26.R1's electronic medication administration record (EMAR) dated March 2026, from 3/11/26 through 3/21/26, identified:-Risperidone oral tablet 0.25 milligrams (mg) give 0.25 mg po. Administered on 3/14/26, 3/15/26, 3/16/26, and 3/17/26. -Quetiapine Fumarate give 50 mg po three times a day. Administered as ordered 3/11/26 through 3/16/26, except on 3/14/26, 8:00 a.m. dose refused. -Alprazolam (anti-anxiety) oral tablet 0.25 mg. Give 0.25 mg po as needed for anxiety three times a day (morning, noon, and evening). Administered one time a day on 3/3/26, 3/4/26, 3/6/26, 3/7/26, 3/8/26, two times a day 3/9/26, 3/10/26, 3/11/26, one time a day on 3/15/26, 3/18/26, 3/19/26, 3/20/26, and two times a day on 3/21/26. R1's nursing target behavior monitoring two times a day (2:00 p.m. and 9:00 p.m.). If target behavior was observed from 3/4/26 through 3/17/26, identified: 1. Restlessness, 2. Increase in complaints, 3 Refusing care. 4. Self-isolation. Document number of those interventions using the code provided. Start date 2/26/26.At 2:00 p.m. on 3/4/26, 3/5/26, 3/9/26, and 3/10/26, no documentation. At 2:00 p.m. on 3/6/26, 3/7/26, 3/8/26, 3/11/26, 3/15/26, 3/16/26, and 3/17/26, no behaviors noted.At 9:00 p.m. on 3/4/36, 3/5/26, 3/6/26, 3/7/26, 3/9/26, 3/11/26, 3/15/26, 3/16/26, and 3/17/26, no behaviors noted.At 9:00 p.m. on 3/8/26, refused care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Many	Intervention: provide 1:1.At 9:00 p.m. on 3/10/26, restlessness. Intervention: redirection, offer activity, reposition, and provided 1:1.At 9:00 p.m. on 3/12/26, restlessness and refusing care. Intervention: redirection, offer activity, reposition, and toileting.At 2:00 p.m. on 3/13/26, restlessness, increase in complaints, refusing care, and wandering into other resident rooms. Interventions: redirection, offer activity, provide 1:1, and offer food/fluids. At 9:00 p.m. self-isolation. Intervention: redirection.At 2:00 p.m. on 3/14/26, no documentation. At 9:00 p.m. X entered each box.R1's NA behavior charting every shift (night, day, evening) from 3/4/26, through 3/16/26, identified:Responses:3/4/36 - Not applicable: all three shifts3/5/36 - Not applicable: all three shifts3/6/26 - Not applicable: nights/days. Crying/expressions of sadness: evening.3/7/26- Not applicable: all three shifts3/8/26 - Not applicable: nights. Crying/expressions of sadness day and evening.3/9/26- Not applicable/none noted: nights and days. Crying/expressions of sadness: evening.3/10/26 - Not applicable: nights and days. Crying/expressions of sadness: evening.3/11/26- Not applicable: nights and days. Calling out/yelling: evening.3/12/26 -Not applicable/none noted: all three shifts3/13/26- Calling out/yelling, hitting or kicking, pinching scratching: nights. Resisting or refusing care: days. Not applicable: evening.3/14/26- Not applicable/none noted: nights and days. Resident not available: evening.3/15/26 - Not applicable/none noted: nights and days. Resisting or refusing care: evening.3/16/26 - Not applicable/none noted: all three shifts.R1's NA meal intake/amount eaten and fluid intake documentation from 3/4/26, through 3/17/26, identified:3/4/26, 51 to 100% of all three meals. Fluids consumed 1200 milliliters (ml). 3/5/26, 51 to 100% of all three meals. Fluids consumed 780 ml. 3/6/26, 51 to 75% of all three meals. Fluids consumed 840 ml. 3/7/26, 51 to 100% of all three meals. Fluids consumed 1060 ml. 3/8/26, 76 to 100% of all three meals. Fluids consumed 720 ml. 3/9/26, refused breakfast and 51 to 75% of lunch and supper. Fluids consumed 490 ml. 3/10/26, 26 to 50% of breakfast, 75 to 100% of lunch and supper. Fluids consumed 840 ml.3/11/26, 26 to 50 % of breakfast, 75 to 100% of lunch and supper. Fluids consumed 840 ml. 3/12/26, 0 to 25% of breakfast, 26 to 50% of lunch, and refused supper. Fluids consumed 360 ml. 3/13/26, refused breakfast and lunch, 76 to 100% of supper. Fluids consumed 450 ml. 3/14/26, refused breakfast and not available for lunch and supper. Fluids consumed 0. 3/15/26, 76 to 100% breakfast and supper, refused lunch. Fluids consumed 490 ml. 3/16/26, breakfast not available, 51 to 75% of lunch and supper. Fluids consumed 690 ml. 3/17/26, 76 to 100% of all meals. Fluids consumed 1210 ml.R1's psychiatric care notes identified:On 2/26/26 at 12:07 p.m., the virtual visit with this writer was cancelled due to her moving from assisted living to a different assisted living facility. R1 will receive ongoing psychiatric medication management by rounding providers at her new home.On 3/16/26 at 3:00 p.m., writer spoke to nursing home facility nurses (2) and was updated R1 had been in ER over the weekend for increased behaviors, anxiety, and agitation. The nursing team was looking for guidance on how to best address R1's psychiatric care going forward. This writer was under the impression she had been moved to a locked memory care unit from AL though her current living situation was not that. Additionally, there had been some hesitancy from the rounding provider at her current place of resident in managing psychiatric conditions and heightened behaviors. Would be best for R1's wellbeing and care to be in an inpatient psychiatric unit, transition to a locked memory care unit and most likely be the best option so aggressive medication adjustments can be made under constant surveillance and supervision and was discussed with her son. R1's progress notes from 3/9/26, through 3/14/26, identified:On 3/9/26 at 8:24 p.m., R1 behaviors this shift very emotional and whiny. Crying at supper and stating she wants to get out of here. Took half of her supper and dumped it on the floor. Sat at nurse's station whining and crying. Called son. Put to bed around 8:00 p.m. and was calm.On 3/10/26 at 5:07 a.m., Tried to slide out of recliner at 4:15 a.m., wanted to get up and look outside. Toileted and transferred back into recliner. Hollered out and tried sliding out again. Unplugged her oxygen (02) concentrator and refused to leave O2 on. Redirected and TV turned on to distract her.On 3/10/26 at 10:55 a.m., Received a call from Mental Health Provider and able to see resident by tele-health but not in person. Will discuss rounding provider.On 3/10/26 at 2:05 p.m., Wandering (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Many	around the unit redirected back to room. Attempted to get on elevator. Crying episode and anxious behaviors noted. Hollering for ride to go home for over four hours repeated cycle from 10:00 a.m. to 2:00 p.m. Less crying and hollering after Seroquel and alprazolam given earlier.On 3/10.26 at 8:32 p.m., Very emotional this shift. Constantly crying, wanted to go to another facility. Redirected many times and activities offered. Wandered halls did not attempt to exit building.On 3/11/26 at 6:49 a.m., Resident did not calm down after PRN. Continued to cry out and screaming she wanted to leave. Tried to soothe her, offer activities to distract her, 1:1 bathroom multiple times, reason with her, and reposition.On 3/12/26 at 3:18 p.m., Resident cried most of the morning. Very restless and difficult to redirect. Writer attempted to give morning pills at 9:00 a.m., gave her cup of water to drink and she almost threw the cup at the writer. Writer unable to get morning medications in at this time. R1 name-calling staff, hitting staff when trying to redirect or toilet. Staff offered county music, coffee snacks, and repositioning. Resident seen wandering into other resident rooms this shift. Writer was able to administer morning medications at 1:00 p.m., with no behavioral issues at this time.On 3/12/26 at 3:30 p.m., received notification of verbal allegations. OHFC filed per policy. Investigation pending. Resident stated she felt safe in facility.On 3/12/26 at 6:48 p.m., R1 wandering halls this shift going into other resident rooms. Unable to redirect. Yelling at staff you're giving into the shit. Refused blood sugar check and medications, will reapproach later. Crying in the halls stating she wants to go home. Offered activity, toileting both ineffective. Hollering out in the halls she needs help. When writer approached resident, she was unable to express what she needed help with. Wants to go home. Wander guard (device placed on a resident to alert staff when resident is too close to an exit or other unsafe area) and video monitoring in place. On 3/12/26 at 9:26 p.m., R1 continued to have behaviors after supper. Hitting out at staff, refused medications, went into resident rooms and was unable to be redirected. Resident yelling out and crying. DON (director of nursing) updated and stated to call family and see if they would be able to provide 1:1 with resident to help with behaviors or call on-call provider and send to ER (emergency room) if behaviors are unable to be managed. Called daughter who tried talking to resident on phone but was not calm enough and unable to talk. Daughter agreed to call on-call and send in if appropriate. Granddaughter called the desk stating she can usually calm resident down and resident did talk to her on the phone. Resident calmed down and took oral medications plus PRN Tylenol. R1 laughed and joked with staff, ate some ice cream, and placed in recliner. On 3/12/26 at 10:36 p.m., R1 also yelling swear words loudly.On 3/13/26 at 12:38 a.m., R1 in her room screaming get out of here and leave me alone at this time loud enough to hear her at the nurse's station. Staff had attempted to reposition, toilet, and offered snacks. R1 screamed at staff, swings, pinches at staff with redirection. Staff will monitor.On 3/13/26 at 5:54 a.m., R1 had been waking periodically throughout the night and yelling then fell back to sleep. Writer approached resident to attempt to get her up for the day. Resident yelled no and began getting agitated. Did not get up on the night shift.On 3/13/26 at 12:33 p.m., Resident yelled out at staff this a.m. so slept until 11:30 a.m. Staff got resident up and dressed. No injuries, bruising noted, or complaints of pain. R1 loudly refused to have blood sugar checked, insulin, and medications given. Yelled at writer and stated, your only out for the money! R1 made her way down the hallway and refused food when offered. Went into another resident's room and loudly protested when wheeled out of room. Door shut per request by another resident. Resident protested stated stop slamming doors.On 3/13/26 at 2:26 p.m., R1 refused all food and drink today. Had been wandering halls in wheelchair and made multiple attempts to go into other residents' rooms. Administered Seroquel with a sip of water. Made frequent statements that people want to take her money.On 3/13/26 at 3:12 p.m., primary provider here and ordered resident monitored for emotional distress. Noted OHFC was filed for allegations of verbal abuse. Recommended consult with psych.On 3/14/26 at 10:34 a.m., Usual Mental Status/Cognition Function before the Acute Change in Condition: Alert, disoriented, but cannot follow simple instructions. Behavioral concerns: combativeness, emotional distress, and inconsolable physical and verbal behaviors. Sent to ER for evaluation for the behavioral concerns.On 3/14/26 at 1:35 p.m., R1 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Many	slept in this afternoon. She repeated statements what am I doing here and tell me what is going on. Reassurance given. Assisted to wheelchair, started crying and hollering out someone please tell me. Attempted to comfort with non-pharmalogical interventions. R1 swung arms at writer when attempted medication administration, food and fluids. Called son, attempted to talk to her. R1 threw phone when son tried to talk resident into taking scheduled medications. R1 cried and screamed on the phone, I said no I don't want to! Son attempted for five minutes to talk and R1 continued to throw phone. Son gave okay for R1 to be sent to hospital. R1 would not allow staff to have the phone, swung arms, kicked out at staff whenever they attempted to come near her. Contacted provider and called 911 for transport, sent two officers and ambulance crew. R1 continued to be aggressive towards officers and ambulance crew, swore and swung at them while they attempted to transfer her onto the stretcher. Ambulance crew administered an IM medication with assistance from the officers. No further outbursts were noted.On 3/14/26 at 2:42 p.m., R1 returned via EMS (emergency medical services) to facility. She was assisted into recliner by staff and EMS. R1 was sleeping upon arrival to facility. New orders for Xanax and Risperidone. Son called and updated.On 3/14/26 at 6:26 p.m., Resident slept in recliner for three hours after return from ER. At 5:00 p.m., R1 was getting out of recliner and yelled out help me. Staff walked into room and resident yelled, get out of here I don't want you, I need help. Staff attempted to give Risperidone prescribed by ER and R1 hit out and yelled at staff shit and assholes. Staff boosted her due to sliding out of chair and she hollered out and hit at staff. R1's behaviors increased as time went on. On call provider notified. R1 was hallucinating things in her room and told EMS she did not feel good. She was unable to express where she did not feel good. Physician Referral Form dated 3/13/26, identified issues to be addressed: R1 will be monitored 14 days for emotional distress. Office of Health Facility Complaints (OHFC) filed for allegation of verbal abuse. Recommend appointment with psychology.Provider verbal order document dated 3/14/26 at 10:31 a.m., Sending to emergency room (ER) for evaluation of symptoms of combativeness and emotional distress.Emergency Department (ED) provider notes dated 3/14/26 at 11:59 a.m., identified R1 presented to ED today via emergency medical system with concerns about behavioral agitation from her dementia. Agitation/behavior currently managed with Seroquel. Per report from staff in the last couple of days she has had poor oral intake, refused oral medications, and increased agitation. Today she was aggressive with staff so 911 was activated for transport to ED for emergency evaluation. She was given intramuscular (IM) injection 50 mg of Benadryl (relieves allergy symptoms and makes you sleepy), Versed (used for sedation) 5 mg and Haldol (antipsychotic used to treat psychotic disorders) 5 mg by EMS was quite sedated and very drowsy on arrival, and did not appear to be in any acute distress. Blood sugar was 65 (normal range 60 to 100 milligrams/deciliter (mg/dl) on arrival and dextrose 10% in water 200 milliliter (ml) was administered via intravenous (IV). Final diagnoses: dementia with aggressive behavior, hypoglycemia (low blood sugar most likely due to not eating/drinking), and elevated blood pressure. discharged back to nursing home on 3/14/26 at 1:11 p.m.ED provider note dated 3/14/26, arrived at 6:26 p.m., and discharged at 9:19 p.m. identified presented to ED via EMS from a local dementia care unit with concerns about dementia, history of dementia with worsening aggression/behaviors. She was seen earlier today in ED given large doses of Benadryl/Versed/Haldol by EMS and quite sedated, then sent back to nursing home. During the afternoon/evening, since the medications wore off, she had became vocally aggressive and refused to take her morning medications. She does not appear to be in any acute distress. Olanzapine (Zyprexa) (antipsychotic) 5 mg in sterile water 1 ml solution was administered intramuscular (IM) on 3/14/26 at 6:56 p.m. Course: reached out to nursing home to see if there was anything specific, they needed us to do so that they would not send the comfort care dementia patient back to the ED. They had no specific recommendations. Diagnosis: dementia and discharged in stable condition back to nursing home facility with encouraged close follow up with primary care provider.A written interview completed by DON with NA-A on 3/13/26 at 2:00 p.m., identified on 3/11/26 at 8:30 p.m., NA-A walked into R1's room. R1 was on the phone with her son crying. NA-A hung up phone and assured R1 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Many	everything would be ok. NA-A stated while she undressed R1, R1 became combative, hitting, hollering, and crying. NA-A told her everything would be ok, please do not hit me, I don't want to hit you back, and called for backup. Three staff assisted R1 to transfer with up/down lift to toilet and then to chair. NA-A stated her voice maybe seemed elevated because R1 was sobbing and hollering the entire time and NA-A tried to get R1's attention. NA-A felt another NA was mad at her because she told her she needed to hurry up with her residents that she assisted to bed. NA-A stated she had been ablet to calm R1 down when crying and did not feel her conversation made her anymore upset. At 8:50 p.m., R1's cares were completed, had stopped crying, placed in her chair, and appeared to be sleeping. At 9:30 p.m., NA-A completed rounds by herself, checked on R1 and was still in her chair sleeping. Additionally, NA-A had assisted five other residents: hearing aids, provided blanket, repositioned and checked brief, assisted to bed, assisted with tootsie rolls, and another checked and changed. NA-A left the facility at 10:30 p.m., end of shift.During an interview on 3/24/26 at 2:00 p.m., trained medication assistant (TMA) stated on 3/11/26, at approximately 9:15 p.m., NA-C and NA-B told her NA-A had been mean to R1. NA-A called R1 names, hollered at R1, and was verbally abusive. Licensed practical nurse (LPN)-A was informed prior to when she left the facility at 9:00 p.m., and nothing was done. TMA stated she encouraged the NAs to call the DON and report it as soon as possible but was unsure if they did. TMA stated both NAs informed her they would report it the next morning, TMA did not report it, left it up to LPN-A to report it as soon as possible and was aware the DON had to be called within two hours so incident could be reported to SA. NA-A continued to work, TMA was unsure if she should have made NA-A leave if abuse was suspected. TMA stated the staff nurse should have taken care of that prior to leaving the shift to protect the residents. TMA monitored NA-A during the remainder of her shift, but was not aware if NA-A had interactions with other residents after the incident with R1. TMA stated NA-A's actions she was aware of included: taking out the garbage and sitting at the nurse's station. TMA-A checked on R1 twice to see if she was ok, R1 was sleepy and didn't really want to talk, no questions were asked.During an interview on 3/24/26 at 3:02 p.m. NA-B stated on 3/11/26, she entered R1's room with the stand lift while she talked on the telephone with her son, persistent she wanted to leave the facility, and cried. Once R1 hung up the phone, NA-A was not being very nice to R1 and repeated loudly, STOP CRYING, STOP CRYING YOU ARE ACITNG LIKE A TWO-YEAR-OLD. NA-A attempted to place sling around R1, was aggressive and could have been gentler, and R1 was in distress and swatted NA-A with her hand. NA-A stated, If you hit me, I'll hit you back, and requested assistance over the walkie. NA-A told R1 she was, in trouble now. NA-B was unsure of what NA-A meant by that. Per NA-B, NA-A stated to R1, they, were going to send her to the locked area so she couldn't get out and she should be, grateful, we were helping her. R1 continued to cry and called NA-A an, asshole. NA-C entered R1's room. A resident call light went on and NA-C instructed NA-A to go answer the call light. NA-A exited R1's room willingly, R1 continued to cry, NA-A returned five minutes later and assisted R1 to the recliner. NA-B along with NA-C informed LPN-A of the allegation of abuse to R1 by NA-A. Licensed practical nurse (LPN)-A informed us to call the floor manager/supervisor registered nurse (RN)-A but did not tell them when they were required to call her. NA-A continued to work the remainder of her shift. NA-B called RN-A the following day at approximately 1:00 p.m.During an interview on 3/25/26 at 11:32 a.m., NA-C stated R1 had behaviors that varied from one day to the next. R1 swore, screamed, cried, wandered, and yelled. NA-C stated on 3/11/26, at approximately 9:00 p.m., NA-C heard a call for assistance with R1 come over the walkie. NA-C entered R1's room. NA-A and NA-B hooked R1 up to the EZ stand and instructed R1 to hold onto the bars. NA-A stated loudly and yelled at R1, HOLD ON! NA-C calmly placed R1's hands on the bars and encouraged her to hold on. NA-A yelled at R1, Stop crying! Where would you be if you were not here? Probably lying on the floor. Stop crying! Who is going to want to take care of you when you cry like a baby? NA-C felt NA-A was obviously upset and overwhelmed dealing with R1. Another resident call light came on and NA-A left room to answer it. Once NA-A left room, R1 was transferred to the toilet and calmed down. NA-B told NA-C about NA-A's comment to R1, If you hit me, I'll hit you (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on the Lake LLC	1020 Lark Street Alexandria, MN 56308

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Many	back. NA-C stated she told NA-B she needed to report it and NA-B seemed uncomfortable with that suggested. NA-A re-entered R1's room five minutes later and assisted NA-C with the EZ Stand to transfer R1 back into her recliner. NA-C stated she exited R1's room with NA-B and they immediately went to the nurse's station and informed LPN-A what they heard NA-A say to R1, the tone of her voice was loud and stern. NA-C and NA-B told LPN-A, they had never witnessed any staff treat a resident like that before. We made it very clear to LPN-A, NA-A yelled at R1 and threatened to hit her. NA-C stated she felt this was verbal abuse, threatening to hit a resident and yelled at them to stop crying. LPN-A did not appear to take the allegation seriously, was told it needed to be reported to someone, LPN-A stated she would talk to RN-A the next day and planned on coming into facility in the morning and would talk to the DON. TMA told NA-C, the DON should be called right away. NA-C trusted LPN-A would take care of it. At 9:30 p.m., NA-A continued to work on the floor. At 10:30 p.m., both NA-C and NA-A clocked out for the night and walked out of the facility together. NA-A stated to NA-C, I will most likely be fired. Prior to this incident, NA-C stated she had witnessed N-A snap at another resident and thought she was just having a bad day. NA-C stated she told NA-A she should not snap at residents, and did not report the incident. NA-A seemed grumpy as time went on. NA-C recalled another occurrence when a resident requested help and NA-A was short with her, tone of her voice stern and loud as NA-A told resident, We'll be right there.During interview on 3/25/26 at 12:41 p.m., LPN-A stated R1 had episodes of behaviors such as resistive to cares, refusals, occasionally cried, verbal with staff telling them to stop talking and to go away. LPN-A was unsure what made them worse, but R1 was not easily redirected. LPN-A stated it was brought to her attention on 3/11/26, between 8:00 p.m. to 8:30 p.m., by NA-B and NA-C concerns of inappropriate interactions between NA-A and R1. NA-A threatened R1, if she hit NA-A, NA-A would hit her back. LPN-A informed both NA's she would talk to nurse manager, RN-A, the next day. LPN-A felt like it was verbal abuse. LPN-A stated according to facility policy, an allegation of abuse was to be reported within two hours, and she thought it was 24 hours due to no injury. The facility policy was not followed. DON called her the next day on 3/12/26 at 2:20 p.m., and informed her NA-A should have been removed from the floor to prevent any further danger to any other residents. After LPN-A found out about the incident, she observed R1 in her room and made sure she was safe in her recliner, eyes were open. R1 acknowledged LPN-A by replying, hi, but did not say anything else. LPN-A did not ask R1 any questions. NA-A remained working on the floor after the allegation of abuse was made until 10:30 p.m. LPN-A left the facility at 9:00 p.m. that day, her shift had ended. LPN- A stated she had previously worked with NA-A and only concern she had was NA-A seemed stressed out at times and frazzled, not enough time to do things, and issues with her home life.During an interview on 3/25/26 at 1:40 p.m., NA-D stated R1 had behaviors but not every day. R1 wandered all over the building in her wheelchair and occasionally cried. NA-D stated R1's behaviors increased when she was rushed, approached in a demanding tone of voice such as get up now, and did not like to be hurried. NA-D stated on 3/12/26, she arrived at work for the day shift and R1 was already up for the day. R1 sat at the nurse's station. This was not typical for R1. After breakfast R1 had increased behaviors: pinching, hitting, crying. NA-D stated R1 had not displayed those types of behaviors when she worked with her prior to this day. She was informed by RN-A about the incident that happened one day ago. NA-D felt this made sense, why R1 was acting out, it was obvious something was bothering her. NA-D charted no behaviors early that morning around 9:18 a.m., noted the change in behaviors after that, and reported the concerns to LPN-B.During an interview on 3/25/26 at 2:04 p.m., LPN-B stated R1 lacked short term memory and had dementia. LPN-B stated approximately two weeks ago she noticed R1's behaviors had increased. On 3/12/26, LPN-B tried to administer R1's medications. R1 refused medications and water. LPN-B stated it appeared R1 was going to through the cup of water at LPN-B. This was an off day for R1, usually happy. R1 seemed irritated. R1 entered another resident's room with family visiting, this was unusual behavior for her. R1 called staff assholes and said t

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and documents review, the facility failed to report an allegation of abuse to the State Agency (SA) within two hours for 1 of 1 resident (R1) who was witnessed being verbally abused by a staff member. Findings Include: Facility Vulnerable Adult Maltreatment Report filed with State Agency (SA) dated 3/12/26 at 5:15 p.m., identified estimated date and time of most recent occurrence: 3/11/26 at 8:30 p.m., in resident [R1's] room. Description of incident: It was reported by nursing assistant (NA) she witnessed verbal aggressive tone and language towards resident by alleged perpetrator (AP) when NA and AP were getting resident ready for bed last evening. NA stated there were no changes with the resident behavior, no signs of injury mentally or physically resulting from the incident. Resident feels safe in facility. Allegations: abuse emotional or mental.Facility investigation 5-day report dated 3/16/26 at 3:10 p.m., indicated on 3/11/26 at 8:30 p.m., NA-A and NA-B assisted R1 with evening cares at 8:30 p.m. R1 was crying, and had ended a phone call with her son when NA-A stated, you need to stop crying, you are acting like a two-year-old. NA-B reported NA-A seemed frustrated and sounded stern. NA-A placed R1's arms on the EZ stand (mechanical device used to lift and lower resident), R1 swatted out at NA-A. NA-A stated if you hit me again, I am going to hit you back. This statement confirmed by NA-A who stated she made the comment not thinking but would never hit a resident. Staff assistance was requested over the walkies. NA-C entered R1's room and heard NA-A yell at R1 in a loud toned voice stop crying, they are going to put you in a locked unit. NA-C felt NA-A was not joking. NA-A left R1's room briefly to assist another resident and returned approximately five minutes later. R1 continued to cry and was distraught. NA-A stated to R1 nobody will want to keep working with you, nobody wants to work with a crybaby.R1's admission Minimum Data Set (MDS) dated [DATE], identified admission to the facility on 2/26/26, from home/community. R1 had severely impaired cognition, feeling down, depressed, or hopeless (2 to 6 days out of 7), and no behaviors noted. She was dependent with toileting hygiene, lower body dressing, sit to stand, all transfers, unable to walk, and used a manual wheelchair for mobility. R1's diagnoses included non-traumatic brain dysfunction, arthritis, muscle weakness, Alzheimer's disease, dementia, anxiety, depression, and psychotic disorder. She takes antipsychotic, antianxiety, and antidepressant medications.R1's care plan dated 3/16/26, identified the following areas of concern and interventions to address each area:An alteration in cognition and psychosocial wellbeing. Staff were directed to allow her time to communicate her needs/wants, provide and maintain consistent environment, provide cues, reorientation/supervision as needed (PRN), monitor and respond to unmet needs, and monitor mood state and refer PRN. AAlteration in mood and behavior related to psychotic disorder with delusions. Staff were directed to monitor and document mood state/behaviors upon occurrence.R1 was a vulnerable adult while she resided in facility. Staff were directed to monitor for signs of emotional distress or mood and behavior changes, continue to follow the facility vulnerable adult and abuse reporting policy, and the local Ombudsman, Adult Protection, Police and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed.A written interview completed by DON with NA-A on 3/13/26 at 2:00 p.m., identified on 3/11/26 at 8:30 p.m., NA-A walked into R1's room. R1 was on the phone with her son crying. NA-A hung up phone and assured R1 everything would be ok. NA-A stated while she undressed R1, R1 became combative, hitting, hollering, and crying. NA-A told her everything would be ok, please do not hit me, I don't want to hit you back, and called for backup. Three staff assisted R1 to transfer with up/down lift to toilet and then to chair. NA-A stated her voice maybe seemed elevated because R1 was sobbing and hollering the entire time and NA-A tried to get R1's attention. NA-A felt another NA was mad at her because she told her she needed to hurry up with her residents that she assisted to bed. NA-A stated she had been ablet (able)to calm R1 down when crying and did not feel her conversation made her (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and yelled at them to stop crying. LPN-A did not appear to take the allegation seriously, was told it needed to be reported to someone, LPN-A stated she would talk to RN-A the next day and planned on coming into facility in the morning and would talk to the DON. TMA told NA-C, the DON should be called right away. NA-C trusted LPN-A would take care of it. At 9:30 p.m., NA-A continued to work on the floor. At 10:30 p.m., both NA-C and NA-A clocked out for the night and walked out of the facility together. NA-A stated to NA-C, I will most likely be fired. Prior to this incident, NA-C stated she had witnessed N-A snap at another resident and thought she was just having a bad day. NA-C stated she told NA-A she should not snap at residents, and did not report the incident. NA-A seemed grumpy as time went on. NA-C recalled another occurrence when a resident requested help and NA-A was short with her, tone of her voice stern and loud as NA-A told resident, We'll be right there.During interview on 3/25/26 at 12:41 p.m., LPN-A stated R1 had episodes of behaviors such as resistive to cares, refusals, occasionally cried, verbal with staff telling them to stop talking and to go away. LPN-A was unsure what made them worse, but R1 was not easily redirected. LPN-A stated it was brought to her attention on 3/11/26, between 8:00 p.m. to 8:30 p.m., by NA-B and NA-C concerns of inappropriate interactions between NA-A and R1. NA-A threatened R1, if she hit NA-A, NA-A would hit her back. LPN-A informed both NA's she would talk to nurse manager, RN-A, the next day. LPN-A felt like it was verbal abuse. LPN-A stated according to facility policy, an allegation of abuse was to be reported within two hours, and she thought it was 24 hours due to no injury. The facility policy was not followed. DON called her the next day on 3/12/26 at 2:20 p.m., and informed her NA-A should have been removed from the floor to prevent any further danger to any other residents. After LPN-A found out about the incident, she observed R1 in her room and made sure she was safe in her recliner, eyes were open. R1 acknowledged LPN-A by replying, hi, but did not say anything else. LPN-A did not ask R1 any questions. NA-A remained working on the floor after the allegation of abuse was made until 10:30 p.m. LPN-A left the facility at 9:00 p.m. that day, her shift had ended. LPN- A stated she had previously worked with NA-A and only concern she had was NA-A seemed stressed out at times and frazzled, not enough time to do things, and issues with her home life.During an interview on 3/26/26 at 10:00 a.m., RN-A stated she was notified on 3/12/26, in the early afternoon by an NA via phone, on 3/11/26, NA-A told R1 while assisting her with cares, if you do not stop crying, NA-A would give her something to cry about and, if R1 hit NA-A again she would, hit her back. This would have made R1 feel belittled, humiliated, unable to express herself verbally, could not put it into words with what was going on, and how she felt in general other than crying. The staff that witnessed the allegation of abuse immediately informed LPN-A, the nurse on duty. LPN-A should have called the manager on call. RN-A thought direction would have been provided to LPN-A to remove NA-A from the facility to protect other residents. RN-A stated there was a lack of immediate, placing other residents at risk. NA-A was allowed to remain working that evening until her shift ended at 10:30 p.m. RN-A was unsure if NA-A was allowed unsupervised contact with R1 or other residents.During an interview on 3/26/26 at 1:00 p.m., DON stated on 3/11/26, the NAs did a great job of recognizing the alleged verbal abuse and reported it to the staff nurse. The staff nurse should have called her immediately. DON was not notified until 3/12/26, approximately 1:30 p.m. We had only two hours to report, the facility policy was not followed and therefore reported late to the SA. LPN-A should have intervened immediately, removed NA-A from the situation and contacted her. DON stated she would have initiated the suspension of NA-A, to protect other residents and reported the allegation of abuse to the SA. DON stated, she was told by LPN-A, she thought only physical abuse had to be reported within two hours and was unsure if verbal abuse had to be reported within two hours or 24 hours. DON stated, NA-A remained working independently after the incident. NA-A had unsupervised contact with five residents that evening until 10:30 p.m., when NA-A's shift ended. DON stated she called NA-A on 3/12/26 at 1:45 p.m., to get her story. NA-A told DON, she spoke before she thought and said to R1, if you hit me, I don't want to have to hit you back. DON stated she suspended NA-A on 3/12/26 at 1:45 p.m. via phone. DON stated LPN-A informed DON, as the allegation was verbal abuse, there was no need to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reassess R1 or immediately report the allegation to the manager on call. LPN-A did not think there was anything wrong at the time and planned to inform floor manager, RN-A the following day. LPN-A left the facility at 9:00 p.m., when her shift ended. During an interview on 3/26/26 at 1:51 p.m., administrator stated he was on vacation on 3/11/26. The administrator would have expected staff to notify either the DON or himself immediately on 3/11/26. Staff were expected to always protect the residents. The allegation was verbal abuse, policy was not followed, there was a small delay, reported to the SA the next day. Administrator stated staff had been educated if they hear, see or know of abuse to immediately protect all residents. The alleged perpetrator should have been immediately removed, and either call DON or himself if needed for direction or assistance. Administrator stated he felt the residents were always safe, a staff made a mistake of words they used, resident safety was not in jeopardy at that time.Facility policy Abuse Prohibition/Vulnerable Adult dated 11/2025, identified guidelines for prevention of maltreatment of vulnerable adults in healthcare centers. Purpose: protect residents against abuse by anyone, to promptly report, document, and investigate all incidents of alleged or suspected abuse/neglect and determine probable cause of unknown injuries and identify and remedy any potentially abusive situations. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries). A supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. The nurse will take the following actions to mitigate any potential for further abuse: a. If this is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed and human resources (HR) will be notified. Notification to the facility administrator will occur immediately for any incidents of resident abuse, alleged or suspected abuse, injury of unknown origin, neglect, financial exploitation, or involuntary seclusion. If the administrator is absent or unavailable, staff will follow the chain of command for notification. Abuse is defined as the willful (as used in definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm) infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition can cause physical harm, pain or mental anguish and include verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Suspected abuse shall be reported to OHFC online reporting process not later than 2 hours after forming the suspicion of abuse.