STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evansville Care Center	649 State Street Northwest Evansville, MN 56326

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review the facility failed to ensure the Quality Assessment and Assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in implementing appropriate action plans to correct quality deficiencies identified in previous surveys related to careplans which resulted in deficiencies identified during this survey. This deficient practice had the potential to affect all 24 residents residing in the facility. Findings include:During an interview on 1/21/2026 at 5:12 p.m., administrator confirmed last survey's plan of correction (POC) and indicated the POC had been discussed at QAPI but was not a current QAPI project. Administrator stated after a recertification survey is completed, the results and POC are reviewed. The administrator further stated once the audits were completed meeting the POC's timeline, it would be considered completed. The administrator revealed the facility did not use past survey results for current QAPI projects. The administrator further revealed the facilities projects were generated from the [NAME] report and additional reports the facility had ran. The administrators stated it would be important to use the past survey results for QAPI projects and that is something the facility will look at in the future. The QAPI meeting minutes dated 10/9/25, current performance improvement projects were food enjoyment and relationship. QAPI meeting minutes further identified no changes were going to be made. Next meeting would be scheduled for 1/15/26. Facility policy titled QAPI policy undated, the purpose of QAPI in our organization is to take a proactive approach to improving the comprehensive range of care and services provided by our facility including clinical care, quality of life and resident choice and safety. We will continually be improving our facility in line with our vision to be the premier choice for care while exceeding expectations.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, document review, and observation, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate care was provided for 2 of 12 (R21, R20) residents reviewed for comprehensive care plan. R20 R20's quarterly Minimum Data Set (MDS) dated [DATE], identified R20 was cognitively intact and had diagnoses which included heart failure, arthritis, and seizure disorder. Indicated R20 was independent with activities of daily living (ADLs). R20s quarterly care area assessment (CAA) dated [DATE], had cognitive lose/dementia, behavioral issues, and issues with psychosocial wellbeing. R20's care plan dated [DATE], indicated resident had the potential for social emotional disturbances related to a diagnosis of cognitive communication deficit. Further indicated resident had target behaviors of refusal of cares, rude demeaning remarks to staff and abrasive behaviors. R20s care plan interventions stated daily monitoring of resident's target behaviors, interventions and outcomes to be documented on the POC. Review and adjust target interventions based on residents' response. Education provided to staff on mental health diagnosis including memory impairment. Care plan lacked evidence of planned interventions staff were to complete if resident was having target behaviors. Review of R20's behaviors displayed during shift report dated [DATE] to [DATE], lacked documentation for interventions staff were to follow if R20 was having behaviors. During an interview with R20 on [DATE] at 5:03 p.m., R20 stated she wanted to leave the facility. R20 stated that it would be a better place if certain political figures were deceased and groups of color were to leave. During an interview in on [DATE] at 3:28 p.m., nursing assistant (NA)-A stated R20 had a lot of behaviors. NA-A stated that staff talk to R20 in a calm voice and come back to R20s room after a while and reapproach R20 when staff are unable to help her at the time. NA-A stated she was unaware of any specific behavior interventions for R20. During an interview on [DATE] at 3:42 p.m., licensed practical nurse (LPN)-A indicated R20 requires a lot of reapproaching and reeducating. LPN-A further indicated R20 has a medical background and is very set in her ways. LPN-A stated R20 has behaviors that come and go and R20 can become very angry at times. LPN-A revealed R20 required a lot of education and redirection. LPN-A stated she was unaware of any specific interventions for R20 when her behaviors had arisen. During an interview on [DATE] at 3:44 p.m., minimum data set (MDS) coordinator (MDSC), stated resident is very resistant to any interventions. MDSC further stated the facility would need to include every intervention because the facility is not sure what intervention would work for R20. During an interview on [DATE] at 3:55 p.m., director of nursing designee (DOND) indicated R20 confirmed there were no interventions on R20s careplan to dear with R20s behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] 4:05 p.m., social services designee (SWD) indicated R20 had not been addressed by SWD for additional psychosocial services. SWD further indicated if staff felt a resident needed to be seen by psychological services SWD would be notified. SWD stated SWD does not do anything with the care plan and does not edit anything. During an interview on [DATE] at 5:03 p.m., DON and administrator confirmed R20s careplan lacked interventions for behavior. DON and administrator indicated it was important to have intervention to ensure R20 was receiving the best care possible. R21 R21 admission Minimum Data Set (MDS), dated [DATE], indicated R21 was admitted to the facility on [DATE], and had moderate cognitive impairment. R21 was dependent on staff for toileting and needed maximal assistance for dressing and transferring. R21 had a diagnosis of diabetes, hypertension, hip fracture, Parkinson's disease (movement disorder of the nervous system), malnutrition, and depression. R21 was taking medications, including antidepressants and opioids (medication for severe pain). R21 care area assessment (CAA) dated [DATE], triggered for cognitive loss, visual function, ADL functional rehabilitation, urinary incontinence, psychosocial wellbeing, behavioral symptoms, activities, falls, nutritional status, dehydration, dental care, pressure ulcer, psychotropic drug use, and pain. R21's care plan initiated on [DATE], identified R21 at risk for dependence with activities of daily living (ADLs) related to activity intolerance, cognitive impairment, physical impairment, decreased muscle strength, imposed restrictions of movement, pain or discomfort, and reliance on an assistive device. R21 care plan lacked evidence of the following areas being identified in the care plan after being identified in the CAA: cognitive loss, visual function, urinary incontinence, psychosocial, wellbeing, behavioral symptoms, activities, falls, nutritional status, dehydration, dental care, pressure ulcer, psychotropic drug use, and pain. During an interview on [DATE] at 11:44 a.m., dietary manager (DM)-A confirmed R21 had a weight loss. DM-A indicated R21's weight was 148 pounds (lbs.) before being admitted to the hospital, and had a weight of 129 lbs. after returning from the hospital. R21 was started on a magic cup (supplement for weight loss) every day and a mighty sake (supplement for weight loss) once a day to help with the weight loss. DM-A confirmed it is important to have information regarding diet located in the care plan to inform staff in order to resident to receive appropriate diet recommendations. DM-A expectation would be for R21's care plan to be updated with the current changes. DM-A verified R21 care plan was not up to date. During an interview on [DATE] at 2:12 p.m., activity staff (AS)-A indicated R21 participated in one-to-one visits with staff in R21's room, but has not been participating in other activities out of his room and was unaware of other activities R21 would enjoy. During an interview on [DATE] at [DATE] at 2:14p.m., nursing assistant (NA)-A indicated all staff had access to the care plan, but NA-A had not viewed R21's care plan. NA-A was not aware R21 had depression or aware of interventions on how to assist R21 when experiencing depression symptoms. During an interview on [DATE] at 2:23 p.m., NA-B indicated she was unaware of R21 having a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis of depression or interventions on how to assist R21 when having depression symptoms. NA-B indicated staff used a care sheet that identified how to care for each resident. NA-B pulled the care sheet out of her pocket, which identified R21 needed assistance with ADLs. NA-B indicated the care sheets had a category titled other/notes, if R21 was depressed or had special interventions, it would be listed there. The care sheet, other/notes did not identify R21 of having depression or interventions to help manage depression symptoms. During an interview on [DATE] at 12:08 p.m., MDS coordinator indicated the process was to write a comprehensive care plan after the initial MDS was completed. MDS coordinator confirmed the initial MDS was completed. MDS coordinator confirmed the comprehensive care plan was not completed and should have been completed. During an interview on [DATE] at 4:48 p.m., director of nursing designee confirmed R21's comprehensive care plan should have been completed per regulations. The director of nursing designee expected care plans to be completed on time for staff to know how to adequately care for residents. Requested policy on care plans however, did not receive one.