STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Gardens	5919 Centerville Road North Oaks, MN 55127

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 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.ˆ Findings include:ˆ R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was admitted to the facility on [DATE], 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 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.ˆ 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 5/22/26, identified: ˆPolyethylene 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). (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	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. ˆ 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 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 [DATE] through 4/22/26 for acute ischemic stroke. While at a transitional care unit (TCU) occupational therapy (OT) was working with R1, andˆ had a very large stool (bowel movement) (BM) after some prolonged constipation, dizziness leaving the bathroom, syncope (fainting or passing 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. ˆ 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 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, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 [DATE], identified areas affecting elimination patterns: decreased mobility, chair bound, and poor fluid intake. Bowel movement frequency was 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 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 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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.ˆ 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 onˆ5/22/26 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 [DATE] 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 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.ˆ 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 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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.ˆ 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) statedˆR1 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 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 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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.ˆ 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 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. ˆRN-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 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 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Gardens	5919 Centerville Road North Oaks, MN 55127

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 he 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 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 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

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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 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 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 [DATE], identified she was admitted to the facility on [DATE], from the hospital. R1 had moderately impaired cognition and no behaviors. R1 had functional limitations in range of motion (ROM) in 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. -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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (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 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 identfied 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 againDuring 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, 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 (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.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 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 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 approximaelty 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, 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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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), 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 [NAME] 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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], identified she was admitted to the facility on [DATE], 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 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. 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 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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, 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standing right there. During a follow-up interview onˆ5/22/26 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 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 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, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Gardens	5919 Centerville Road North Oaks, MN 55127

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical director of allegation and investigation 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.