STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norris Square	6993 80th Street South Cottage Grove, MN 55016

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to develop interventions to ensure residents call lights were answered in a timely manner for 3 of 3 residents (R5, R21, R37) who filed grievances related to long call light times.Finding include: R5 R5's quarterly Minimum Data Set (MDS) assessment, dated 11/21/25 indicated R5 was cognitively intact with no behaviors. R5 had no upper or lower body range of motion impairment and requires substantial assist for toileting hygiene and transfers. R5's diagnoses list included generalized muscle weakness and abnormal gait/mobility. R5's care plan included 1 assist for activities of daily living, bed mobility, and 1 assist with stand (mechanical) lift for transferring. R5 was also at risk for falls with interventions to, place call light withing reach and answer call light promptly. R5's frequently incontinent of bladder and bowel. A toileting schedule indicated offer toileting upon rising and before/after meals and before going to sleep. R5 also uses an incontinence product. During an interview on 12/8/25 at 5:41 p.m., R5 stated she often waits a long time for staff to answer her call light which is very upsetting to her. R5 stated she waited 45 minutes this morning to get ready for the day. The facility call light system includes a light outside the room and at each end of the halls. In addition, staff carry walkie talkies to which notifies them when a room light comes on. During continuous observation on 12/9/25 beginning at 9:29 a.m., a light was illuminated outside R5's door and at the end of the hall. In addition, R5's room number was heard from a nearby staff member's walkie talkie. An unidentified staff member walked past R5's room and enter a different room. At 9:31 a.m., the light outside R5's room remained on. An unidentified staff member entered the room next door that did not have an illuminated call light. At 9:38 a.m., a nurse is heard around the corner dispensing medications. R5's call light remains on. At 9:44 a.m., a staff member entered a room at the end of the hall. R5's and two other call lights are illuminated in the hall. At 9:48 a.m., nursing assistant (NA)-A entered the neighboring resident's room whose call light was (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not illuminated. R5's call light remained on. At 10:01 a.m., an unidentified staff member entered R5's room. The staff member was heard saying Do you have to go to the bathroom? The staff member left R5's room. The call light was still on. During an observation and interview at 10:05 a.m., R5 was sitting in the wheelchair in their room. R5 stated she placed her call light on at 9:30 a.m., to go to the bathroom and thought she had to have a bowel movement. NA-A was seen taking the neighboring resident out of their room and to the common area. R5's call light remained on. At 10:13 a.m., NA-A walked towards R5's room, turned, and started walking away. The staff turned back to R5's room and answered the call light. R5 was taken to the bathroom [ROOM NUMBER] minutes after the beginning of the observation. During interview on 12/9/25 at 10:23 a.m., NA-B stated R5 always goes to the bathroom after breakfast. During follow up interview on 12/9/25 at 11:48 a.m., R5 stated she is not incontinent and always knows when she has to go to the bathroom. R5 stated she gets up for the day at 6:30 a.m. and toilets again at 9:30 a.m., after breakfast. She will toilet again at 11:30 a.m. and then not again until 3:30 p.m. At 6:30 p.m., she goes to the bathroom again prior to going to bed. R5 stated she has not had any accidents in a long time but will sometimes urinate in her incontinence product because she can't hold it. During interview on 12/09/25 at 12:02 p.m., NA-A stated R5 will use her call light when needing to toilet however is incontinent most of the time. NA-A stated was incontinent of bowel during last toileting. During interview on 12/10/2025 at 11:50 a.m., NA-C stated, feels there are enough staff to answer call lights timely and provide for residents' needs. Review of call light logs from 12/3/25-12/10/25 indicated R5 had 21 call lights ranging from 16-55 minutes. Twenty of the 21 call lights coincided with R5's toileting schedule of 6:30 a.m., 9:30 a.m., 11:30 a.m., and 3:30 p.m. R21 During an interview on 12/10/25 at 10:30 a.m., R 21 stated she has reported to administration several times about long call light times. R21 stated each time she was told we are short-staffed. R21 stated the long call light times bother her because when she must use the bathroom in the morning upon waking, it is urgent, and she can't hold it very long. R21 stated she is anxious in the morning and has had accidents in the morning because it has taken them over an hour to assist her. R21's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R21 was cognitively intact with no behaviors. A grievance form dated 9/18/25 indicated R21 reported she waited 45-60 minutes for someone to help her get out of bed in the morning. Follow up by Administrator confirmed the long wait time, with an explanation of short-staffed. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A grievance form dated 10/14/25 indicated R21 reported chronic problem with long call light times. Follow up by Administrator confirmed the long wait time, and staff would benefit from knowing wake up times. Review of call lights from 9/18/25 from 6am to 9am ranged from 20 minutes to 76 minutes. R37 R37's comprehensive Minimum Data Set (MDS) assessment, dated 11/28/25 indicated R37 had moderate cognitive impairment with no behaviors. A grievance form dated 11/25/25 indicated R37's wife reported long waits for call light response. Initial investigation response re-educated staff on timeliness of answering call lights. Review of call lights from 11/25/25 showed call light ranges of 18 minutes to 44 minutes. A random audit of call light logs from 12/3/225 to 12/10/25 indicated R6, R13, R17, R30, R32, and R38 had a total of 30 call lights ranging from 20-304 minutes. During an interview on 12/10/25 at 12:01 p.m., administrator stated all grievances are reviewed and investigated and she follows up with the resident once grievance investigation is completed. Administrator confirmed she was aware of the long call light grievances from September and October. Administrator verified call light audit report reviewed during survey had long call light times. Administrator stated they strive to have call lights answered within 10 minutes. Administrator confirmed long call lights times remain a problem.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure proper cleaning of wheelchairs for 1 of 1 resident (R38) reviewed for safe, clean, and homelike environment.Findings include:R38's quarterly Minimum Data Set (MDS) assessment, dated 11/21/25, included R38 was cognitively intact with no behaviors. R38 used a wheelchair for mobility, required partial to moderate assistance with upper body dressing, required substantial to maximal assistance for lower body dressing.During observation and interview on 12/8/25at 2:57 p.m., R38 stated his wheelchair foot plate has left over food on it; he doesn't like it but doesn't know who is supposed to clean it. R38 stated he doesn't remember anyone ever cleaning the foot plate; wishes they would though.During observation on 12/9/2025 8:42 a.m., crusted food, dried liquid, and dirt remained on R38's wheelchair foot plate.During observation on 12/10/25 at 11:33 a.m., crusted food, dried liquid, and dirt remained on R38's wheelchair foot plate.During an interview on 12/10/2025 11:37 a.m., nursing assistant (NA)-D stated resident wheelchairs are cleaned on the resident's designated laundry day. The wheelchair cleaning schedule is posted at the nursing station. NA-D confirmed R38's wheelchair cleaning day was Thursdays; with a special note to put the wheelchair back in his room when clean. NA-D stated if she saw a foot plate with food or beverages dropped on it; everyone is responsible for cleaning immediately, even if it isn't his cleaning day. NA-D stated there is not a place to chart that wheelchair cleaning was completed; just assume someone is getting it done. During an interview on 12/10/2025 at 12:31 p.m., administrator stated wheelchairs are cleaned on the same day the resident's laundry is assigned to be done. Administrator confirmed R38 was supposed to have his wheelchair cleaned on Thursdays. The wheelchair cleaning schedule is posted at the nursing stations. Administrator stated the facility did not currently chart anywhere that wheelchair cleaning is being done. Administrator stated the process to clean wheelchairs is evening NA's place the wheelchair outside resident room to be deep cleaned on laundry day. Night NA's use shower room to deep clean wheelchair and place back outside room when dry. Administrator can not verify the last day confirmed she could not definitely say if R38's wheelchair had been cleaned recently. A policy for wheelchair cleaning was requested and not received.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and document review the facility failed to appropriately assess past trauma and implement person centered care plan interventions utilizing a trauma-informed approach for 1 of 1 resident (R1) reviewed who had a history of past traumatic experiences.Findings include:R1's quarterly Minimum Data Set (MDS) assessment, dated 7/8/25, indicated R1 had mild cognitive impairment, requires a wheelchair for mobility, dependent on staff for hygiene, bathing, dressing, and positioning. R1's active diagnosis included: post-traumatic stress disorder (PTSD), major depressive disorder, anxiety disorder, bipolar disorder, and mild cognitive impairment. R1's care plan lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization. R1's Electronic Health Record (EHR) lacked evidence the facility assessed R1 for trauma. During observation on 12/9/25 at 10:07 a.m., R1 was observed calling out for staff assistance, asking staff to sit with him; staff sat with him briefly and left room. During observation on 12/9/25 at 10:34 a.m., R1 was observed calling out for staff to come sit with him; staff sat with him briefly and left room again. During observation on 12/9/25 at 10:47 a.m., R1 was yelling help me, help me, staff entered room to assist R1. R1 stated he wanted staff to sit with him again to assist him with eating breakfast; R1 resumed eating breakfast without assistance. During interview on 12/9/25 at 10:03 a.m., nursing assistant (NA)-C stated she did not think R1 had a diagnosis of PTSD; if he did, she does not know what his trauma was nor what his triggers were. NA-C stated it would be important to know because you don't' want to re-traumatize someone. NA-C stated the care plan would be where she would look to find out more about a residents' PTSD. NA-C reviewed the care plan and task list for R1; neither care plan nor associated task list contained information about R1's PTSD. During interview on 12/9/25 at 10:37 a.m., registered nurse (RN)-A stated R1 does not have a care plan for PTSD. RN-A stated he was unsure what R1's PTSD was related to and what his potential triggers were. RN-A stated it is important to know the traumatizing event and the triggers so you could avoid re-traumatizing the resident. RN-A stated usually the PTSD assessment is completed at admission or if the diagnosis is made after admission. RN-A stated R1 does have behaviors of calling out or emotional outbursts; unsure if this behavior could be related to a PTSD diagnosis. During an interview on 12/09/2025 at 11:04 a.m., director of nursing (DON), registered nurse (RN)-B, and administrator confirmed R1 had an active diagnosis of PTSD. The DON confirmed R1 lacked an individualized trauma-informed care plan. The administrator stated at the time of diagnosis (6/13/24), R1 had experienced the unexpected loss of his brother due to suicide. Further, R1 gets quite sad and upset still; more so, when his family hasn't visited him recently. Administrator stated the trauma assessment was not completed until 12/4/25, but was not follow up. Administrator stated it was important to complete the trauma assessment and care plan, so staff were aware of event and triggers. This would allow staff to provide the best possible care without re-traumatizing the resident. A trauma informed care policy was requested and not received.