DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2026

Administrator
LAKESHORE REHABILITATION CENTER LLC
108 8TH STREET NORTHWEST
WASECA, MN 56093

RE: CCN:245388

Cycle Start Date: July 16, 2026

Dear Administrator:

On July 16, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 16, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 16, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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

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Administrator
LAKESHORE REHABILITATION CENTER LLC
108 8TH STREET NORTHWEST
WASECA, MN 56093

Re: State Nursing Home Licensing Orders
Event ID: 235CEB-H1

Dear Administrator:

The above facility survey was completed on July 16, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING **01 - MAIN BUILD...** B. WING	**07/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE REHABILITATION CENTER LLC	**108 8TH STREET NORTHWEST , WASECA, Minnesota, 56093**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/15/2026. At the time of this survey, LAKESHORE REHABILITATION CENTER found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		08/21/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/15/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. LAKESHORE REHABILITATION CENTER is a 1 story building with partial basement. The building was constructed at (4) different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1968, addition was constructed to the South Wing that was determined to be of Type II(111) construction. In 1984, another addition was added to the South Wing and was determined to be Type II (111). In 1998, an addition was added to the East Wing and was determined to be Type II (111) construction. Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm	K0000		08/21/2026

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K0000 Bldg. 01	Continued from page 2 system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		08/21/2026
K0374 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2025 at 11:00 AM, it was revealed by observation that the smoke barrier door assembly, by RM S-19, did not close and seal the opening upon test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0374	How corrective action will be taken for those affected by the alleged deficient practice: The door sweep by RM S-19 has been adjusted and passes compliance of the regulation. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance supervisor has been educated on the regulation of the smoke barrier doors and will conduct random audits of the doors to ensure compliance Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

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K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document or conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 4.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2025 between 09:30 AM and 12:30 PM, it was revealed by review of available documentation that the documentation present for review exhibited a lack of randomness in the conducting of fire drills, log-sheets were incomplete in data capture and record of participating staff. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	How corrective action will be taken for those affected by the alleged deficient practice: The maintenance supervisor has been educated about the importance of the randomness of the fire drills to ensure all staff are prepared. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance supervisor has been educated on the regulation of the fire drill requirement and understands the importance of randomness to ensure staff preparedness. Audits will be conducted to ensure randomness Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K0918	How corrective action will be taken for those affected by the alleged deficient practice: The generator was annually tested on 7/21/26 and is compliant per the regulation How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/15/2026**

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K0918 SS = F Bldg. 01	Continued from page 4 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2025 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that annual emergency generator fuel testing is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918	Continued from page 4 The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance supervisor has been educated and understands the regulation for generator testing. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K0920	How corrective action will be taken for those affected by the alleged deficient practice: The maintenance supervisor has removed all power cords and extension cords from areas that do not meet the standard of the regulation.	08/21/2026

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K0920 SS = D Bldg. 01	Continued from page 5 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to manage usage of flexible cords and cables as-well-as listed and labeled equipment in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1). This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 07/15/2025 at 11:30 AM, it was revealed by observation that Staff Utility Room, adjacent to the East/West Nurses Station, that two (2) appliances were connected to a relocatable power-strip. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0920	Continued from page 5 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance supervisor has been educated on the use of power strips and extension cords per the regulation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026
K0346 SS = C Bldg. 01	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and	K0346	How corrective action will be taken for those affected by the alleged deficient practice: We have updated the policy per the regulation, and the form contains associated notification content. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/21/2026

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LAKESHORE REHABILITATION CENTER LLC	**108 8TH STREET NORTHWEST , WASECA, Minnesota, 56093**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0346 SS = C Bldg. 01	Continued from page 6 the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6* and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.2.1, 14.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2025 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the facility fire alarm out-of-service policy out-of-service policy was of template format and did not contain associated notification content. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0346	Continued from page 6 All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance supervisor has been educated and understands the regulation of fire watch and has updated the appropriate forms. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026
K0354 SS = C Bldg. 01	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and	K0354	How corrective action will be taken for those affected by the alleged deficient practice: The form has been updated per the regulation and contains the associated notification content . How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance supervisor has been educated and understands the regulation. Quality Assurance plans to monitor facility	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/15/2026**

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K0354 SS = C Bldg. 01	Continued from page 7 staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 6.1.6, 10.1.6.1, 15.5.2(6). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2025 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that in the facility the fire sprinkler system out-of-service policy there was of template format and not contain associated notification content. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0354	Continued from page 7 performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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E0000	Initial Comments On 7/13/26 to 7/16/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		08/21/2026
F0000	INITIAL COMMENTS On 7/13/26 to 7/16/26, a standard recertification survey (S5388040) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. NO deficiencies were cited. H53883229C iQies # 2717031 H53883337C iQies # 3000657 H53883338C iQies # 2997280 H53883232C iQies # 2624776 H53883232C iQies # 2624512 The following complaints were reviewed with deficiencies cited at: H53883228C iQies # 2741658 with deficiencies cited at F725 H53883230C iQies # 2653216 with deficiencies cited at F676	F0000		08/21/2026

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

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

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D F0000	Continued from page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		08/21/2026
F F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by:	F0725	How corrective action will be taken for those affected by the alleged deficient practice: Residents (R7, R4,R13, R31,R45,R35, R37, R42, R29, R35,R8, R24, R33) were reviewed to ensure that all nursing care, treatments, activities of daily living, and any other need for assistance were provided timely and according to each resident's plan of care. Any identified unmet needs were immediately addressed. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit of call light response times including R7, R4,R13, R31,R45,R35, R37, R42, R29, R35,R8, R24, R33 was completed and identified concerns were investigated. The regulation and Lakeshore's Facility Assessment were reviewed. Updates were made to the Facility Assessment as required. Facility staffing expectations were developed to ensure sufficient staffing for providing care and assistance in a timely manner which staff were educated on. All staff were educated on the importance of answering call lights in a timely manner. Nursing staff were educated on the expectation of using walkie talkies to increase communication.	08/21/2026

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F0725 SS = F	Continued from page 2 Based on interview and document review, the facility failed to provide sufficient nursing staff to ensure 13 of 13 residents (R7, R4, R13, R31, R45, R35, R37, R42, R29, R35, R8, R24, R33), reviewed for sufficient staffing, received care and assistance in a timely manner. The lack of sufficient staff had the potential to affect all 42 residents who resided in the facility. . Findings include: Refer to F676: Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain ral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance. Refer to F677: Based on interview and document review, the facility failed to provide oral care to 1 of 1 resident (R13) who was reviewed for assistance with activities of daily living (ADLs) and who was dependent upon staff for ADL cares. Refer to F688: Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. RESIDENT/FAMILY INTERVIEWS/ CALL LIGHT RESPONSE TIMES R7’s quarterly Minimum Data Set (MDS) assessment dated 6/26/26, indicated orthopedic aftercare for hip fracture. R7 had intact cognition, clear speech, could understand and be understood. R7 required substantial assistance or was dependent upon staff for activities of daily living (ADLs). R7 was always incontinent of bowel and did not walk. During an interview on 7/13/26 at 11:21 a.m., R7 stated the facility was chronically short-handed; he didn’t have bowel control and used his call lights to have his brief changed or to get in or out of bed. R7 stated he was frustrated with the length of time it took staff to answer his call light. R7 had 216 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 17	F0725	Continued from page 2 Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random staffing schedule, call light, & census audits to ensure compliance 3x per week x 1, weekly x 3, monthly x2, and reported to QAPI committee for further review and recommendations.	08/21/2026

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F0725 SS = F	Continued from page 3 31-40 minutes = 6 41-50 minutes = 5 51-60 minutes = 1 61-70 minutes = 1 >70 minutes = 2 >130 minutes = 2 >150 minutes = 1 R4's quarterly MDS assessment dated 7/17/26, indicated cardio/respiratory condition, including congestive heart failure (when the heart cannot pump efficiently to meet the body's needs). R4 had intact cognition, clear speech, could understand and be understood. R4 required substantial assistance with oral hygiene, dressing, standing, sitting, toileting and walking short distances. During an interview on 7/13/26 at 10:25 a.m., R4 stated it took a long time for staff to answer her call light, "I'm at the end of the hallway and I feel pissed off; happens daily." R4 had 342 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 19 31-40 minutes = 2 41-50 minutes = 1 51-60 minutes = 2 61-70 minutes = 1 R13's admission MDS assessment dated 7/7/26, indicated orthopedic after care for fractures and other multiple trauma. R13 had intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all ADLs, was frequently incontinent of stool and did not walk. During an interview on 7/13/26 at 1:33 p.m., family member (FM)-A stated a few times when she had come into R13's room, her call light was not in reach and R13 had to yell for help. FM-A stated R13 was able to activate her call light and had waited up to 45 minutes for someone to respond. FM-A stated	F0725		08/21/2026

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F0725 SS = F	Continued from page 4 R13 had called her crying when no one came. FM-A stated R13 had pounded a cup on the overbed table to get the staff's attention. Observed call light on the floor behind the bedside dresser. FM-A handed it to R13. R13 had 111 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 3 31-40 minutes = 3 41-50 minutes = 2 51-60 minutes = 2 >80 minutes = 1 R31's quarterly MDS assessment dated 6/15/26, indicated fractures, heart failure and Alzheimer's disease. R31 had severe cognitive impairment, clear speech, could understand and be understood. R31 required substantial assistance with most ADLs, was always incontinent of bladder and bowel, and did not walk. During an interview on 7/13/26 at 2:08 p.m., R31 stated the facility was short staffed in the evening, and it took a long time for his call light to be answered. R31 stated he waited up to 45 - 60 minutes. R31 stated call lights were discussed at resident council meetings, but residents were pretty much blown off. R31 stated he used his call light to use bathroom or lay down. R31 stated staff ran and hurried and apologized, but there were not enough of them. R31 had 172 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 13 31-40 minutes = 5 41-50 minutes = 6 51-60 minutes = 1 71-80 minutes = 1 >140 minutes = 1 R45's quarterly MDS assessment dated 7/6/26,	F0725		08/21/2026

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F0725 SS = F	Continued from page 5 indicated stroke and heart failure. R45 had moderately impaired cognition, clear speech, could understand and be understood. R45 was always incontinent of bladder and bowel and did not walk. During an interview on 7/13/26 at 11:08 a.m., R45 stated he waited a long time for his call light to be answered. R45 stated service was better when he moved in (2024), but not now. R45 stated he had called the fire department and his sister for help in the past when no one answered his call light. R45 stated he used his call light for brief changes, get in or get out of bed. R45 had 34 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: >30 minutes = 1 >40 minutes = 2 R35's quarterly MDS assessment dated 6/19/26, indicated heart failure and diabetes. R35 had intact cognition, clear speech, could understand and be understood. R35 required substantial assistance for most all ADLs, was always incontinent of bladder and bowel and did not walk. During an interview on 7/13/26 at 3:13 p.m., R35 stated she had waited up to 1 1/2 hours for staff to answer her call light. R35 stated she used her call light for the bathroom and to go to activities. R35 stated she stayed in her wheelchair rather than recliner because it took too long for staff to come, and if in her wheelchair, was ready to go. R35 had 257 activations call light activations dated 5/12/26- 7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 19 31-40 minutes = 11 41-50 minutes = 6 51-60 minutes = 1 61-70 minutes = 4 71-80 minutes = 1 91-100 minutes = 1	F0725		08/21/2026

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F0725 SS = F	Continued from page 6 R37's annual MDS assessment dated 4/15/26, indicated R42 was cognitively intact, required supervision with personal hygiene, and partial/moderate assistance with dressing and transfers, utilized a manual wheelchair and diagnoses included muscle weakness. R37's care plan dated 6/2/26, indicated fall risk related to weakness, history of falling, assistance with ADL (activity of daily living) and transferring and interventions including monitor and document on safety, reminder sign on bathroom door to call for staff assist with toileting, assist of one with toileting. On 7/13/26 at 11:30 a.m., R37 was seated in a wheelchair in their room and stated they sometimes had to wait a long time for assistance while in the bathroom. R37 stated when they were unable to clean themselves after toileting, they remained in the bathroom waiting for staff assistance for approximately 30 minutes to one hour. R37 stated they would do what they could independently and return to their room without receiving assistance. R37 stated they did not like having to wait but understood staff were busy. R37 stated the delay was worse on the day shift and stated they were no longer able to clean themselves independently. Call light times dated 5/12/26-7/12/26, indicated the following : 143 activations 21-30 minutes = 8 31-40 minutes = 9 41-50 minutes = 8 51-60 minutes = 3 61-70 minutes = 1 >70 minutes = 2 R42's admission MDS dated 5/20/26, indicated cognitively intact, no rejection of care, required supervision or touching assistance with oral hygiene, diagnosis included displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture (break of the lower leg), and history of falling. R42's CAA (care area assessment) dated 5/21/26, indicated R42 had a decline in mobility following	F0725		08/21/2026

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F0725 SS = F	Continued from page 7 hospitalization for a fall that resulted in a right ankle fracture, in PT (physical therapy) and OT (occupational therapy) at this time, needing assistance with mobility and ADLs (activities of daily living), alert and oriented and able to make her needs known, plan to continue to provide assistance with ADLs and follow therapy recommendations. R42's care plan dated 5/15/26, indicated alternation in mobility, does not walk, assist with movement in bed and in/out bed, set up with personal hygiene. On 7/13/26 at 10:46 a.m., R42 stated they had to wait approximately 30 to 45 minutes for staff assistance with toileting needs, including urination and bowel movements. R42 stated they had not experienced accidents due to the delays but began wearing a brief because of the concern. R42 stated weekends were the worst due to short staffing and stated delays also occurred during shift change and during the week. R42 stated they learned to request assistance before shift change because staff would tell them, "Sorry, we are short staffed." R42 stated there were times when they were left waiting on the commode and reported they had previously complained and cried about the delays, resulting in a room change to a different hallway. R42 stated delays continued after the move and were especially concerning when only one staff member was available when two staff members were needed for assistance. Call light times dated 5/12/26-7/12/26, indicated the following : 280 activations 21-30 minutes = 20 31-40 minutes = 11 41-50 minutes = 3 RESIDENT COUNCIL R29’s quarterly MDS assessment dated 5/1/26, indicated intact cognition, use of walker and wheelchair, partial assistance with toileting, bathing, and transfers, and diagnoses of heart failure and high blood pressure. R35’s quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of wheelchair, dependent with toilet use, substantial assistance with bathing, substantial assistance for transfers, and diagnoses of heart failure and kidney	F0725		08/21/2026

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F0725 SS = F	Continued from page 8 insufficiency. R8's admission MDS assessment dated 6/26/26, indicated intact cognition, use of walker and wheelchair, substantial assistance for toileting and dressing, independent with transfers, and diagnoses of high blood pressure and diabetes mellitus. R24's quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of walker, independent with hygiene, dressing, and transfers, and diagnoses of cancer and heart failure. R33's quarterly MDS assessment dated 6/5/26, indicated intact cognition, use of walker and wheelchair, independent with dressing, eating, and transfers, and diagnoses of high blood pressure and Parkinson's disease. During resident council meeting on 7/14/26 at 1:50 p.m., the following statements were documented: R29 stated staffing was a big concern at the facility. R29 stated she waited over 30 minutes for her light to be answered and sometimes had to have her bath rescheduled. R29 further stated concerns had been brought up at resident council meetings but the council had not heard back on what had been done about staffing concerns and long call light wait times. R35 stated her call light was answered after 30 minutes and sometimes up to 90 minutes. R35 stated that was too long to wait. R35 also stated she missed her bath due to lack of staff at the facility. R8 stated she was fairly independent and did not need much help, but has heard other residents say it took a long time for their lights to be answered. R8 stated she participated in resident council meetings and staff response time and lack of staff was always a topic, but had not heard a response from the facility. R24 stated she waited over 30 minutes multiple times for her light to be answered and she thought weekends were particularly worse. R24 further stated she had missed her bath and it sometimes took three days for staff to get caught up and give her a bath. R24 stated she did not like waiting an additional three days. R33 stated 20 minutes was too long for him, and he often had to wait over 20 minutes. R33 further stated if he had to go to the bathroom and waited over 20 minutes, he would have an accident in his brief. R33	F0725		08/21/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0725 SS = F	Continued from page 9 stated he had accidents due to waiting more than he would like to admit. During interview on 7/15/26 at 7:58 a.m., activities assistant (AA)-A stated she facilitated resident council meetings and took meeting minutes. AA-A stated the facility did not do a formal follow-up to resident concerns, did not have anything in writing, and did not recall how or if resident council concerns regarding staffing had been addressed. STAFF INTERVIEWS During a confidential interview, employee-C stated the unit known as the south unit, used to have three nursing assistants (NAs) and now had two. Employee-C was aware some residents complained of long call light wait times. Employee-C stated the unit had a lot of residents who required significant assistance from NA staff for dressing, toileting, and two staff for transfers and/or use of mechanical lifts. In addition, employee-C stated staff were not provided walkie-talkies so spent a lot of time looking for each other. Employee C stated it was important for NA staff to be able to communicate information to the nurse quickly, and if had to go room to room looking for the nurse, valuable time could be wasted. Employee C stated many times she has had to go room to room looking for an NA. During a confidential interview, employee-F stated it was pretty common to get complaints from residents about long call light wait times and they were surprised when she got there right away. Employee-F stated the facility did not use walkie-talkies and often had to go room to room to look for a coworker. Employee F stated she had been in a situation where a resident fell, had to put a pillow under their head, and leave the room to find the nurse. Employee-F stated they had a meeting last year after State surveyors left and they brought up walkie-talkies, but nothing changed. Employee F stated a lot of things were talked about, but nothing got done. Employee-F stated currently six residents required the use of a mechanical lift which tied up two NAs for long periods. Employee F stated NAs gave baths on the evening shift which she didn't think was good because that left the other NA on the floor alone causing delays in helping with two-person assists. During a confidential interview, employee B stated she was aware some agency nurses would not return to work at the facility because staffing levels never improved. Employee B stated the south unit had 24 high-acuity residents with only two NAs,	F0725		08/21/2026

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F0725 SS = F	Continued from page 10 adding that was a safety concern. Employee-B stated leadership knew they were short staffed and should be doing something about it. Employee-B stated staff were afraid to speak up for fear of losing their job. Employee-B stated there were no walkie-talkies for communication, so staff had to run around to track people down. Employee-B stated the facility was not able to meet the needs of residents and was aware some families had removed their family member from the facility because of that. During a confidential interview, employee-D stated they were short staffed and used a lot of agency staff. Employee D stated they did their best but acknowledged residents sometimes waited a long time to get care. Employee D stated they did not use walkie-talkies, so often had to go up and down the hall looking for help and that caused delays. On 7/13/26 at 5:00 p.m., nursing assistant (NA)-B stated there were two nursing assistants working today. NA-B stated that on the previous evening, after 6:00 p.m., they were the only nursing assistant because the agency staff member who had been scheduled to work did not report. NA-B stated the agency staff member had been scheduled to work doubles throughout the weekend but was unsure whether they had reported for any of the shifts. NA-B stated they provided evening cares and answered call lights by herself the day prior. NA-B stated it was not common to have only one nursing assistant scheduled on the east and west, due to agency staff not showing for the scheduled shift. NA-B stated there were usually two nursing assistants assigned to the south hall and estimated approximately six residents required two-person assistance. NA-B stated call light response times could be delayed depending on the how many staff were working and the needs of the residents. NA-B stated the facility does not have any tools in place to assist staff with requesting help such as walkie talkies and staff would need to yell if assistance was needed. On 7/13/26 at 5:10 p.m., licensed practical nurse (LPN)-A, stated two nursing assistants were sufficient for the east and west hallway, but if only one nursing assistant was available the nurse would need to assist. LPN-A stated it occurred more often that only one nursing assistant was available because agency staff failed to report for work. LPN-A stated when this occurred, staff attempted to call employees who were off duty and notified the director of nursing for direction. On 7/13/26 at 5:43 p.m., a call light illuminated for	F0725		08/21/2026

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F0725 SS = F	Continued from page 11 Room 11. NA-C was observed responding to the call light. At 5:46 p.m., another call light illuminated for Room W-2 while NA-C remained in Room 11. NA-C stated, "I can't leave this resident alone. My partner is on break." The call light remained active until 5:57 p.m. On 7/13/26 at 6:21 p.m., NA-C stated they had been asked to report early to their shift because baths scheduled over the weekend had not been completed and staff were attempting to complete the missed baths. On 7/14/26 at 8:32 a.m., the trained medication aide (TMA)-B stated it was difficult for one TMA to complete medication administration and additional help would be beneficial. The TMA stated they were the only TMA for the building. The TMA stated there were usually two NA's scheduled for east and west hall but occasionally only one was available when someone called in or agency staff did not report. On 7/14/26 at 8:46 a.m., NA-A stated they were scheduled to work from 6:00 a.m. to 2:30 p.m., on 7/11/26, but remained at the facility until 6:00 p.m. because another staff member did not report. NA-A stated they were the only nursing assistant on Sunday 7/12/26, from 6:00 a.m. to 2:30 p.m. NA-A stated baths, resident weights, and ambulation were not completed because only one nursing assistant was available. NA-A stated residents experienced delays in call light response times and questioned why staff took longer to respond. NA-A stated it was not uncommon to have only one nursing assistant working on weekends. On 7/14/26 at 9:07 a.m., the social services director (SS)-A stated residents had complained about call light response times and was "not a surprise". SS-A stated when residents have concerns regarding call light response times, residents were encouraged to speak with the charge nurse and staff are educated regarding the concerns. SS-A stated concerns regarding call light response times were a known concern at the facility and stated it was not a surprise that concerns regarding resident call lights were identified during the survey. On 7/14/26 at 9:09 a.m., the administrator stated call light response times had previously been reviewed and acknowledged there were some lengthy response times. The administrator stated they could not specifically recall any exceeding 30 minutes but believed any response time over 30 minutes would be considered significant. The administrator stated R42 voiced concerns with long	F0725		08/21/2026

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F0725 SS = F	Continued from page 12 call light times and R42 call lights were reviewed and the administrator stated they did not remember whether there were more than two occurrences over 30 minutes. The administrator stated staff discussed the concerns with R42 and believed transferring R42 to another wing would improve response times. The administrator stated additional call light logs were not reviewed because no grievances had been filed. The administrator stated the facility does not routinely conduct call light audits. The administrator stated the last review of call light logs occurred approximately two months earlier during an investigation in which each wing was reviewed. The administrator stated concern would generally be identified if more than two or three rooms demonstrated call light response times exceeding 30 minutes. The administrator stated they did not review the call light logs provided during this survey, did not believe the facility had long call light response time issues, and stated concerns would be addressed in real time rather than through the QAPI process. On 7/14/26 at 9:36 a.m., LPN-B stated call light response times on the south hall could exceed 30 minutes. LPN-B stated staff were burned out, were frequently called on their days off to pick up shifts due to staffing shortage, residents missed baths and resident ambulation was not completed occurred due to staffing shortages. LPN-B stated some residents did not receive breakfast until approximately 9:30 a.m. because morning cares were delayed. LPN-B further stated the facility did not provide walkie-talkies, requiring staff to search for coworkers when assistance was needed, which further delayed resident care and call light response. On 7/14/26 at 9:45 a.m., NA-D stated when staff members leave for breaks, only one staff member remains on the unit, resulting in residents frequently experiencing long wait times for assistance. NA-D stated when a resident requires a two-person transfer to the toilet, other residents may have to wait for assistance until additional staff are available. NA-D stated management was aware of long call light response times and that the facility's computer system tracked call light response times. NA-D stated staff had voiced concerns regarding delayed response times to management and were instructed to respond to residents more timely; however, staffing levels were not increased. NA-D stated staff responded to call lights as quickly as possible and did not have downtime but could not respond more quickly when there were not enough staff available. NA-D further stated staffing decisions were based solely on resident census. NA-D confirmed R42 had	F0725		08/21/2026

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F0725 SS = F	Continued from page 13 been moved to a different unit due to concerns regarding delays in receiving care. NA-D further stated overnight staff would at times assist R42 to the toilet and then leave to assist another resident, resulting in R42 waiting approximately 30 minutes for assistance before staff returned. On 7/14/26 at 2:42 p.m., nursing assistant (NA)-C stated the facility had a lot of staff who didn't come for their shifts, especially on the weekends, particularly agency staff. NA-C further stated the facility used a star system to ensure coverage and she had to stay later than her scheduled shift often to cover for other staff who didn't show up. NA-C stated staffing was not adjusted based on resident needs, there was always a set number of three or four nursing assistants no matter how many residents there were in the facility. NA-C stated it was hard to get help when needed and residents had to wait a long time. On 7/14/26 at 2:46 p.m., NA-B stated when they were short-staffed residents had to wait a long time for help. NA-B further stated they were short-staffed a lot, especially on weekends. On 7/14/26 at 4:51 p.m., the director of nursing (DON) stated weekend staffing schedules posted in the facility were not updated in real time to reflect actual staffing. The DON stated they spent a significant portion of her day providing resident care because of staffing shortages and stated agency staff had contributed to the staffing problems and doing a disservice to the facility. On 7/15/26 at 6:38 a.m., LPN-C stated she worked the night shift and if there were 42 residents, one nurse and two NAs were adequate, but when the census rose to 47 or 48 it was not. LPN-C stated there were one NA on each floor and her, and at 1:30 a.m., and 4:30 a.m., the NA from first floor went to second floor to help, and they covered each other for breaks. LPN-C stated they used to have walkie-talkies but didn't anymore and didn't know why, so they used their personal cell phones or the house phone to contact each other. In order to know if a call light was going off, LPN-C stated staff had to be in the hallway to observe the scrolling marquee and might hear the beep (indicating a call light was activated) or you might not. On 7/15/26 at 8:49 a.m., LPN-A stated that when staffing is limited, nurses may need to assist; however, one staff member caring for approximately 21 residents is insufficient. LPN-A stated they have heard residents report staffing shortages on multiple	F0725		08/21/2026

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F0725 SS = F	Continued from page 14 occasions. LPN-A further stated the south wing requires three staff members and delays occur when staff must search room-to-room for assistance. LPN-A stated staff previously used walkie-talkies, but without them staff may not know another resident requires assistance. LPN-A stated they had spent significant time looking for available staff and has been told by residents they have waited up to 30 minutes for assistance. LPN-A stated the director of nursing (DON) was aware of these concerns and frequently works on the floor, where the issues should be readily apparent. LPN-A stated the facility did not provide staff with walkie-talkies. LPN-A stated this created a safety concern because if a resident fell, was bleeding, or required immediate assistance while staff were in another resident's room, they would not be able to quickly obtain help from another staff member. On 7/15/26 at 9:05 a.m., maintenance director (MD)-A provided resident care unit distance measurements: first floor from beginning of the east hallway to end of the west hallway was 130 feet (equivalent to a 12-13 story building). Distance on the south unit, from first room to last room was 206 feet (more than half the distance of a football field) On 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the time of the interview and that he was covering her responsibilities. VPO stated the facility administrator was responsible for completing the facility assessment, and stated that he would expect the facility assessment to include staffing numbers and information regarding the facility's staffing levels. VPO did not identify any specific staffing concerns and stated that the facility occasionally utilizes agency staff to address staffing needs when necessary. VPO stated that the administrator would be expected to review staffing trends and patterns, ask specific questions regarding identified issues, and ensure that appropriate actions were implemented. VPO stated if concerns such as extended call light response times were identified, the administrator would be expected to investigate the issue by asking questions such as when the delays are occurring, whether they are isolated to a particular shift and what interventions were needed. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program.	F0725		08/21/2026

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F0725 SS = F	Continued from page 15 On 7/15/26 at 2:30 p.m., the DON stated staffing levels were determined based on resident acuity, resident census, holidays, anticipated resident needs, and hours per resident day (PPD), with a target of approximately 3.0 PPD. The DON stated resident needs were reviewed during the morning meeting, including new admissions and residents requiring additional assistance. However, when asked how resident acuity was incorporated into staffing decisions, the DON was unable to clearly explain the process or identify how staffing assignments were adjusted to meet resident care needs. The DON stated staffing assignments varied by unit, with lighter staffing on the east and west halls and staff floating to the south hall as needed. The DON stated staff were supposed to carry pagers to receive call light notifications but acknowledged the pagers were missing and stated, "Maybe they're lost." The DON further stated staff would have to leave a resident's room to view the scrolling call light display at the end of the hallway. The DON stated the facility had purchased walkie-talkies approximately one month earlier but had not implemented their use. After discussion regarding delayed staff response, the DON stated walkie-talkies could be implemented that evening to improve communication. When asked how the facility determined staffing was adequate, the DON stated residents were cared for, there were no odors, pressure ulcers were not worsening, residents were happy, and meals were provided. However, the DON was unable to identify specific monitoring processes to ensure resident oral care, bathing, and other activities of daily living (ADLs) were consistently completed. The DON acknowledged managers, including the DON, frequently provided direct resident care because of staffing shortages and stated the facility did not have enough staff to add additional personnel. The DON further stated nursing assistant documentation was poor because some staff lacked electronic medical record (EMR) access, documentation was lost, agency staff lost documentation, and staff did not have time to complete documentation. When informed that multiple residents and staff independently reported delays in care and prolonged call light response times, the DON stated there was no explanation for why this was occurring. On 7/15/26 at 3:03 p.m., the administrator stated daily staffing decisions were based on resident census, resident acuity, and PPD following discussion of admissions, discharges, and resident needs during the daily stand-up meeting. The administrator stated staffing adequacy was evaluated by the absence of wounds, falls, odors, resident	F0725		08/21/2026

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F0725 SS = F	Continued from page 16 complaints, and whether residents were coming to the nurses' station. The administrator acknowledged the facility did not routinely monitor call light response times and stated the last review of call light data occurred approximately two weeks earlier for a single resident concern rather than reviewing facility-wide trends. The administrator stated staffing was adjusted for resident acuity, including hospice residents, residents requiring mechanical lifts, extensive wounds, and psychosocial needs. However, the administrator acknowledged staff communication regarding resident call lights was not functioning as expected. The administrator believed staff carried pagers but acknowledged only one working pager was available at each end of the building and stated staff would have to leave a resident's room to obtain assistance or holler for help because no established communication process was in place. The administrator further stated staff were expected to complete documentation throughout the shift "when they have a minute", however no time is dedicated to documentation. On 7/15/26 at 3:41 p.m., RN-C, known as the regional nurse consultant, stated staffing levels were based on PPD and resident acuity, with staffing increased when residents required additional care. RN-C stated the facility was budgeted for a specific PPD and staffing adjustments required clinical justification. However, RN-C acknowledged resident care was not consistently being completed and specifically identified oral care not being completed, resident ambulation needs not being met, and prolonged call light response times. RN-C stated two nursing assistants assigned to the south hall were "probably not enough." RN-C further stated there had been no documented staff meetings or documented follow-up regarding staffing concerns and would have expected documentation of education and corrective actions related to identified staffing issues. On 7/16/26 at 8:20 a.m., NA-E stated the facility needed four or more nursing assistants during the day and evening because of the floor plan of the facility, especially during busy times. NA-E stated they put on a lot of steps each day and covered a lot of area. NA-E stated it was hard to get everything done on time and baths got missed and pushed off to other days. On 7/16/26 at 8:22 a.m., NA-A stated it was hard to get her work done on time, especially because there was no way to communicate with other staff. NA-A stated when she needed assistance she would have to search for another staff member and that took up	F0725		08/21/2026

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F0725 SS = F	Continued from page 17 extra time. Review of the facility assessment dated 6/1/26, indicated the following: Direct Care Staffing Plan: To ensure an adequate amount of staff at Lakeshore Rehabilitation Center at all times, the resident population, CMI, and census is taken into account daily to determine sufficient staffing needs. Lakeshore's IDT reviews census on the daily census template sent out daily by Health Information to determine the needs on each unit. Any admission and discharges planned also factor in and assist in determining the staffing needs for each day on each unit. Individual assignments for continuity of care for residents and across staff assignments is determined by the DON, Nurse Management, Charge Nurse, Unit Nurse in that order of hierarchy. During interview on 7/15/26 at 2:34 p.m., administrator stated staffing should be based off the facility assessment, but the facility assessment was lacking any indication of how many staff were needed at the facility. Administrator further stated she did not have a specific algorithm for determining staffing levels and making necessary adjustments. A staffing policy was requested but not received.	F0725		08/21/2026
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to:	F0838	How corrective action will be taken for those affected by the alleged deficient practice: The facility assessment has been modified to include staffing levels needed for specific shifts. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Lakeshore’s Facility Assessment was reviewed, updated, and will continue to be reviewed annually and as needed.	08/21/2026

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F0838 SS = F	Continued from page 18 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based	F0838	Continued from page 18 The IDT was educated and understands the requirements of the facility assessment. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Audit of the facility assessment will be conducted quarterly at the QAPI meeting to ensure all parts are included and will adjust as necessary.	08/21/2026

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F0838 SS = F	Continued from page 19 risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the	F0838		08/21/2026

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F0838 SS = F	Continued from page 20 availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Facility Assessment included information on staffing levels needed for specific shifts. This deficient practice had the potential to affect all 42 residents who resided in the facility. Findings include: Review of Facility Assessment dated 6/2026, indicated the following: Section 3. Facility resources needed to provide competent support and care for our resident population every day and during emergencies: 3.2 & 3.3. Direct Care Staffing Plan: To ensure an adequate amount of staff at Lakeshore Rehabilitation Center at all times, the resident population, case mix index (CMI), and census if taken into account daily to determine sufficient staffing needs. Lakeshore's interdisciplinary team (IDT) reviews census on the daily census template sent out daily by Health Information to determine the needs on each unit. Any admissions and discharges planned also factor in and assist in determining the staffing needs for each day on each unit. Individual staff assignments for continuity of care for residents and across staff assignments is determined by the director of nursing (DON), nurse management, charge nurse, unit nurse in that order of hierarchy. The facility assessment did not include information on staffing levels needed for specific shifts, such as day, evening, and night and adjusted as necessary based on changes to resident population. During interview on 7/14/26 at 3:37 p.m., when confirming the provided facility assessment was correct, administrator stated she gave the state agency (SA) the correct and most current version and she would not put specific information in the facility assessment about staff requirements for each shift because staffing fluctuates so much. During interview on 7/15/26 at 8:02 a.m., administrator stated she was aware specific staffing date should be in the facility assessment, and she must have accidentally deleted the staffing information. Administrator stated she reached out to corporate for an updated version. Administrator further confirmed the facility did not use the daily	F0838		08/21/2026

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F0838 SS = F	Continued from page 21 census template to review staffing needs as directed in the facility assessment, but the IDT did talk about census daily. Administrator also stated the facility did not have a specific algorithm they used to determine needed staffing levels and would refer to their facility assessment to determine staff needed to meet resident's needs. A facility document titled Staffing Levels Per Patient Day (PPD) Compliant undated, indicated staffing levels were based on resident census numbers. A facility policy on facility assessment requirements was requested but not received.	F0838		08/21/2026
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State	F0865	How corrective action will be taken for those affected by the alleged deficient practice: The facility implemented an Ad Hoc QAPI for call light wait time concerns. Current call light data was reviewed and residents identified to have long call light wait times were interviewed for concerns. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Reviewed Monarch's Quality Assurance and Performance Improvement (QAPI) Plan. The IDT were educated on the facility's QAPI process, documentation expectations, and their responsibility to identify and address quality concerns. Staff were educated on the Ad Hoc QAPI for call light wait time concerns. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random call light audits to identify concerns and ensure compliance weekly x4, monthly x 2 and will report	08/21/2026

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F0865 SS = F	Continued from page 22 Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services	F0865	Continued from page 22 to QAPI committee for further review and recommendations.	08/21/2026

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F0865 SS = F	Continued from page 23 provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the quality assurance and performance improvement (QAPI) committee failed to identify resident call light wait time concerns prior to survey, nor make a good faith attempt to correct the deficiency. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: QAPI meeting minutes dated 3/31/25, indicated, "Call lights tend to be #1 issue." Call light response times had not been included/mentioned again in the subsequent six QAPI meeting minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn't an issue, however there was no documentation to support this. During an interview on 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the	F0865		08/21/2026

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F0865 SS = F	Continued from page 24 time of the interview and that he was covering her responsibilities. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. During QAPI meetings, the facility is expected to analyze data, discuss findings, review audit results, perform root cause analyses, develop action plans, and monitor the effectiveness of interventions. VPO stated regarding call light response times, that if ongoing concerns existed, the facility should utilize call light logs to identify trends, review the information through the QAPI process, and implement corrective actions. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program. During an interview on 7/16/26 at 9:46 a.m., the administrator stated current survey findings of long call light response times had not been on her radar. The administrator admitted there had been no staff meetings where QAPI meeting activities had been communicated to employees nor were employees asked for feedback about potential concerns related to resident care. Facility QAPI Plan with review date of 1/2/26, indicated the organization used QAPI to make decisions and guide their day-to-day operations, and included all employees, all departments and all processes. Decisions were based on data which included input from caregivers, residents, families and other stakeholders. Data sources for bench making progress would include information from residents and family interviews and staff surveys. All staff would be encouraged to communicate concerns and ideas to any department manager.	F0865		08/21/2026
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F0867	How corrective action will be taken for those affected by the alleged deficient practice: A review of the facility's QAPI program was completed to identify gaps in the development, implementation, monitoring, and evaluation of performance improvement activities. All current QAPI projects and identified quality concerns were reviewed to ensure the facility developed and implemented action plans, measured the success of actions and tracked performance, and reviewed, analyzed, and acted on data collected. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/21/2026

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F0867 SS = F	Continued from page 25 resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F0867	Continued from page 25 All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Reviewed Monarch’s Quality Assurance and Performance Improvement (QAPI) Plan policy. The IDT were educated on the facility's QAPI process, documentation expectations, and their responsibility to identify and address quality concerns. Call light response time has been added as a PIP Project, QA form includes a note section for documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits of QAPI plan and forms to ensure all required parts of the regulation are present and in compliance weekly x4, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0867 SS = F	Continued from page 26 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by:	F0867		08/21/2026

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F0867 SS = F	Continued from page 27 Based on interview and document review, the facility failed to develop and implement action plans, measure the success of actions and track performance, conduct a performance improvement project (PIP), and regularly review, analyze, and act on data collected. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: Due to numerous sufficient staffing and long call light wait time concerns expressed by residents, family members and staff, QAPI (quality assurance and performance improvement) meeting minutes were reviewed. QAPI meeting minutes from March 2025 through June 2026, indicated the following: 3/31/25 - Minutes lacked substance. No actions or resolutions. Identified under grievances: "call lights tend to be #1 issue." Not mentioned again. 6/18/25 – No documentation of minutes. 9/30/25 - Minutes lacked substance. Not able to determine actions or resolutions. 12/17/25 – No documentation of minutes. 1/14/26 – No documentation of minutes. 3/18/26 – No documentation of minutes. 6/10/26 – No documentation of minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the lack of documentation of actions or resolutions at QAPI meetings, the administrator stated their meeting discussions were mostly verbal and admitted the minutes did not reflect their discussions. The administrator stated they needed to take better notes. With regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn't an issue, however there was no documentation to support this. During an interview on 7/16/26 at 9:46 a.m., the administrator stated she set the QAPI meeting agenda, facilitated the meetings and documented the meeting minutes, and that quality measures were monitored at both a corporate level and locally. The	F0867		08/21/2026

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F0867 SS = F	Continued from page 28 administrator admitted the minutes lacked identification of issues, analysis, monitoring, auditing, outcomes, and acknowledged the documentation needed to be improved as the minutes did not reflect activities of the committee. During the same interview, the administrator stated a PIP for 2026, had been unplanned weight loss. The administrator stated the only data obtained had been weight loss information from the dietician, and admitted they had not conducted a root cause analysis nor considered other important data such as diet orders, food preferences, observations of residents eating, involvement of family, use of supplements, etc. The administrator admitted their work lacked all available data and did not include a comprehensive analysis, action plan or audits. During a telephone interview on 7/15/26 at 11:00 a.m., vice president of operations (VPO) stated he had not been aware of anything specific related to quality indicator concerns at the facility. If there were resident concerns about call lights, he would ask specific questions, look at trends and patterns. For example, if long call lights were around the supper meal, he would expect an analysis of the situation and potentially add staff or reassign responsibilities. VPO stated he would expect QAPI minutes to identify data had been analyzed, a root cause analysis completed, action/interventions identified. For long call light wait times, circle back with residents, look at specific grievances, ask specific questions - time of day, day of week, etc. Adjust operations and business practices, monitor, audit. Call light logs should be utilized if a facility can run them, and then data presented to the QAPI committee for review.	F0867		08/21/2026
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F0565	How corrective action will be taken for those affected by the alleged deficient practice: All Resident concerns identified at resident council meetings during the last 60 days were reviewed, addressed, and residents notified of a resolution or ongoing measures to ensure compliance. The resident identified in the deficiency (R8, R24, R25, R28, R29, R30, R33, R35, R36 were individually spoken to and had all current concerns/issues addressed. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/21/2026

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F0565 SS = E	Continued from page 29 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident concerns identified at resident council meetings were addressed and residents notified of a resolution or ongoing measures to ensure compliance. This affected all 9 residents (R8, R24, R25, R28, R29, R30, R33, R35, and R36) who attended resident council. Findings include: R29's quarterly Minimum Data Set (MDS) assessment dated 5/1/26, indicated intact cognition, use of walker and wheelchair, partial assistance with toileting, bathing, and transfers, and diagnoses of heart failure and high blood pressure. R35's quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of wheelchair, dependent with toilet use, substantial assistance with bathing, substantial assistance for transfers, and diagnoses of heart failure and kidney insufficiency. Review of the resident council minutes dated 7/6/26, 6/10/26, 3/26/26, and 3/11/26, indicated concerns with wheelchair maintenance, toilet leaking, missing	F0565	Continued from page 29 All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility expectations and regulation were reviewed for resident council requirements. Implemented Resident Council Departmental Response Form to document resident concerns, investigation, and resolution. Education provided to Therapeutic Recreation Director and IDT on process and expectations. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Audits will be conducted monthly x3 to ensure the process change has been implemented, and the Resident Council Department Response Form has been completed for the previous month, and will report to QAPI committee for further review and recommendations.	08/21/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE REHABILITATION CENTER LLC	108 8TH STREET NORTHWEST , WASECA, Minnesota, 56093

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F0565 SS = E	Continued from page 30 socks, mealtime service delays, food quality and temperature, and long call light times. The meeting minutes did not include follow-up or explanations of how or when the concerns would be addressed, or if they were ever addressed. During resident council interview on 7/14/26 at 1:50 p.m., R29 stated staffing was a big concern at the facility and she sometimes waited over 30 minutes for her call light to be answered. R29 further stated she had brought those concerns up at resident council but had never gotten any answer from facility staff whether her concern was addressed. R29 stated the council brought things up at meetings but didn't hear back and nothing was ever done about it. R20 stated she didn't know the council was supposed to get a response to their concerns. During resident council interview on 7/14/26 at 1:50 p.m., R35 stated she was unaware of any follow-up on resident council concerns and had never heard any solutions to concerns brought up at resident council. During interview on 7/15/26 at 7:58 a.m., activities assistant (AA)-A stated she helped facilitate the resident council meetings and typed the minutes. AA-A stated she was unable to find any evidence of replies to resident council concerns but was sure they were addressed verbally. AA-A stated she was not aware a formal response in written form should be given to the resident council and would have to start documenting follow-up for resident concerns. During interview on 7/15/26 at 1:40 p.m., administrator stated she would expect the resident council to receive responses from leadership addressing their concerns. Administrator further stated she was unaware concerns were not being addressed or documented. Administrator stated she would expect staff to follow federal regulations. A facility policy on responses to grievances and resident council concerns was requested but not received.	F0565		08/21/2026
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F0921	How corrective action will be taken for those affected by the alleged deficient practice: The ceiling tiles in the East hallway bath tub room were replaced. The carpets on the East and West hallways were shampooed. The facility will obtain flooring replacement bids and have the carpet/flooring replaced in both effected/impacted	08/21/2026

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F0921 SS = E	Continued from page 31 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment for residents residing in East and West hallways resulting in large dark stains, fraying and worn carpet throughout the hallway and damaged, cracked, sagging, and discolored ceiling tiles in the east hallway bath tub room. Findings Include: On 7/13/26 at 5:09 p.m., observation of the east hallway outside resident rooms identified a discolored dark stain on the flooring measuring approximately 1½ feet by 6 inches, irregularly shaped with darkened edges and concentrated areas of discoloration. The stains were distributed throughout the hallway and were readily visible from a distance due to the contrast between the stained areas and the surrounding carpet. The carpeting appeared worn and soiled. On 7/13/26 at 5:21 p.m., the licensed practical nurse (LPN)-A stated the hallway carpeting was stained and frayed, and further stated the carpet was not securely attached at the seams. LPN-A stated the carpet had been shampooed the previous week; however, the stains remained because the carpeting was old. On 7/13/26 at 5:53 p.m., the environmental services manager (EVSM)-C stated the flooring had been scrubbed multiple times without improvement and that requests for replacement flooring had been ongoing for an extended period. EVSM-C stated the ripped carpet and stained flooring were maintenance issues, described the condition as "embarrassing" and "unfair to the residents," and confirmed the concerns were included in weekly reports submitted to environmental management. EVSM-C stated the carpeting was a concern and reported attempts had been made to clean the carpet; however, the staining worsened during humid conditions. On 7/14/26 at 10:04 a.m., the maintenance director (MD)-A and administrator confirmed the carpeting was not secure and frayed and stated "anything could be tripped on." They stated the carpet had been glued previously at the seams and replacement had been discussed; however, no replacement date had been established. The administrator acknowledged residents would not be expected to live with frayed carpeting or holes in the carpet as it is not a homelike environment. The administrator stated the carpet condition was a known concern and acknowledged the stains remained despite	F0921	Continued from page 31 areas in the East and West hallways. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was conducted to ensure no other ceiling tiles were affected and those that were damaged, were replaced. The facility has contacted flooring companies to provide carpet replacement quotes and is scheduling service. All Staff were educated on expectations to maintain a clean, comfortable, and homelike environment. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random facility homelike environment audits of the flooring, bathtub rooms, dining room, activities room, nurses stations, public areas, resident rooms, to ensure compliance weekly x4, monthly x2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0921 SS = E	Continued from page 32 shampooing. The administrator stated the carpeting "does not look good or homelike," confirmed awareness of the condition. The administrator confirmed the carpets on the East and West halls did not provide a homelike environment. On 7/14/26 at 12:23 p.m., observation of the east hallway identified multiple areas where the carpeting was worn through with the carpet backing visible. Several carpet seams were frayed and separated, creating raised edges. Numerous irregularly shaped dark brown and black discolored areas of varying sizes were present throughout the hallway carpeting. On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed a ceiling tile surrounding the sprinkler head with a large circular brown discolored area measuring approximately 18 to 24 inches in diameter, with a darker brown ring around the outer edge and a lighter-colored center. An adjacent ceiling tile had an additional irregularly shaped brown discolored area extending across the edge of the tile. Additional ceiling tiles were observed to be cracked, broken, and sagging, with visible deterioration to the tile surfacesOn 7/15/26 at 12:55 p.m., MD-A while observing the ceiling confirmed the ceiling tile in the bathroom was stained and stated the facility has a flat roof. MD-A further stated the ceiling tile was "busted." On 7/15/26 at 12:59 p.m., the administrator observed the condition of the ceiling and confirmed they would expect the stained and cracked ceiling tiles to be replaced. The Facility document The Revisor of Statues dated 2007, indicatedA nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongs to the extent possible.	F0921		08/21/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641	How corrective action will be taken for those affected by the alleged deficient practice: The facility reviewed R50's discharge MDS assessment, supporting documentation, and the RAI Manual. The affected MDS was modified and resubmitted according to the RAI Manual. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/21/2026

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F0641 SS = D	Continued from page 33 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) assessment was coded accurately for 1 of 1 resident (R50) reviewed for discharge a by inaccurately coding a planned discharge as an unplanned discharge, and failed to follow the Resident Assessment Instrument (RAI) Manual. Findings include: R50's discharge assessment - return not anticipated MDS dated 6/28/26, indicated unplanned discharge to home/community on 6/28/26, cognitive skills for daily decision making: modified independence - some difficulty in new situations only; was independent with oral hygiene, toileting hygiene, dressing, personal hygiene, transfers, walking, did not use a wheelchair, diagnoses indicated hemiplegia following cerebral infarction affecting left non-dominant side (stroke-related condition where a blood clot or blockage; has caused paralysis or severe weakness on the left side of the body). R50's discharge instructions dated 6/25/26 at 1:37 p.m., licensed practical nurse (LPN)-A indicated discharge home, reason for discharge: resident	F0641	Continued from page 33 All discharged residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed to identify unplanned discharge MDSs in the last 90 days. Each identified resident's medical record was reviewed to verify that the discharge documentation supported accurate MDS coding. Education was provided to Director of Nursing and MDS Coordinator on the RAI Manual's definition of planned vs unplanned discharges and accurate coding. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random audits for compliance weekly x4, monthly x2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0641 SS = D	Continued from page 34 request, admission date 4/28/26, came to our facility following hospitalization for CVA (stroke) with left sided weakness and left sided vision deficit. Has worked with therapy and is now independent with all cares, further the document was signed by R50 and indicated understood the medication instructions and other instructions given to me by the healthcare professional. R50's document titled notice of resident/patient transfer or discharge 6/29/26, social services (SS) director-A indicated date of anticipated discharge 6/28/26, date notice provided 6/26/26, the transfer or discharge is/was appropriate because the resident's health has/had improved sufficiently so the resident no longer needs/needed the services provided by the facility R50's provider note progress note dated 6/25/26, nurse practitioner (NP)-D indicated okay to discharge to home with current meds and treatment plan. R50's progress note dated 6/28/26 at 8:45 a.m. the director of nursing (DON) indicated R50 packed personal belongings and brought to the front door awaiting on dtr (daughter) pick up, ambulating independently w/o (without) aid, reviewed d/c medications with resident again. Understanding noted AEB (as evidenced by)resident repeating instructions, reading out loud and familiarity/awareness with names and dosing of medications, provided printed out MAR (medication administration record) for June/July so resident has 'a graph' so she can check off after taking. informed resident and dtr that writer spoke with pharmacist at pharmacy yesterday to ensure medications were ready for pick up, R50 excited to be returning home. D/C (discharge) instructions, meds and personal belongings with resident. discharged to home via private vehicle/dtr. On 7/15/26 at 10:00 a.m., the director of nursing (DON) stated R50's MDS had been completed as an unplanned discharge because the timing of the discharge changed at the last minute and the facility was not prepared for the resident to leave that day. The DON stated the family situation was dysfunctional and there was uncertainty regarding transportation and whether R50 would return home with family or independently. The DON confirmed R50 was ready for discharge; however, the facility had not planned for the resident to leave on the day of discharge. The DON confirmed the discharge process was followed, a provider discharge order was obtained, all necessary discharge paperwork	F0641		08/21/2026

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F0641 SS = D	Continued from page 35 and education were provided to R50, and R50 did not leave AMA (against medical advice). On 7/15/26 at 11:49 a.m., registered nurse (RN)-A, the MDS coordinator, stated R50's discharge arrangements were finalized only a couple of days before discharge and the assessment was coded as an unexpected discharge because they believed that coding was consistent with the Resident Assessment Instrument (RAI) Manual. The MDS coordinator stated R50 did not leave AMA and that although the facility did not know the exact day R50 would leave until shortly before discharge, a provider discharge order had been obtained and facility discharge instructions had been completed. On 7/15/26 at 11:59 a.m., licensed practical nurse (LPN)-A stated R50 had been working toward discharge home, discharge planning discussions had occurred several days before discharge, and a provider discharge order had been obtained. The nurse stated the uncertainty involved whether R50 would return home with family or independently, not whether R50 would be discharged from the facility. On 7/15/26 at 12:22 p.m., the nurse practitioner (NP)-D stated R50's discharge was planned and was not an unexpected discharge. On 7/15/26 at 12:47 p.m., the social services (SS)-A director stated R50's discharge had been planned, a care conference had been held regarding the discharge, and the MDS would not be expected to be coded as an unplanned discharge. Review of the RAI Manual dated 10/25, indicated an unplanned discharge occurs when the discharge was unexpected, such as an acute hospitalization or the resident leaving against medical advice. Because R50's discharge planning had occurred over several days, a provider discharge order had been obtained, discharge instructions were completed, and the resident did not leave AMA, the discharge did not meet the definition of an unplanned discharge. Facility Discharge Planning Policy dated 1/25, indicated at discharge the rounding provider must write an order for discharge, if the rounding provider refuses to write a discharge order and the resident insists on being discharged anyway refer to Against Medical advice policy.	F0641		08/21/2026
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment	F0676	How corrective action will be taken for those affected by the alleged deficient practice: R42 discharged the facility on 08/12/26.	08/21/2026

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F0676 SS = D	Continued from page 36 of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain oral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance. Findings include:	F0676	Continued from page 36 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents requiring assistance with ADLs have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed of residents requiring assistance with oral care to ensure each resident's identified oral hygiene needs and required level of assistance are accurately reflected in the care plan and are being provided. Any discrepancies were immediately corrected. Reviewed Monarch’s Activities of Daily Living (ADL)/Maintain Abilities policy and facility expectations for oral hygiene. Education provided to nursing staff on policy and facility expectations for oral hygiene assistance and documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random oral hygiene completion audits 3x week x1, weekly x 3, monthly x 2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0676 SS = D	Continued from page 37 R42's admission Minimum Data Set (MDS) dated 5/20/26, indicated cognitively intact, no rejection of care, required supervision or touching assistance with oral hygiene, diagnosis included displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture (break of the lower leg), and history of falling. R42's CAA (care area assessment) dated 5/21/26, indicated R42 had a decline in mobility following hospitalization for a fall that resulted in a right ankle fracture, in PT (physical therapy) and OT (occupational therapy) at this time, needing assistance with mobility and ADLs (activities of daily living), alert and oriented and able to make her needs known, plan to continue to provide assistance with ADLs and follow therapy recommendations. R42's care plan dated 5/15/26, indicated alternation in mobility, does not walk, assist with movement in bed and in/out bed, set up with personal hygiene. R42's task: personal hygiene the ability to use suitable items to clean teeth, dated 6/16/26-7/14/26, indicated the following data that R42 was provided setup assistance, partial assistance, or independent 6/19/26 6/20/26 6/22/26 6/24/26 6/26/26 6/27/26 6/28/26 6/29/26 6/30/26 67/1/26 7/2/26 7/3/26 7/5/26 7/7/26	F0676		08/21/2026

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F0676 SS = D	Continued from page 38 7/9/26 7/13/26 The data provided failed to indicate R42 was provided daily set up assistance with oral care. R42's treatment administration record (TAR) dated 7/1/26-7/30/26, indicated start date 5/14/26, NWB (non-weight bearing) rt (right) leg every shift, CAM boot; wea with all activities including sleeping. May remove for skin hygiene, icing and ankle ROM every shift for right ankle fracture On 7/13/26 at 10:51 a.m., R42 was observed seated in a recliner wearing a black orthopedic boot on the right lower leg. R42 stated she was non-weight bearing due to a fractured leg and required staff assistance to obtain her toothbrush, toothpaste, a cup of water, and assistance to empty the water after brushing her teeth. R42 stated she did not receive assistance with morning oral care every day. R42 stated she frequently requested assistance; however, staff told her they did not have time because they were assisting other residents. R42 stated she stopped asking because she did not want another resident to have to wait for care. R42 stated she had been moved from another area of the facility because she was told the current hallway was less busy and she would receive timelier assistance. On 7/14/26 at 8:18 a.m., R42 stated she had not yet received morning care. She stated she preferred to eat breakfast before receiving assistance to wash up. R42 also stated she previously experienced long call light response times and had been instructed to call the facility's main telephone number when her call light was not answered. On 7/14/26 at 8:51 a.m., nursing assistant (NA)-A stated there were times staff did not have enough time to assist R42 with obtaining the supplies needed to brush her teeth and acknowledged assistance could be delayed until approximately 1:00 p.m. NA-A confirmed there were occasions when R42 requested assistance and they told R42 they were too busy. NA-A further stated R42 required assistance to obtain a glass of water and to empty the cup after brushing her teeth. On 7/14/26 at 9:00 a.m., the social services director (SS)-A stated R42 had previously been moved to another hallway due to concerns regarding long call	F0676		08/21/2026

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F0676 SS = D	Continued from page 39 light response times. SS-A confirmed review of call light logs identified response times exceeding 25 minutes for R42. Staff were educated regarding timely responses, and R42 was provided the front desk telephone number if assistance was not received. SS-A acknowledged R42 should not have to call the front desk to obtain assistance. On 7/14/26 at 9:09 a.m., the administrator confirmed R42 had expressed concerns regarding long call light response times and that the call light logs had been reviewed. The administrator stated she did not recall response times greater than 30 minutes and considered call light response times exceeding 30 minutes to be significant. The adminstrator stated R42 to was moved to a "less busy hallway". On 7/14/26 at 12:37 p.m., R42 stated her teeth had been brushed that day; however, she reported she was not routinely offered assistance with brushing her teeth on weekend mornings. On 7/15/26 at 8:19 a.m., NA-A confirmed they did not have sufficient time to provide all required care to R42 on Saturday, 7/11/26, including oral care. On 7/15/26 at 8:49 a.m., licensed practical nurse (LPN)-A stated staff were expected to provide R42 with assistance to set up for teeth brushing. LPN-A stated nursing assistants were expected to notify the nurse if they were unable to provide the required assistance. LPN-A acknowledged R42 was particular about her oral hygiene. LPN-A further acknowledged staffing shortages could delay care, stating there were not enough staff to care for all residents, staff frequently had difficulty locating assistance, residents had reported waiting up to 30 minutes for assistance, and the director of nursing (DON) was aware of these concerns. On 7/15/26 at 10:20 a.m., the DON stated staff were expected to provide R42 with daily assistance to set up for tooth brushing and document the care provided. The DON stated staff were expected to complete ADL (activity of daily living) documentation before leaving their shift. The DON confirmed R42's documentation did not identify oral care was completed daily. Facility Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary are and services to ensure that a resident's abilities	F0676		08/21/2026

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F0676 SS = D	Continued from page 40 in activities of daily living do not diminish.... 3. The facility will provide care and services for the following activities of daily living a. hygiene-bathing, dressing, grooming, and oral care.	F0676		08/21/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide oral care to 1 of 1 resident (R13) who was reviewed for assistance with activities of daily living (ADLs) and who was dependent upon staff for ADL cares. Findings include: R13's diagnosis report dated 7/16/26, included diagnoses of fractured vertebrae, fracture of right radius (bone in forearm) and fracture right humerus (bone in upper arm). R13's admission Minimum Data Set (MDS) assessment dated 7/7/26, indicated intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all ADLs, including oral hygiene. R13 did not walk. R13's care plan dated 7/7/26, indicated self-care deficient related to impaired mobility and right arm fractures. Staff would assist with dental hygiene for upper denture and lower partial. During an interview on 7/13/26 at 1:43 p.m., family member (FM)-A stated staff had not been cleaning R13's dentures, a full upper and partial on the bottom. R13 stated the same, that staff did not clean her dentures. FM-A stated R13 slept with her dentures in and when FM-A removed them to clean them, they would have food and white material on them. During an interview on 7/15/26 at 10:55 a.m., nursing assistant (NA)-G stated R13 had her own teeth (R13 had upper dentures and lower partial) and admitted she had not provided oral care that morning. NA-G stated she probably should have and could have done it when R13 was sitting up in the	F0677	How corrective action will be taken for those affected by the alleged deficient practice: R13 was assisted with oral hygiene needs and care plan was reviewed to ensure resident's dependence on staff for oral care was clearly identified. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who are dependent on assistance with ADLs have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed of residents requiring assistance with oral care to ensure each resident's identified oral hygiene needs and required level of assistance are accurately reflected in the care plan and are being provided. Any discrepancies were immediately corrected. Reviewed Monarch's Activities of Daily Living (ADL)/Maintain Abilities policy and facility expectations for oral hygiene. Education provided to nursing staff on policy and facility expectations for oral hygiene assistance and documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random oral care audits 3x week x1, weekly x 3, monthly x 2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0677 SS = D	Continued from page 41 wheelchair earlier. During an interview on 7/15/26 at 1:20 p.m., both R13 and family member (FM)-A stated R13's dentures and teeth had not been cleaned yet. During an interview on 7/15/26 at 1:35 p.m., NA-G stated she still had not cleaned R13's dentures/teeth, adding that it had been busy. NA-G stated it was important to clean a resident's teeth for their overall health. During an interview on 7/16/26 at 8:48 a.m., the director of nursing (DON) was informed of findings and stated oral care was the responsibility of NAs and would expect it to be done at least twice a day. The DON stated R13 was not able to do her own oral care due to her arm injuries. Together looked POC (point of care) in the electronic medical record where NAs documented cares. For "oral hygiene," in the 15 days and 30 opportunities to complete oral care there were only 12 checkmarks indicating the level of care R13 needed for oral care, not specifically if oral care had been completed or not. Facility Activity of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would provide care and services for oral care. A resident who was not able to carry out ADLs would receive the services to maintain oral hygiene.	F0677		08/21/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement a bowel movement (BM) protocol for 1 of 1 resident (R13) reviewed for constipation. Findings include: R13's diagnosis report dated 7/16/26, included diagnoses of fractured vertebrae, fracture of right	F0684	How corrective action will be taken for those affected by the alleged deficient practice: R13 had a documented BM after administration of PRN suppository on 07/15/26. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed to ensure that no other residents were experiencing constipation and require bowel intervention. Reviewed facility standing	08/21/2026

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F0684 SS = D	Continued from page 42 radius (bone in forearm) and fracture right humerus (bone in upper arm). R13's admission Minimum Data Set (MDS) assessment dated 7/7/26, indicated intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all activities of daily living (ADLs) and did not walk. R13's physician orders dated 6/30/26, included senna (laxative) oral tablet 8.6 mg (milligrams), give three tablets by mouth as needed for constipation; three tablets two times a day as needed for constipation. In addition, orders dated 6/30/26, included: may use standing orders as signed by provider. Standing orders signed by provider 3/11/26, indicated for bowel protocol: --Milk of Magnesia (laxative) 30 cc (cubic centimeter) orally daily PRN (as needed) if no bowel movement for two days. --Dulcolax suppository (laxative), one per rectum daily PRN if no bowel movement for three days. --Fleets (brand name) or tap water enema rectally daily PRN constipation. R13's care plan dated 7/7/26, indicated an alteration in elimination related to mobility limitations and R13 would move bowels every three days or greater. R13's bowel movement task list completed by NAs, indicated R13 did not have a documented BM from 7/9/26 through the morning of 7/14/26 (six days). During an observation on 7/14/26 at 11:17 a.m., licensed practical nurse (LPN)-B spoke to R13 to ask how she was feeling. R13 reported pressure down there (hand over lower abdomen) and stated she had not had a BM for a while. After leaving the room, LPN-B accessed the electronic medical record (EMR) and saw the last documented BM for R13 had been on 7/8/26, six days ago. LPN-B had not been aware if the facility had a BM protocol or standing orders and stated she would give R13 the PRN laxative ordered for her. During an interview on 7/14/26 at 2:04 p.m., nursing assistant (NA)-D stated NAs documented resident BMs in POC (point of care) in the EMR. If a resident was independent with toileting, might not know if they had a BM unless asked. For other residents, we know if they had BM because we change their brief or take them to the bathroom. NA-D admitted a NA might forget or not have time to document cares	F0684	Continued from page 42 orders for bowel interventions. Education provided to nurses/TMAs on standing orders, BM monitoring, and facility expectations. Education provided to CNAs on facility expectations for BM documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random Bowel Movement audits to ensure compliance twice weekly x1 week, weekly x3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0684 SS = D	Continued from page 43 including BMs, in POC. During an interview on 7/15/26 at 11:45 a.m., registered nurse (RN)-C stated R13 had no results from the PRN medication given the day before, and therefore gave R13 a suppository that morning and R13 had a BM. During an interview on 7/15/26 at 12:50 p.m., RN-C stated nursing staff were expected to monitor resident BMs via the EMR and the BM sheet the night shift staff filled out indicating residents to receive a suppository after not having a BM for three days. If a resident went more than three days without a BM, staff should start the protocol per the standing orders which indicated to start with a stool softener or Milk of Magnesia, then a suppository, then an enema. RN-C pointed to the standing orders posted on the bulletin board in the nurses' station office. RN-C confirmed by what she could see, nursing staff had not been monitoring R13’s BMs since she had gone six days without a BM and no intervention. During an interview on 7/16/26 at 8:48 a.m., the director of nursing (DON) had been informed of findings. The DON stated it was not okay for a resident to go six days without a BM. The DON stated by day three, should receive a suppository per the standing orders and that all nursing staff should know that. The DON acknowledged staff had not been monitoring and addressing R13’s BMs per the standing orders. A bowel monitoring policy was requested and not received.	F0684		08/21/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F0688	How corrective action will be taken for those affected by the alleged deficient practice: R29 and R37s ambulation programs were reviewed for appropriateness and were reflected across the medical record (physician orders, care plan, Kardex, and POC). How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with ambulation programs have the potential to be affected by the alleged deficient practice	08/21/2026

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F0688 SS = D	Continued from page 44 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. Findings include: R29's diagnosis report dated 7/16/26, included generalized osteoarthritis, diabetes, generalized muscle weakness and obesity. R29's quarterly Minimum Data Set (MDS) assessment dated 4/28/26, indicated intact cognition, clear speech, could understand and be understood. R29 required partial to moderate assistance with most ADLs including walking 150 feet. R29 used a walker and wheelchair for mobility. R29's physician orders dated 7/15/25, indicated per therapy, ensure resident is walked two times a day with staff, every day and evening shift. R29's "Therapy Alert" from PT dated 7/15/25, indicated R29 should ambulate one to two times a day with FWW (front wheeled walker) and assistance of one staff. R29's care plan dated 1/26/25, indicated R29 had an alteration in mobility related to impaired mobility and to follow PT instructions. On 7/15/25, care plan indicated to ambulate R29 two times a day with FWW and assist of one. R29's Kardex (a quick reference used by nursing assistants to inform them of a resident's care) printed on 7/16/26, indicated ambulate resident two times/day with FWW and assist of one. May progress distance as tolerated by resident. R29's documentation of ambulation in POC (point of care, where NAs document in the electronic medical record) indicated out of 28 days and 56 opportunities, documentation indicated R29 had been walked only nine times.	F0688	Continued from page 44 The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit of residents with ambulation programs was completed to ensure appropriateness and were reflected across the medical record. Reviewed Monarch's Activities of Daily Living (ADL)/Maintain Abilities policy and facility expectations for mobility. Nurses and CNAs were educated on policy and facility expectations regarding compliance with therapy recommendations for ambulation programs and documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee with complete random resident walk audits to ensure compliance twice weekly x1 week, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0688 SS = D	Continued from page 45 R29's TAR (treatment administration record) completed by nursing staff, indicated: ensure R29 walked two times a day with staff every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R29 was walked 21 times. Documentation between the NA who was responsible to perform the task and documentation of the nurse who was to be informed of task completion, did not match. During an interview on 7/15/26, at 9:36 a.m., R29 had been sitting in her wheelchair in her room with walker off to the side. R29 stated she used to be on a walking program but had not walked for a while because the facility was short staffed. R13 stated she would like to walk in the hallway, so her legs stayed strong. R37's diagnosis report dated 7/16/26, included diagnoses of congestive heart failure (when the heart doesn't pump as well as it should) diabetes, generalized muscle weakness, history of falling, and obesity. R37's annual MDS assessment dated 4/15/26, indicated intact cognition, clear speech, could understand and be understood. R37 required partial to moderate assistance with ADLs, including walking 150 feet. R37 used a walker and wheelchair for mobility. R37's physician orders dated 4/13/26, indicated ensure resident ambulates one to two times per day with assist of one to manage O2 (oxygen), every day and evening shift. R37's "Therapy Alert" from PT staff dated 4/7/26, indicated ambulate resident one to two times a day with FWW and assist of one to manage O2 tubing. R37's care plan dated 4/10/24, indicated alteration in mobility related to weakness and history of falling, and to follow PT instructions. PT's walking recommendations/instructions from 4/7/26, were not included in the care plan. R37's Kardex printed on 7/16/26, did not include ambulation recommendations by PT. R37's POC had not been set up to include recommendations from PT and therefore no location in POC for NAs to document if/when they ambulated R37. R37's TAR completed by nursing staff, indicated: ensure R37 ambulates 1-2x/day with assist of 1 to	F0688		08/21/2026

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F0688 SS = D	Continued from page 46 manage O2 tubing, every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R37 was walked 27 times. However there had been no documentation by the NAs who were responsible for performing the task. During an interview on 7/15/26 at 9:30 a.m. R37 had been sitting in a wheelchair in her room with a walker off to the side. R37 stated she used to walk in the hallway but didn't anymore. R37 stated it was something she wanted to do in order to keep mobile, adding it was good for her to walk. R37 stated she used to walk to the shower room, but no longer. R37 felt she could walk if staff helped her. During an interview on 7/15/26, at 10:16 a.m., physical therapy assistant (PTA)-E, who was also the department director provided "Therapy Alert" forms for R29 and R37. PTA-E stated copies of the forms were given to the director of nursing (DON) and NAs. During an interview on 07/15/2026 1:40 p.m., nursing assistant (NA)-D stated R29 and R37 were on walking programs but admitted NAs were not always able to walk residents, including R29 and R37, due to being so busy. NA-D stated residents would usually be walked on the day and the evening shifts and sometimes that depended upon what was going on, such as an activity. NA-D stated walking was important, so residents didn't lose the ability to walk. During an interview on 7/15/26 at 4:48 p.m., with nursing assistant NA-E and NA-F, NA-E stated R29 and R37 were on a list at the desk to be walked in the morning and the afternoon. NA-E stated residents only got walked once a day due to their workload – it gets so heavy, we don't have time. NA-F agreed. NA-E stated if a resident was walked, it was charted in POC. NA-E stated sometimes the nurse would ask if they got it done and would document it too. NA-F stated most residents were in the facility for rehabilitation, and it was important they walked, adding, if you don't use it, you lose it. During an interview on 7/15/26 at 4:53 p.m., licensed practical nurse (LPN)-D stated she documented on the TAR when NAs ambulated a resident. LPN-D stated she did not always see residents being ambulated so asked the NA; if they said yes, she documented it and didn't question it. During an interview on 7/16/26 at 8:22 a.m., licensed practical nurse (LPN)-A, stated she did not know why nurses were asked to document a task	F0688		08/21/2026

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F0688 SS = D	Continued from page 47 they did not do themselves. LPN-A stated she kept track if she saw a resident being walked, or if an NA told her they walked a resident, adding she had to trust what they told her. During an interview on 7/16/26 at 8:56 a.m., the director of nursing (DON) stated resident recommendations for walking came from PT. When received, the residents name would be added to a list at the nurses' station to inform NAs which residents should be walked. The DON was asked to look in POC for documentation of R29 and R37 being walked. For R29, the DON admitted R29 had not been walked according to PT recommendation, physician order, care plan and Kardex. For R37, POC had not been set up for NAs to document her walking and couldn’t say why, or how NAs documented this task without POC. The DON stated she did not monitor whether or not residents were walked according to PT recommendations, nor did she monitor documentation. The DON stated she asked the nurses if residents were walked even though they did not perform the task. The DON stated she knew the afternoon shift struggled with walking residents due to meals, bedtime and staff breaks. The DON stated it was important to walk residents, so they didn’t lose the ability to walk, it improved breathing and prevented formation of contractures. The DON stated she had been informed by NA staff they didn’t have time to walk residents but told them they could ask nurses to help them. Facility Activities of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would ensure a resident was given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility would provide care and services including walking.	F0688		08/21/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F0880	How corrective action will be taken for those affected by the alleged deficient practice: East hall bath tub chair cushions were replaced on July 16, 2026 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who use the tub room have the potential to be affected by the alleged deficient practice	08/21/2026

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F0880 SS = D	Continued from page 48 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 48 The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed to ensure no other bath tub chair cushions needed replacement. Reviewed Monarch's Infection Prevention and Control Program policy and facility process for reporting infection control or maintenance concerns. Education provided to all staff on policy and expectations for reporting concerns of items that have been broken down and do not meet the regulatory requirements required for homelike environment or infection control. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance Director or designee with audit facility bath tub chair cushions monthly and will report to QAPI committee for further review and recommendations.	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE REHABILITATION CENTER LLC	108 8TH STREET NORTHWEST , WASECA, Minnesota, 56093

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F0880 SS = D	Continued from page 49 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to maintain reusable resident care equipment in a manner that could be effectively cleaned and disinfected by continuing to use a bathtub chair with torn and cracked cushion surfaces in the east hallway bath room. This had the potential to affect any of the 19 residents residing on the east and west hallways who used the tub room. Findings include: On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed the shower chair seat with a black vinyl cushion contained multiple tears, cracks, and openings throughout the seating surface. Portions of the vinyl covering were missing, exposing the underlying light-colored cushion material. The damaged areas created multiple irregular surfaces and openings across the seat cushion. On 7/15/26 at 12:50 p.m., nursing assistant (NA)-A stated the bathtub room was used for residents and confirmed the cracked shower chair was used. NA-A stated they placed a towel on the chair before residents use it. On 7/15/26 at 12:51 p.m., licensed practical nurse (LPN)-A stated the bathtub chair cushion was cracked and had openings and stated it "could be an infection control issue." On 7/15/26 at 12:55 p.m., maintenance director (MD)-A confirmed the bathtub chair cushion was cracked and damaged and stated they it would be expected to be replaced and stated they were not aware of the cushion's condition. On 7/15/26 at 12:59 p.m., the administrator observed the bathtub chair cushion and confirmed the cushion should not be in that condition due to infection control concerns. The administrator stated staff would not be expected to use the shower chair if the cushion was cracked. On 7/15/26 at 4:48 p.m., the director nursing (DON), also known as the infection preventionist, stated the	F0880		08/21/2026

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D F0880 SS = D	Continued from page 50 shower chair was not expected to have cracked cushions and stated the damaged cushion could present an infection control problem. The facility Infection Prevention and Control Program policy dated 11/24, indicatedPrevention of Infectioninstituting measures to avoid complicationseducating staff and ensuring that they adhere to proper techniques and procedures	F0880		08/21/2026
F F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F0732	How corrective action will be taken for those affected by the alleged deficient practice: The current nursing hours were posted, according to regulatory requirements, when the concerns were identified. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The regulation for Posted Nurse Staffing Information has been reviewed. Facility process of ensuring accuracy at the beginning and end of day and expectations were implemented. Scheduler was educated on facility expectation to ensuring accuracy and updated when there is a change to staffing levels. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits of posted staffing information to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0732 SS = C	Continued from page 51 (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure the posted nursing hours were updated when there was a change to staffing levels. This had the potential to affect all residents and visitors of the facility. Findings include: During an observation and interview on 3/14/26 at 10:45 a.m., the daily staffing hours were posted in the main entrance area visible to all residents and visitors but were dated 3/13/26. Licensed practical nurse (LPN)-A was observed taking out the page for 3/13/26, and inserting the new daily staffing hours for 3/14/26. Review of the daily staffing hours posted for 3/13/25, indicated the following hours: Days: one registered nurse (RN), one LPN, one trained medication aide (TMA), four nursing assistants (NAs). Evenings: two RNs, four NAs. Nights: one LPN, two NAs. Review of the daily staffing hours posted for 3/14/26, indicated the following hours: Days: two LPNs, one TMA, four NAs. Evenings: one RN, one LPN, four NAs. Nights: one LPN, two NAs.	F0732		08/21/2026

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F0732 SS = C	Continued from page 52 Review of facility schedules dated 7/13/26 and 7/14/26, indicated additional NAs on each day to assist with baths that were missed on the weekend. On 7/13/26, an additional nursing assistant was scheduled from 10:30 a.m. to 2:30 p.m., and on 7/14/26, an additional nursing assistant was scheduled from 11:00 a.m. to 2:30 p.m. There were no changes made to the daily staffing posting to reflect these changes in staffing totals. During interview on 7/14/26 at 10:45 a.m., director of nursing (DON) stated she had added extra staff to assist with making up baths from the weekend that did not get done. DON further stated she would expect the daily staff posting to be updated when there were changes to the schedule. DON confirmed the postings had not been updated to reflect accurate information on either 7/13/26 or 7/14/26. During interview on 7/16/26 at 2:45 p.m., administrator stated it was the responsibility of the TMA to update the daily staff posting in real time, but she also kept on eye on it. Administrator confirmed the updates had not been made on 7/13/26 or 7/14/26, and she would have expected them updated to reflect accurate staffing levels. A policy on daily staff postings was requested but not received.	F0732		08/21/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 1, 2026

Administrator
LAKESHORE REHABILITATION CENTER LLC
108 8TH STREET NORTHWEST
WASECA, MN 56093

RE: CCN: 245388
Cycle Start Date: July 16, 2026

Dear Administrator:

On August 26, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 1, 2026

Administrator
LAKESHORE REHABILITATION CENTER LLC
108 8TH STREET NORTHWEST
WASECA, MN 56093

Re: Reinspection Results
Event ID: 235CEB-H2

Dear Administrator:

On August 26, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 16, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.

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E0000	Initial Comments On 7/13/26 to 7/16/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		08/21/2026
F0000	INITIAL COMMENTS On 7/13/26 to 7/16/26, a standard recertification survey (S5388040) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. NO deficiencies were cited. H53883229C iQies # 2717031 H53883337C iQies # 3000657 H53883338C iQies # 2997280 H53883232C iQies # 2624776 H53883232C iQies # 2624512 The following complaints were reviewed with deficiencies cited at: H53883228C iQies # 2741658 with deficiencies cited at F725 H53883230C iQies # 2653216 with deficiencies cited at F676	F0000		08/21/2026

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

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

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D F0000	Continued from page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		08/21/2026
F F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by:	F0725	How corrective action will be taken for those affected by the alleged deficient practice: Residents (R7, R4,R13, R31,R45,R35, R37, R42, R29, R35,R8, R24, R33) were reviewed to ensure that all nursing care, treatments, activities of daily living, and any other need for assistance were provided timely and according to each resident's plan of care. Any identified unmet needs were immediately addressed. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit of call light response times including R7, R4,R13, R31,R45,R35, R37, R42, R29, R35,R8, R24, R33 was completed and identified concerns were investigated. The regulation and Lakeshore's Facility Assessment were reviewed. Updates were made to the Facility Assessment as required. Facility staffing expectations were developed to ensure sufficient staffing for providing care and assistance in a timely manner which staff were educated on. All staff were educated on the importance of answering call lights in a timely manner. Nursing staff were educated on the expectation of using walkie talkies to increase communication.	08/21/2026

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F0725 SS = F	Continued from page 2 Based on interview and document review, the facility failed to provide sufficient nursing staff to ensure 13 of 13 residents (R7, R4, R13, R31, R45, R35, R37, R42, R29, R35, R8, R24, R33), reviewed for sufficient staffing, received care and assistance in a timely manner. The lack of sufficient staff had the potential to affect all 42 residents who resided in the facility. . Findings include: Refer to F676: Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain ral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance. Refer to F677: Based on interview and document review, the facility failed to provide oral care to 1 of 1 resident (R13) who was reviewed for assistance with activities of daily living (ADLs) and who was dependent upon staff for ADL cares. Refer to F688: Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. RESIDENT/FAMILY INTERVIEWS/ CALL LIGHT RESPONSE TIMES R7’s quarterly Minimum Data Set (MDS) assessment dated 6/26/26, indicated orthopedic aftercare for hip fracture. R7 had intact cognition, clear speech, could understand and be understood. R7 required substantial assistance or was dependent upon staff for activities of daily living (ADLs). R7 was always incontinent of bowel and did not walk. During an interview on 7/13/26 at 11:21 a.m., R7 stated the facility was chronically short-handed; he didn’t have bowel control and used his call lights to have his brief changed or to get in or out of bed. R7 stated he was frustrated with the length of time it took staff to answer his call light. R7 had 216 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 17	F0725	Continued from page 2 Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random staffing schedule, call light, & census audits to ensure compliance 3x per week x 1, weekly x 3, monthly x2, and reported to QAPI committee for further review and recommendations.	08/21/2026

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F0725 SS = F	Continued from page 3 31-40 minutes = 6 41-50 minutes = 5 51-60 minutes = 1 61-70 minutes = 1 >70 minutes = 2 >130 minutes = 2 >150 minutes = 1 R4's quarterly MDS assessment dated 7/17/26, indicated cardio/respiratory condition, including congestive heart failure (when the heart cannot pump efficiently to meet the body's needs). R4 had intact cognition, clear speech, could understand and be understood. R4 required substantial assistance with oral hygiene, dressing, standing, sitting, toileting and walking short distances. During an interview on 7/13/26 at 10:25 a.m., R4 stated it took a long time for staff to answer her call light, "I'm at the end of the hallway and I feel pissed off; happens daily." R4 had 342 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 19 31-40 minutes = 2 41-50 minutes = 1 51-60 minutes = 2 61-70 minutes = 1 R13's admission MDS assessment dated 7/7/26, indicated orthopedic after care for fractures and other multiple trauma. R13 had intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all ADLs, was frequently incontinent of stool and did not walk. During an interview on 7/13/26 at 1:33 p.m., family member (FM)-A stated a few times when she had come into R13's room, her call light was not in reach and R13 had to yell for help. FM-A stated R13 was able to activate her call light and had waited up to 45 minutes for someone to respond. FM-A stated	F0725		08/21/2026

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F0725 SS = F	Continued from page 4 R13 had called her crying when no one came. FM-A stated R13 had pounded a cup on the overbed table to get the staff's attention. Observed call light on the floor behind the bedside dresser. FM-A handed it to R13. R13 had 111 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 3 31-40 minutes = 3 41-50 minutes = 2 51-60 minutes = 2 >80 minutes = 1 R31's quarterly MDS assessment dated 6/15/26, indicated fractures, heart failure and Alzheimer's disease. R31 had severe cognitive impairment, clear speech, could understand and be understood. R31 required substantial assistance with most ADLs, was always incontinent of bladder and bowel, and did not walk. During an interview on 7/13/26 at 2:08 p.m., R31 stated the facility was short staffed in the evening, and it took a long time for his call light to be answered. R31 stated he waited up to 45 - 60 minutes. R31 stated call lights were discussed at resident council meetings, but residents were pretty much blown off. R31 stated he used his call light to use bathroom or lay down. R31 stated staff ran and hurried and apologized, but there were not enough of them. R31 had 172 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 13 31-40 minutes = 5 41-50 minutes = 6 51-60 minutes = 1 71-80 minutes = 1 >140 minutes = 1 R45's quarterly MDS assessment dated 7/6/26,	F0725		08/21/2026

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F0725 SS = F	Continued from page 5 indicated stroke and heart failure. R45 had moderately impaired cognition, clear speech, could understand and be understood. R45 was always incontinent of bladder and bowel and did not walk. During an interview on 7/13/26 at 11:08 a.m., R45 stated he waited a long time for his call light to be answered. R45 stated service was better when he moved in (2024), but not now. R45 stated he had called the fire department and his sister for help in the past when no one answered his call light. R45 stated he used his call light for brief changes, get in or get out of bed. R45 had 34 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: >30 minutes = 1 >40 minutes = 2 R35's quarterly MDS assessment dated 6/19/26, indicated heart failure and diabetes. R35 had intact cognition, clear speech, could understand and be understood. R35 required substantial assistance for most all ADLs, was always incontinent of bladder and bowel and did not walk. During an interview on 7/13/26 at 3:13 p.m., R35 stated she had waited up to 1 1/2 hours for staff to answer her call light. R35 stated she used her call light for the bathroom and to go to activities. R35 stated she stayed in her wheelchair rather than recliner because it took too long for staff to come, and if in her wheelchair, was ready to go. R35 had 257 activations call light activations dated 5/12/26- 7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 19 31-40 minutes = 11 41-50 minutes = 6 51-60 minutes = 1 61-70 minutes = 4 71-80 minutes = 1 91-100 minutes = 1	F0725		08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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F0725 SS = F	Continued from page 6 R37's annual MDS assessment dated 4/15/26, indicated R42 was cognitively intact, required supervision with personal hygiene, and partial/moderate assistance with dressing and transfers, utilized a manual wheelchair and diagnoses included muscle weakness. R37's care plan dated 6/2/26, indicated fall risk related to weakness, history of falling, assistance with ADL (activity of daily living) and transferring and interventions including monitor and document on safety, reminder sign on bathroom door to call for staff assist with toileting, assist of one with toileting. On 7/13/26 at 11:30 a.m., R37 was seated in a wheelchair in their room and stated they sometimes had to wait a long time for assistance while in the bathroom. R37 stated when they were unable to clean themselves after toileting, they remained in the bathroom waiting for staff assistance for approximately 30 minutes to one hour. R37 stated they would do what they could independently and return to their room without receiving assistance. R37 stated they did not like having to wait but understood staff were busy. R37 stated the delay was worse on the day shift and stated they were no longer able to clean themselves independently. Call light times dated 5/12/26-7/12/26, indicated the following : 143 activations 21-30 minutes = 8 31-40 minutes = 9 41-50 minutes = 8 51-60 minutes = 3 61-70 minutes = 1 >70 minutes = 2 R42's admission MDS dated 5/20/26, indicated cognitively intact, no rejection of care, required supervision or touching assistance with oral hygiene, diagnosis included displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture (break of the lower leg), and history of falling. R42's CAA (care area assessment) dated 5/21/26, indicated R42 had a decline in mobility following	F0725		08/21/2026

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F0725 SS = F	Continued from page 7 hospitalization for a fall that resulted in a right ankle fracture, in PT (physical therapy) and OT (occupational therapy) at this time, needing assistance with mobility and ADLs (activities of daily living), alert and oriented and able to make her needs known, plan to continue to provide assistance with ADLs and follow therapy recommendations. R42's care plan dated 5/15/26, indicated alternation in mobility, does not walk, assist with movement in bed and in/out bed, set up with personal hygiene. On 7/13/26 at 10:46 a.m., R42 stated they had to wait approximately 30 to 45 minutes for staff assistance with toileting needs, including urination and bowel movements. R42 stated they had not experienced accidents due to the delays but began wearing a brief because of the concern. R42 stated weekends were the worst due to short staffing and stated delays also occurred during shift change and during the week. R42 stated they learned to request assistance before shift change because staff would tell them, "Sorry, we are short staffed." R42 stated there were times when they were left waiting on the commode and reported they had previously complained and cried about the delays, resulting in a room change to a different hallway. R42 stated delays continued after the move and were especially concerning when only one staff member was available when two staff members were needed for assistance. Call light times dated 5/12/26-7/12/26, indicated the following : 280 activations 21-30 minutes = 20 31-40 minutes = 11 41-50 minutes = 3 RESIDENT COUNCIL R29’s quarterly MDS assessment dated 5/1/26, indicated intact cognition, use of walker and wheelchair, partial assistance with toileting, bathing, and transfers, and diagnoses of heart failure and high blood pressure. R35’s quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of wheelchair, dependent with toilet use, substantial assistance with bathing, substantial assistance for transfers, and diagnoses of heart failure and kidney	F0725		08/21/2026

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F0725 SS = F	Continued from page 8 insufficiency. R8's admission MDS assessment dated 6/26/26, indicated intact cognition, use of walker and wheelchair, substantial assistance for toileting and dressing, independent with transfers, and diagnoses of high blood pressure and diabetes mellitus. R24's quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of walker, independent with hygiene, dressing, and transfers, and diagnoses of cancer and heart failure. R33's quarterly MDS assessment dated 6/5/26, indicated intact cognition, use of walker and wheelchair, independent with dressing, eating, and transfers, and diagnoses of high blood pressure and Parkinson's disease. During resident council meeting on 7/14/26 at 1:50 p.m., the following statements were documented: R29 stated staffing was a big concern at the facility. R29 stated she waited over 30 minutes for her light to be answered and sometimes had to have her bath rescheduled. R29 further stated concerns had been brought up at resident council meetings but the council had not heard back on what had been done about staffing concerns and long call light wait times. R35 stated her call light was answered after 30 minutes and sometimes up to 90 minutes. R35 stated that was too long to wait. R35 also stated she missed her bath due to lack of staff at the facility. R8 stated she was fairly independent and did not need much help, but has heard other residents say it took a long time for their lights to be answered. R8 stated she participated in resident council meetings and staff response time and lack of staff was always a topic, but had not heard a response from the facility. R24 stated she waited over 30 minutes multiple times for her light to be answered and she thought weekends were particularly worse. R24 further stated she had missed her bath and it sometimes took three days for staff to get caught up and give her a bath. R24 stated she did not like waiting an additional three days. R33 stated 20 minutes was too long for him, and he often had to wait over 20 minutes. R33 further stated if he had to go to the bathroom and waited over 20 minutes, he would have an accident in his brief. R33	F0725		08/21/2026

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F0725 SS = F	Continued from page 9 stated he had accidents due to waiting more than he would like to admit. During interview on 7/15/26 at 7:58 a.m., activities assistant (AA)-A stated she facilitated resident council meetings and took meeting minutes. AA-A stated the facility did not do a formal follow-up to resident concerns, did not have anything in writing, and did not recall how or if resident council concerns regarding staffing had been addressed. STAFF INTERVIEWS During a confidential interview, employee-C stated the unit known as the south unit, used to have three nursing assistants (NAs) and now had two. Employee-C was aware some residents complained of long call light wait times. Employee-C stated the unit had a lot of residents who required significant assistance from NA staff for dressing, toileting, and two staff for transfers and/or use of mechanical lifts. In addition, employee-C stated staff were not provided walkie-talkies so spent a lot of time looking for each other. Employee C stated it was important for NA staff to be able to communicate information to the nurse quickly, and if had to go room to room looking for the nurse, valuable time could be wasted. Employee C stated many times she has had to go room to room looking for an NA. During a confidential interview, employee-F stated it was pretty common to get complaints from residents about long call light wait times and they were surprised when she got there right away. Employee-F stated the facility did not use walkie-talkies and often had to go room to room to look for a coworker. Employee F stated she had been in a situation where a resident fell, had to put a pillow under their head, and leave the room to find the nurse. Employee-F stated they had a meeting last year after State surveyors left and they brought up walkie-talkies, but nothing changed. Employee F stated a lot of things were talked about, but nothing got done. Employee-F stated currently six residents required the use of a mechanical lift which tied up two NAs for long periods. Employee F stated NAs gave baths on the evening shift which she didn't think was good because that left the other NA on the floor alone causing delays in helping with two-person assists. During a confidential interview, employee B stated she was aware some agency nurses would not return to work at the facility because staffing levels never improved. Employee B stated the south unit had 24 high-acuity residents with only two NAs,	F0725		08/21/2026

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F0725 SS = F	Continued from page 10 adding that was a safety concern. Employee-B stated leadership knew they were short staffed and should be doing something about it. Employee-B stated staff were afraid to speak up for fear of losing their job. Employee-B stated there were no walkie-talkies for communication, so staff had to run around to track people down. Employee-B stated the facility was not able to meet the needs of residents and was aware some families had removed their family member from the facility because of that. During a confidential interview, employee-D stated they were short staffed and used a lot of agency staff. Employee D stated they did their best but acknowledged residents sometimes waited a long time to get care. Employee D stated they did not use walkie-talkies, so often had to go up and down the hall looking for help and that caused delays. On 7/13/26 at 5:00 p.m., nursing assistant (NA)-B stated there were two nursing assistants working today. NA-B stated that on the previous evening, after 6:00 p.m., they were the only nursing assistant because the agency staff member who had been scheduled to work did not report. NA-B stated the agency staff member had been scheduled to work doubles throughout the weekend but was unsure whether they had reported for any of the shifts. NA-B stated they provided evening cares and answered call lights by herself the day prior. NA-B stated it was not common to have only one nursing assistant scheduled on the east and west, due to agency staff not showing for the scheduled shift. NA-B stated there were usually two nursing assistants assigned to the south hall and estimated approximately six residents required two-person assistance. NA-B stated call light response times could be delayed depending on the how many staff were working and the needs of the residents. NA-B stated the facility does not have any tools in place to assist staff with requesting help such as walkie talkies and staff would need to yell if assistance was needed. On 7/13/26 at 5:10 p.m., licensed practical nurse (LPN)-A, stated two nursing assistants were sufficient for the east and west hallway, but if only one nursing assistant was available the nurse would need to assist. LPN-A stated it occurred more often that only one nursing assistant was available because agency staff failed to report for work. LPN-A stated when this occurred, staff attempted to call employees who were off duty and notified the director of nursing for direction. On 7/13/26 at 5:43 p.m., a call light illuminated for	F0725		08/21/2026

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F0725 SS = F	Continued from page 11 Room 11. NA-C was observed responding to the call light. At 5:46 p.m., another call light illuminated for Room W-2 while NA-C remained in Room 11. NA-C stated, "I can't leave this resident alone. My partner is on break." The call light remained active until 5:57 p.m. On 7/13/26 at 6:21 p.m., NA-C stated they had been asked to report early to their shift because baths scheduled over the weekend had not been completed and staff were attempting to complete the missed baths. On 7/14/26 at 8:32 a.m., the trained medication aide (TMA)-B stated it was difficult for one TMA to complete medication administration and additional help would be beneficial. The TMA stated they were the only TMA for the building. The TMA stated there were usually two NA's scheduled for east and west hall but occasionally only one was available when someone called in or agency staff did not report. On 7/14/26 at 8:46 a.m., NA-A stated they were scheduled to work from 6:00 a.m. to 2:30 p.m., on 7/11/26, but remained at the facility until 6:00 p.m. because another staff member did not report. NA-A stated they were the only nursing assistant on Sunday 7/12/26, from 6:00 a.m. to 2:30 p.m. NA-A stated baths, resident weights, and ambulation were not completed because only one nursing assistant was available. NA-A stated residents experienced delays in call light response times and questioned why staff took longer to respond. NA-A stated it was not uncommon to have only one nursing assistant working on weekends. On 7/14/26 at 9:07 a.m., the social services director (SS)-A stated residents had complained about call light response times and was "not a surprise". SS-A stated when residents have concerns regarding call light response times, residents were encouraged to speak with the charge nurse and staff are educated regarding the concerns. SS-A stated concerns regarding call light response times were a known concern at the facility and stated it was not a surprise that concerns regarding resident call lights were identified during the survey. On 7/14/26 at 9:09 a.m., the administrator stated call light response times had previously been reviewed and acknowledged there were some lengthy response times. The administrator stated they could not specifically recall any exceeding 30 minutes but believed any response time over 30 minutes would be considered significant. The administrator stated R42 voiced concerns with long	F0725		08/21/2026

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F0725 SS = F	Continued from page 12 call light times and R42 call lights were reviewed and the administrator stated they did not remember whether there were more than two occurrences over 30 minutes. The administrator stated staff discussed the concerns with R42 and believed transferring R42 to another wing would improve response times. The administrator stated additional call light logs were not reviewed because no grievances had been filed. The administrator stated the facility does not routinely conduct call light audits. The administrator stated the last review of call light logs occurred approximately two months earlier during an investigation in which each wing was reviewed. The administrator stated concern would generally be identified if more than two or three rooms demonstrated call light response times exceeding 30 minutes. The administrator stated they did not review the call light logs provided during this survey, did not believe the facility had long call light response time issues, and stated concerns would be addressed in real time rather than through the QAPI process. On 7/14/26 at 9:36 a.m., LPN-B stated call light response times on the south hall could exceed 30 minutes. LPN-B stated staff were burned out, were frequently called on their days off to pick up shifts due to staffing shortage, residents missed baths and resident ambulation was not completed occurred due to staffing shortages. LPN-B stated some residents did not receive breakfast until approximately 9:30 a.m. because morning cares were delayed. LPN-B further stated the facility did not provide walkie-talkies, requiring staff to search for coworkers when assistance was needed, which further delayed resident care and call light response. On 7/14/26 at 9:45 a.m., NA-D stated when staff members leave for breaks, only one staff member remains on the unit, resulting in residents frequently experiencing long wait times for assistance. NA-D stated when a resident requires a two-person transfer to the toilet, other residents may have to wait for assistance until additional staff are available. NA-D stated management was aware of long call light response times and that the facility's computer system tracked call light response times. NA-D stated staff had voiced concerns regarding delayed response times to management and were instructed to respond to residents more timely; however, staffing levels were not increased. NA-D stated staff responded to call lights as quickly as possible and did not have downtime but could not respond more quickly when there were not enough staff available. NA-D further stated staffing decisions were based solely on resident census. NA-D confirmed R42 had	F0725		08/21/2026

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F0725 SS = F	Continued from page 13 been moved to a different unit due to concerns regarding delays in receiving care. NA-D further stated overnight staff would at times assist R42 to the toilet and then leave to assist another resident, resulting in R42 waiting approximately 30 minutes for assistance before staff returned. On 7/14/26 at 2:42 p.m., nursing assistant (NA)-C stated the facility had a lot of staff who didn't come for their shifts, especially on the weekends, particularly agency staff. NA-C further stated the facility used a star system to ensure coverage and she had to stay later than her scheduled shift often to cover for other staff who didn't show up. NA-C stated staffing was not adjusted based on resident needs, there was always a set number of three or four nursing assistants no matter how many residents there were in the facility. NA-C stated it was hard to get help when needed and residents had to wait a long time. On 7/14/26 at 2:46 p.m., NA-B stated when they were short-staffed residents had to wait a long time for help. NA-B further stated they were short-staffed a lot, especially on weekends. On 7/14/26 at 4:51 p.m., the director of nursing (DON) stated weekend staffing schedules posted in the facility were not updated in real time to reflect actual staffing. The DON stated they spent a significant portion of her day providing resident care because of staffing shortages and stated agency staff had contributed to the staffing problems and doing a disservice to the facility. On 7/15/26 at 6:38 a.m., LPN-C stated she worked the night shift and if there were 42 residents, one nurse and two NAs were adequate, but when the census rose to 47 or 48 it was not. LPN-C stated there were one NA on each floor and her, and at 1:30 a.m., and 4:30 a.m., the NA from first floor went to second floor to help, and they covered each other for breaks. LPN-C stated they used to have walkie-talkies but didn't anymore and didn't know why, so they used their personal cell phones or the house phone to contact each other. In order to know if a call light was going off, LPN-C stated staff had to be in the hallway to observe the scrolling marquee and might hear the beep (indicating a call light was activated) or you might not. On 7/15/26 at 8:49 a.m., LPN-A stated that when staffing is limited, nurses may need to assist; however, one staff member caring for approximately 21 residents is insufficient. LPN-A stated they have heard residents report staffing shortages on multiple	F0725		08/21/2026

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F0725 SS = F	Continued from page 14 occasions. LPN-A further stated the south wing requires three staff members and delays occur when staff must search room-to-room for assistance. LPN-A stated staff previously used walkie-talkies, but without them staff may not know another resident requires assistance. LPN-A stated they had spent significant time looking for available staff and has been told by residents they have waited up to 30 minutes for assistance. LPN-A stated the director of nursing (DON) was aware of these concerns and frequently works on the floor, where the issues should be readily apparent. LPN-A stated the facility did not provide staff with walkie-talkies. LPN-A stated this created a safety concern because if a resident fell, was bleeding, or required immediate assistance while staff were in another resident's room, they would not be able to quickly obtain help from another staff member. On 7/15/26 at 9:05 a.m., maintenance director (MD)-A provided resident care unit distance measurements: first floor from beginning of the east hallway to end of the west hallway was 130 feet (equivalent to a 12-13 story building). Distance on the south unit, from first room to last room was 206 feet (more than half the distance of a football field) On 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the time of the interview and that he was covering her responsibilities. VPO stated the facility administrator was responsible for completing the facility assessment, and stated that he would expect the facility assessment to include staffing numbers and information regarding the facility's staffing levels. VPO did not identify any specific staffing concerns and stated that the facility occasionally utilizes agency staff to address staffing needs when necessary. VPO stated that the administrator would be expected to review staffing trends and patterns, ask specific questions regarding identified issues, and ensure that appropriate actions were implemented. VPO stated if concerns such as extended call light response times were identified, the administrator would be expected to investigate the issue by asking questions such as when the delays are occurring, whether they are isolated to a particular shift and what interventions were needed. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program.	F0725		08/21/2026

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F0725 SS = F	Continued from page 15 On 7/15/26 at 2:30 p.m., the DON stated staffing levels were determined based on resident acuity, resident census, holidays, anticipated resident needs, and hours per resident day (PPD), with a target of approximately 3.0 PPD. The DON stated resident needs were reviewed during the morning meeting, including new admissions and residents requiring additional assistance. However, when asked how resident acuity was incorporated into staffing decisions, the DON was unable to clearly explain the process or identify how staffing assignments were adjusted to meet resident care needs. The DON stated staffing assignments varied by unit, with lighter staffing on the east and west halls and staff floating to the south hall as needed. The DON stated staff were supposed to carry pagers to receive call light notifications but acknowledged the pagers were missing and stated, "Maybe they're lost." The DON further stated staff would have to leave a resident's room to view the scrolling call light display at the end of the hallway. The DON stated the facility had purchased walkie-talkies approximately one month earlier but had not implemented their use. After discussion regarding delayed staff response, the DON stated walkie-talkies could be implemented that evening to improve communication. When asked how the facility determined staffing was adequate, the DON stated residents were cared for, there were no odors, pressure ulcers were not worsening, residents were happy, and meals were provided. However, the DON was unable to identify specific monitoring processes to ensure resident oral care, bathing, and other activities of daily living (ADLs) were consistently completed. The DON acknowledged managers, including the DON, frequently provided direct resident care because of staffing shortages and stated the facility did not have enough staff to add additional personnel. The DON further stated nursing assistant documentation was poor because some staff lacked electronic medical record (EMR) access, documentation was lost, agency staff lost documentation, and staff did not have time to complete documentation. When informed that multiple residents and staff independently reported delays in care and prolonged call light response times, the DON stated there was no explanation for why this was occurring. On 7/15/26 at 3:03 p.m., the administrator stated daily staffing decisions were based on resident census, resident acuity, and PPD following discussion of admissions, discharges, and resident needs during the daily stand-up meeting. The administrator stated staffing adequacy was evaluated by the absence of wounds, falls, odors, resident	F0725		08/21/2026

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F0725 SS = F	Continued from page 16 complaints, and whether residents were coming to the nurses' station. The administrator acknowledged the facility did not routinely monitor call light response times and stated the last review of call light data occurred approximately two weeks earlier for a single resident concern rather than reviewing facility-wide trends. The administrator stated staffing was adjusted for resident acuity, including hospice residents, residents requiring mechanical lifts, extensive wounds, and psychosocial needs. However, the administrator acknowledged staff communication regarding resident call lights was not functioning as expected. The administrator believed staff carried pagers but acknowledged only one working pager was available at each end of the building and stated staff would have to leave a resident's room to obtain assistance or holler for help because no established communication process was in place. The administrator further stated staff were expected to complete documentation throughout the shift "when they have a minute", however no time is dedicated to documentation. On 7/15/26 at 3:41 p.m., RN-C, known as the regional nurse consultant, stated staffing levels were based on PPD and resident acuity, with staffing increased when residents required additional care. RN-C stated the facility was budgeted for a specific PPD and staffing adjustments required clinical justification. However, RN-C acknowledged resident care was not consistently being completed and specifically identified oral care not being completed, resident ambulation needs not being met, and prolonged call light response times. RN-C stated two nursing assistants assigned to the south hall were "probably not enough." RN-C further stated there had been no documented staff meetings or documented follow-up regarding staffing concerns and would have expected documentation of education and corrective actions related to identified staffing issues. On 7/16/26 at 8:20 a.m., NA-E stated the facility needed four or more nursing assistants during the day and evening because of the floor plan of the facility, especially during busy times. NA-E stated they put on a lot of steps each day and covered a lot of area. NA-E stated it was hard to get everything done on time and baths got missed and pushed off to other days. On 7/16/26 at 8:22 a.m., NA-A stated it was hard to get her work done on time, especially because there was no way to communicate with other staff. NA-A stated when she needed assistance she would have to search for another staff member and that took up	F0725		08/21/2026

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F0725 SS = F	Continued from page 17 extra time. Review of the facility assessment dated 6/1/26, indicated the following: Direct Care Staffing Plan: To ensure an adequate amount of staff at Lakeshore Rehabilitation Center at all times, the resident population, CMI, and census is taken into account daily to determine sufficient staffing needs. Lakeshore's IDT reviews census on the daily census template sent out daily by Health Information to determine the needs on each unit. Any admission and discharges planned also factor in and assist in determining the staffing needs for each day on each unit. Individual assignments for continuity of care for residents and across staff assignments is determined by the DON, Nurse Management, Charge Nurse, Unit Nurse in that order of hierarchy. During interview on 7/15/26 at 2:34 p.m., administrator stated staffing should be based off the facility assessment, but the facility assessment was lacking any indication of how many staff were needed at the facility. Administrator further stated she did not have a specific algorithm for determining staffing levels and making necessary adjustments. A staffing policy was requested but not received.	F0725		08/21/2026
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to:	F0838	How corrective action will be taken for those affected by the alleged deficient practice: The facility assessment has been modified to include staffing levels needed for specific shifts. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Lakeshore’s Facility Assessment was reviewed, updated, and will continue to be reviewed annually and as needed.	08/21/2026

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F0838 SS = F	Continued from page 18 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based	F0838	Continued from page 18 The IDT was educated and understands the requirements of the facility assessment. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Audit of the facility assessment will be conducted quarterly at the QAPI meeting to ensure all parts are included and will adjust as necessary.	08/21/2026

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F0838 SS = F	Continued from page 19 risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the	F0838		08/21/2026

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F0838 SS = F	Continued from page 20 availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Facility Assessment included information on staffing levels needed for specific shifts. This deficient practice had the potential to affect all 42 residents who resided in the facility. Findings include: Review of Facility Assessment dated 6/2026, indicated the following: Section 3. Facility resources needed to provide competent support and care for our resident population every day and during emergencies: 3.2 & 3.3. Direct Care Staffing Plan: To ensure an adequate amount of staff at Lakeshore Rehabilitation Center at all times, the resident population, case mix index (CMI), and census if taken into account daily to determine sufficient staffing needs. Lakeshore's interdisciplinary team (IDT) reviews census on the daily census template sent out daily by Health Information to determine the needs on each unit. Any admissions and discharges planned also factor in and assist in determining the staffing needs for each day on each unit. Individual staff assignments for continuity of care for residents and across staff assignments is determined by the director of nursing (DON), nurse management, charge nurse, unit nurse in that order of hierarchy. The facility assessment did not include information on staffing levels needed for specific shifts, such as day, evening, and night and adjusted as necessary based on changes to resident population. During interview on 7/14/26 at 3:37 p.m., when confirming the provided facility assessment was correct, administrator stated she gave the state agency (SA) the correct and most current version and she would not put specific information in the facility assessment about staff requirements for each shift because staffing fluctuates so much. During interview on 7/15/26 at 8:02 a.m., administrator stated she was aware specific staffing date should be in the facility assessment, and she must have accidentally deleted the staffing information. Administrator stated she reached out to corporate for an updated version. Administrator further confirmed the facility did not use the daily	F0838		08/21/2026

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F0838 SS = F	Continued from page 21 census template to review staffing needs as directed in the facility assessment, but the IDT did talk about census daily. Administrator also stated the facility did not have a specific algorithm they used to determine needed staffing levels and would refer to their facility assessment to determine staff needed to meet resident's needs. A facility document titled Staffing Levels Per Patient Day (PPD) Compliant undated, indicated staffing levels were based on resident census numbers. A facility policy on facility assessment requirements was requested but not received.	F0838		08/21/2026
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State	F0865	How corrective action will be taken for those affected by the alleged deficient practice: The facility implemented an Ad Hoc QAPI for call light wait time concerns. Current call light data was reviewed and residents identified to have long call light wait times were interviewed for concerns. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Reviewed Monarch's Quality Assurance and Performance Improvement (QAPI) Plan. The IDT were educated on the facility's QAPI process, documentation expectations, and their responsibility to identify and address quality concerns. Staff were educated on the Ad Hoc QAPI for call light wait time concerns. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random call light audits to identify concerns and ensure compliance weekly x4, monthly x 2 and will report	08/21/2026

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F0865 SS = F	Continued from page 22 Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services	F0865	Continued from page 22 to QAPI committee for further review and recommendations.	08/21/2026

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F0865 SS = F	Continued from page 23 provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the quality assurance and performance improvement (QAPI) committee failed to identify resident call light wait time concerns prior to survey, nor make a good faith attempt to correct the deficiency. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: QAPI meeting minutes dated 3/31/25, indicated, "Call lights tend to be #1 issue." Call light response times had not been included/mentioned again in the subsequent six QAPI meeting minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn't an issue, however there was no documentation to support this. During an interview on 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the	F0865		08/21/2026

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F0865 SS = F	Continued from page 24 time of the interview and that he was covering her responsibilities. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. During QAPI meetings, the facility is expected to analyze data, discuss findings, review audit results, perform root cause analyses, develop action plans, and monitor the effectiveness of interventions. VPO stated regarding call light response times, that if ongoing concerns existed, the facility should utilize call light logs to identify trends, review the information through the QAPI process, and implement corrective actions. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program. During an interview on 7/16/26 at 9:46 a.m., the administrator stated current survey findings of long call light response times had not been on her radar. The administrator admitted there had been no staff meetings where QAPI meeting activities had been communicated to employees nor were employees asked for feedback about potential concerns related to resident care. Facility QAPI Plan with review date of 1/2/26, indicated the organization used QAPI to make decisions and guide their day-to-day operations, and included all employees, all departments and all processes. Decisions were based on data which included input from caregivers, residents, families and other stakeholders. Data sources for bench making progress would include information from residents and family interviews and staff surveys. All staff would be encouraged to communicate concerns and ideas to any department manager.	F0865		08/21/2026
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F0867	How corrective action will be taken for those affected by the alleged deficient practice: A review of the facility's QAPI program was completed to identify gaps in the development, implementation, monitoring, and evaluation of performance improvement activities. All current QAPI projects and identified quality concerns were reviewed to ensure the facility developed and implemented action plans, measured the success of actions and tracked performance, and reviewed, analyzed, and acted on data collected. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/21/2026

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F0867 SS = F	Continued from page 25 resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F0867	Continued from page 25 All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Reviewed Monarch’s Quality Assurance and Performance Improvement (QAPI) Plan policy. The IDT were educated on the facility's QAPI process, documentation expectations, and their responsibility to identify and address quality concerns. Call light response time has been added as a PIP Project, QA form includes a note section for documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits of QAPI plan and forms to ensure all required parts of the regulation are present and in compliance weekly x4, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE REHABILITATION CENTER LLC	108 8TH STREET NORTHWEST , WASECA, Minnesota, 56093

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F0867 SS = F	Continued from page 26 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by:	F0867		08/21/2026

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F0867 SS = F	Continued from page 27 Based on interview and document review, the facility failed to develop and implement action plans, measure the success of actions and track performance, conduct a performance improvement project (PIP), and regularly review, analyze, and act on data collected. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: Due to numerous sufficient staffing and long call light wait time concerns expressed by residents, family members and staff, QAPI (quality assurance and performance improvement) meeting minutes were reviewed. QAPI meeting minutes from March 2025 through June 2026, indicated the following: 3/31/25 - Minutes lacked substance. No actions or resolutions. Identified under grievances: "call lights tend to be #1 issue." Not mentioned again. 6/18/25 – No documentation of minutes. 9/30/25 - Minutes lacked substance. Not able to determine actions or resolutions. 12/17/25 – No documentation of minutes. 1/14/26 – No documentation of minutes. 3/18/26 – No documentation of minutes. 6/10/26 – No documentation of minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the lack of documentation of actions or resolutions at QAPI meetings, the administrator stated their meeting discussions were mostly verbal and admitted the minutes did not reflect their discussions. The administrator stated they needed to take better notes. With regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn't an issue, however there was no documentation to support this. During an interview on 7/16/26 at 9:46 a.m., the administrator stated she set the QAPI meeting agenda, facilitated the meetings and documented the meeting minutes, and that quality measures were monitored at both a corporate level and locally. The	F0867		08/21/2026

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F0867 SS = F	Continued from page 28 administrator admitted the minutes lacked identification of issues, analysis, monitoring, auditing, outcomes, and acknowledged the documentation needed to be improved as the minutes did not reflect activities of the committee. During the same interview, the administrator stated a PIP for 2026, had been unplanned weight loss. The administrator stated the only data obtained had been weight loss information from the dietician, and admitted they had not conducted a root cause analysis nor considered other important data such as diet orders, food preferences, observations of residents eating, involvement of family, use of supplements, etc. The administrator admitted their work lacked all available data and did not include a comprehensive analysis, action plan or audits. During a telephone interview on 7/15/26 at 11:00 a.m., vice president of operations (VPO) stated he had not been aware of anything specific related to quality indicator concerns at the facility. If there were resident concerns about call lights, he would ask specific questions, look at trends and patterns. For example, if long call lights were around the supper meal, he would expect an analysis of the situation and potentially add staff or reassign responsibilities. VPO stated he would expect QAPI minutes to identify data had been analyzed, a root cause analysis completed, action/interventions identified. For long call light wait times, circle back with residents, look at specific grievances, ask specific questions - time of day, day of week, etc. Adjust operations and business practices, monitor, audit. Call light logs should be utilized if a facility can run them, and then data presented to the QAPI committee for review.	F0867		08/21/2026
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F0565	How corrective action will be taken for those affected by the alleged deficient practice: All Resident concerns identified at resident council meetings during the last 60 days were reviewed, addressed, and residents notified of a resolution or ongoing measures to ensure compliance. The resident identified in the deficiency (R8, R24, R25, R28, R29, R30, R33, R35, R36 were individually spoken to and had all current concerns/issues addressed. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/21/2026

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F0565 SS = E	Continued from page 29 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident concerns identified at resident council meetings were addressed and residents notified of a resolution or ongoing measures to ensure compliance. This affected all 9 residents (R8, R24, R25, R28, R29, R30, R33, R35, and R36) who attended resident council. Findings include: R29's quarterly Minimum Data Set (MDS) assessment dated 5/1/26, indicated intact cognition, use of walker and wheelchair, partial assistance with toileting, bathing, and transfers, and diagnoses of heart failure and high blood pressure. R35's quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of wheelchair, dependent with toilet use, substantial assistance with bathing, substantial assistance for transfers, and diagnoses of heart failure and kidney insufficiency. Review of the resident council minutes dated 7/6/26, 6/10/26, 3/26/26, and 3/11/26, indicated concerns with wheelchair maintenance, toilet leaking, missing	F0565	Continued from page 29 All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility expectations and regulation were reviewed for resident council requirements. Implemented Resident Council Departmental Response Form to document resident concerns, investigation, and resolution. Education provided to Therapeutic Recreation Director and IDT on process and expectations. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Audits will be conducted monthly x3 to ensure the process change has been implemented, and the Resident Council Department Response Form has been completed for the previous month, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0565 SS = E	Continued from page 30 socks, mealtime service delays, food quality and temperature, and long call light times. The meeting minutes did not include follow-up or explanations of how or when the concerns would be addressed, or if they were ever addressed. During resident council interview on 7/14/26 at 1:50 p.m., R29 stated staffing was a big concern at the facility and she sometimes waited over 30 minutes for her call light to be answered. R29 further stated she had brought those concerns up at resident council but had never gotten any answer from facility staff whether her concern was addressed. R29 stated the council brought things up at meetings but didn't hear back and nothing was ever done about it. R20 stated she didn't know the council was supposed to get a response to their concerns. During resident council interview on 7/14/26 at 1:50 p.m., R35 stated she was unaware of any follow-up on resident council concerns and had never heard any solutions to concerns brought up at resident council. During interview on 7/15/26 at 7:58 a.m., activities assistant (AA)-A stated she helped facilitate the resident council meetings and typed the minutes. AA-A stated she was unable to find any evidence of replies to resident council concerns but was sure they were addressed verbally. AA-A stated she was not aware a formal response in written form should be given to the resident council and would have to start documenting follow-up for resident concerns. During interview on 7/15/26 at 1:40 p.m., administrator stated she would expect the resident council to receive responses from leadership addressing their concerns. Administrator further stated she was unaware concerns were not being addressed or documented. Administrator stated she would expect staff to follow federal regulations. A facility policy on responses to grievances and resident council concerns was requested but not received.	F0565		08/21/2026
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F0921	How corrective action will be taken for those affected by the alleged deficient practice: The ceiling tiles in the East hallway bath tub room were replaced. The carpets on the East and West hallways were shampooed. The facility will obtain flooring replacement bids and have the carpet/flooring replaced in both effected/impacted	08/21/2026

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F0921 SS = E	Continued from page 31 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment for residents residing in East and West hallways resulting in large dark stains, fraying and worn carpet throughout the hallway and damaged, cracked, sagging, and discolored ceiling tiles in the east hallway bath tub room. Findings Include: On 7/13/26 at 5:09 p.m., observation of the east hallway outside resident rooms identified a discolored dark stain on the flooring measuring approximately 1½ feet by 6 inches, irregularly shaped with darkened edges and concentrated areas of discoloration. The stains were distributed throughout the hallway and were readily visible from a distance due to the contrast between the stained areas and the surrounding carpet. The carpeting appeared worn and soiled. On 7/13/26 at 5:21 p.m., the licensed practical nurse (LPN)-A stated the hallway carpeting was stained and frayed, and further stated the carpet was not securely attached at the seams. LPN-A stated the carpet had been shampooed the previous week; however, the stains remained because the carpeting was old. On 7/13/26 at 5:53 p.m., the environmental services manager (EVSM)-C stated the flooring had been scrubbed multiple times without improvement and that requests for replacement flooring had been ongoing for an extended period. EVSM-C stated the ripped carpet and stained flooring were maintenance issues, described the condition as "embarrassing" and "unfair to the residents," and confirmed the concerns were included in weekly reports submitted to environmental management. EVSM-C stated the carpeting was a concern and reported attempts had been made to clean the carpet; however, the staining worsened during humid conditions. On 7/14/26 at 10:04 a.m., the maintenance director (MD)-A and administrator confirmed the carpeting was not secure and frayed and stated "anything could be tripped on." They stated the carpet had been glued previously at the seams and replacement had been discussed; however, no replacement date had been established. The administrator acknowledged residents would not be expected to live with frayed carpeting or holes in the carpet as it is not a homelike environment. The administrator stated the carpet condition was a known concern and acknowledged the stains remained despite	F0921	Continued from page 31 areas in the East and West hallways. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was conducted to ensure no other ceiling tiles were affected and those that were damaged, were replaced. The facility has contacted flooring companies to provide carpet replacement quotes and is scheduling service. All Staff were educated on expectations to maintain a clean, comfortable, and homelike environment. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random facility homelike environment audits of the flooring, bathtub rooms, dining room, activities room, nurses stations, public areas, resident rooms, to ensure compliance weekly x4, monthly x2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0921 SS = E	Continued from page 32 shampooing. The administrator stated the carpeting "does not look good or homelike," confirmed awareness of the condition. The administrator confirmed the carpets on the East and West halls did not provide a homelike environment. On 7/14/26 at 12:23 p.m., observation of the east hallway identified multiple areas where the carpeting was worn through with the carpet backing visible. Several carpet seams were frayed and separated, creating raised edges. Numerous irregularly shaped dark brown and black discolored areas of varying sizes were present throughout the hallway carpeting. On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed a ceiling tile surrounding the sprinkler head with a large circular brown discolored area measuring approximately 18 to 24 inches in diameter, with a darker brown ring around the outer edge and a lighter-colored center. An adjacent ceiling tile had an additional irregularly shaped brown discolored area extending across the edge of the tile. Additional ceiling tiles were observed to be cracked, broken, and sagging, with visible deterioration to the tile surfacesOn 7/15/26 at 12:55 p.m., MD-A while observing the ceiling confirmed the ceiling tile in the bathroom was stained and stated the facility has a flat roof. MD-A further stated the ceiling tile was "busted." On 7/15/26 at 12:59 p.m., the administrator observed the condition of the ceiling and confirmed they would expect the stained and cracked ceiling tiles to be replaced. The Facility document The Revisor of Statues dated 2007, indicatedA nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongs to the extent possible.	F0921		08/21/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641	How corrective action will be taken for those affected by the alleged deficient practice: The facility reviewed R50's discharge MDS assessment, supporting documentation, and the RAI Manual. The affected MDS was modified and resubmitted according to the RAI Manual. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/21/2026

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F0641 SS = D	Continued from page 33 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) assessment was coded accurately for 1 of 1 resident (R50) reviewed for discharge a by inaccurately coding a planned discharge as an unplanned discharge, and failed to follow the Resident Assessment Instrument (RAI) Manual. Findings include: R50's discharge assessment - return not anticipated MDS dated 6/28/26, indicated unplanned discharge to home/community on 6/28/26, cognitive skills for daily decision making: modified independence - some difficulty in new situations only; was independent with oral hygiene, toileting hygiene, dressing, personal hygiene, transfers, walking, did not use a wheelchair, diagnoses indicated hemiplegia following cerebral infarction affecting left non-dominant side (stroke-related condition where a blood clot or blockage; has caused paralysis or severe weakness on the left side of the body). R50's discharge instructions dated 6/25/26 at 1:37 p.m., licensed practical nurse (LPN)-A indicated discharge home, reason for discharge: resident	F0641	Continued from page 33 All discharged residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed to identify unplanned discharge MDSs in the last 90 days. Each identified resident's medical record was reviewed to verify that the discharge documentation supported accurate MDS coding. Education was provided to Director of Nursing and MDS Coordinator on the RAI Manual's definition of planned vs unplanned discharges and accurate coding. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random audits for compliance weekly x4, monthly x2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0641 SS = D	Continued from page 34 request, admission date 4/28/26, came to our facility following hospitalization for CVA (stroke) with left sided weakness and left sided vision deficit. Has worked with therapy and is now independent with all cares, further the document was signed by R50 and indicated understood the medication instructions and other instructions given to me by the healthcare professional. R50's document titled notice of resident/patient transfer or discharge 6/29/26, social services (SS) director-A indicated date of anticipated discharge 6/28/26, date notice provided 6/26/26, the transfer or discharge is/was appropriate because the resident's health has/had improved sufficiently so the resident no longer needs/needed the services provided by the facility R50's provider note progress note dated 6/25/26, nurse practitioner (NP)-D indicated okay to discharge to home with current meds and treatment plan. R50's progress note dated 6/28/26 at 8:45 a.m. the director of nursing (DON) indicated R50 packed personal belongings and brought to the front door awaiting on dtr (daughter) pick up, ambulating independently w/o (without) aid, reviewed d/c medications with resident again. Understanding noted AEB (as evidenced by)resident repeating instructions, reading out loud and familiarity/awareness with names and dosing of medications, provided printed out MAR (medication administration record) for June/July so resident has 'a graph' so she can check off after taking. informed resident and dtr that writer spoke with pharmacist at pharmacy yesterday to ensure medications were ready for pick up, R50 excited to be returning home. D/C (discharge) instructions, meds and personal belongings with resident. discharged to home via private vehicle/dtr. On 7/15/26 at 10:00 a.m., the director of nursing (DON) stated R50's MDS had been completed as an unplanned discharge because the timing of the discharge changed at the last minute and the facility was not prepared for the resident to leave that day. The DON stated the family situation was dysfunctional and there was uncertainty regarding transportation and whether R50 would return home with family or independently. The DON confirmed R50 was ready for discharge; however, the facility had not planned for the resident to leave on the day of discharge. The DON confirmed the discharge process was followed, a provider discharge order was obtained, all necessary discharge paperwork	F0641		08/21/2026

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F0641 SS = D	Continued from page 35 and education were provided to R50, and R50 did not leave AMA (against medical advice). On 7/15/26 at 11:49 a.m., registered nurse (RN)-A, the MDS coordinator, stated R50's discharge arrangements were finalized only a couple of days before discharge and the assessment was coded as an unexpected discharge because they believed that coding was consistent with the Resident Assessment Instrument (RAI) Manual. The MDS coordinator stated R50 did not leave AMA and that although the facility did not know the exact day R50 would leave until shortly before discharge, a provider discharge order had been obtained and facility discharge instructions had been completed. On 7/15/26 at 11:59 a.m., licensed practical nurse (LPN)-A stated R50 had been working toward discharge home, discharge planning discussions had occurred several days before discharge, and a provider discharge order had been obtained. The nurse stated the uncertainty involved whether R50 would return home with family or independently, not whether R50 would be discharged from the facility. On 7/15/26 at 12:22 p.m., the nurse practitioner (NP)-D stated R50's discharge was planned and was not an unexpected discharge. On 7/15/26 at 12:47 p.m., the social services (SS)-A director stated R50's discharge had been planned, a care conference had been held regarding the discharge, and the MDS would not be expected to be coded as an unplanned discharge. Review of the RAI Manual dated 10/25, indicated an unplanned discharge occurs when the discharge was unexpected, such as an acute hospitalization or the resident leaving against medical advice. Because R50's discharge planning had occurred over several days, a provider discharge order had been obtained, discharge instructions were completed, and the resident did not leave AMA, the discharge did not meet the definition of an unplanned discharge. Facility Discharge Planning Policy dated 1/25, indicated at discharge the rounding provider must write an order for discharge, if the rounding provider refuses to write a discharge order and the resident insists on being discharged anyway refer to Against Medical advice policy.	F0641		08/21/2026
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment	F0676	How corrective action will be taken for those affected by the alleged deficient practice: R42 discharged the facility on 08/12/26.	08/21/2026

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F0676 SS = D	Continued from page 36 of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain oral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance. Findings include:	F0676	Continued from page 36 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents requiring assistance with ADLs have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed of residents requiring assistance with oral care to ensure each resident's identified oral hygiene needs and required level of assistance are accurately reflected in the care plan and are being provided. Any discrepancies were immediately corrected. Reviewed Monarch’s Activities of Daily Living (ADL)/Maintain Abilities policy and facility expectations for oral hygiene. Education provided to nursing staff on policy and facility expectations for oral hygiene assistance and documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random oral hygiene completion audits 3x week x1, weekly x 3, monthly x 2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0676 SS = D	Continued from page 37 R42's admission Minimum Data Set (MDS) dated 5/20/26, indicated cognitively intact, no rejection of care, required supervision or touching assistance with oral hygiene, diagnosis included displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture (break of the lower leg), and history of falling. R42's CAA (care area assessment) dated 5/21/26, indicated R42 had a decline in mobility following hospitalization for a fall that resulted in a right ankle fracture, in PT (physical therapy) and OT (occupational therapy) at this time, needing assistance with mobility and ADLs (activities of daily living), alert and oriented and able to make her needs known, plan to continue to provide assistance with ADLs and follow therapy recommendations. R42's care plan dated 5/15/26, indicated alternation in mobility, does not walk, assist with movement in bed and in/out bed, set up with personal hygiene. R42's task: personal hygiene the ability to use suitable items to clean teeth, dated 6/16/26-7/14/26, indicated the following data that R42 was provided setup assistance, partial assistance, or independent 6/19/26 6/20/26 6/22/26 6/24/26 6/26/26 6/27/26 6/28/26 6/29/26 6/30/26 67/1/26 7/2/26 7/3/26 7/5/26 7/7/26	F0676		08/21/2026

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F0676 SS = D	Continued from page 38 7/9/26 7/13/26 The data provided failed to indicate R42 was provided daily set up assistance with oral care. R42's treatment administration record (TAR) dated 7/1/26-7/30/26, indicated start date 5/14/26, NWB (non-weight bearing) rt (right) leg every shift, CAM boot; wea with all activities including sleeping. May remove for skin hygiene, icing and ankle ROM every shift for right ankle fracture On 7/13/26 at 10:51 a.m., R42 was observed seated in a recliner wearing a black orthopedic boot on the right lower leg. R42 stated she was non-weight bearing due to a fractured leg and required staff assistance to obtain her toothbrush, toothpaste, a cup of water, and assistance to empty the water after brushing her teeth. R42 stated she did not receive assistance with morning oral care every day. R42 stated she frequently requested assistance; however, staff told her they did not have time because they were assisting other residents. R42 stated she stopped asking because she did not want another resident to have to wait for care. R42 stated she had been moved from another area of the facility because she was told the current hallway was less busy and she would receive timelier assistance. On 7/14/26 at 8:18 a.m., R42 stated she had not yet received morning care. She stated she preferred to eat breakfast before receiving assistance to wash up. R42 also stated she previously experienced long call light response times and had been instructed to call the facility's main telephone number when her call light was not answered. On 7/14/26 at 8:51 a.m., nursing assistant (NA)-A stated there were times staff did not have enough time to assist R42 with obtaining the supplies needed to brush her teeth and acknowledged assistance could be delayed until approximately 1:00 p.m. NA-A confirmed there were occasions when R42 requested assistance and they told R42 they were too busy. NA-A further stated R42 required assistance to obtain a glass of water and to empty the cup after brushing her teeth. On 7/14/26 at 9:00 a.m., the social services director (SS)-A stated R42 had previously been moved to another hallway due to concerns regarding long call	F0676		08/21/2026

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F0676 SS = D	Continued from page 39 light response times. SS-A confirmed review of call light logs identified response times exceeding 25 minutes for R42. Staff were educated regarding timely responses, and R42 was provided the front desk telephone number if assistance was not received. SS-A acknowledged R42 should not have to call the front desk to obtain assistance. On 7/14/26 at 9:09 a.m., the administrator confirmed R42 had expressed concerns regarding long call light response times and that the call light logs had been reviewed. The administrator stated she did not recall response times greater than 30 minutes and considered call light response times exceeding 30 minutes to be significant. The adminstrator stated R42 to was moved to a "less busy hallway". On 7/14/26 at 12:37 p.m., R42 stated her teeth had been brushed that day; however, she reported she was not routinely offered assistance with brushing her teeth on weekend mornings. On 7/15/26 at 8:19 a.m., NA-A confirmed they did not have sufficient time to provide all required care to R42 on Saturday, 7/11/26, including oral care. On 7/15/26 at 8:49 a.m., licensed practical nurse (LPN)-A stated staff were expected to provide R42 with assistance to set up for teeth brushing. LPN-A stated nursing assistants were expected to notify the nurse if they were unable to provide the required assistance. LPN-A acknowledged R42 was particular about her oral hygiene. LPN-A further acknowledged staffing shortages could delay care, stating there were not enough staff to care for all residents, staff frequently had difficulty locating assistance, residents had reported waiting up to 30 minutes for assistance, and the director of nursing (DON) was aware of these concerns. On 7/15/26 at 10:20 a.m., the DON stated staff were expected to provide R42 with daily assistance to set up for tooth brushing and document the care provided. The DON stated staff were expected to complete ADL (activity of daily living) documentation before leaving their shift. The DON confirmed R42's documentation did not identify oral care was completed daily. Facility Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary are and services to ensure that a resident's abilities	F0676		08/21/2026

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F0676 SS = D	Continued from page 40 in activities of daily living do not diminish.... 3. The facility will provide care and services for the following activities of daily living a. hygiene-bathing, dressing, grooming, and oral care.	F0676		08/21/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide oral care to 1 of 1 resident (R13) who was reviewed for assistance with activities of daily living (ADLs) and who was dependent upon staff for ADL cares. Findings include: R13's diagnosis report dated 7/16/26, included diagnoses of fractured vertebrae, fracture of right radius (bone in forearm) and fracture right humerus (bone in upper arm). R13's admission Minimum Data Set (MDS) assessment dated 7/7/26, indicated intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all ADLs, including oral hygiene. R13 did not walk. R13's care plan dated 7/7/26, indicated self-care deficient related to impaired mobility and right arm fractures. Staff would assist with dental hygiene for upper denture and lower partial. During an interview on 7/13/26 at 1:43 p.m., family member (FM)-A stated staff had not been cleaning R13's dentures, a full upper and partial on the bottom. R13 stated the same, that staff did not clean her dentures. FM-A stated R13 slept with her dentures in and when FM-A removed them to clean them, they would have food and white material on them. During an interview on 7/15/26 at 10:55 a.m., nursing assistant (NA)-G stated R13 had her own teeth (R13 had upper dentures and lower partial) and admitted she had not provided oral care that morning. NA-G stated she probably should have and could have done it when R13 was sitting up in the	F0677	How corrective action will be taken for those affected by the alleged deficient practice: R13 was assisted with oral hygiene needs and care plan was reviewed to ensure resident's dependence on staff for oral care was clearly identified. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who are dependent on assistance with ADLs have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed of residents requiring assistance with oral care to ensure each resident's identified oral hygiene needs and required level of assistance are accurately reflected in the care plan and are being provided. Any discrepancies were immediately corrected. Reviewed Monarch's Activities of Daily Living (ADL)/Maintain Abilities policy and facility expectations for oral hygiene. Education provided to nursing staff on policy and facility expectations for oral hygiene assistance and documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random oral care audits 3x week x1, weekly x 3, monthly x 2, and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0677 SS = D	Continued from page 41 wheelchair earlier. During an interview on 7/15/26 at 1:20 p.m., both R13 and family member (FM)-A stated R13's dentures and teeth had not been cleaned yet. During an interview on 7/15/26 at 1:35 p.m., NA-G stated she still had not cleaned R13's dentures/teeth, adding that it had been busy. NA-G stated it was important to clean a resident's teeth for their overall health. During an interview on 7/16/26 at 8:48 a.m., the director of nursing (DON) was informed of findings and stated oral care was the responsibility of NAs and would expect it to be done at least twice a day. The DON stated R13 was not able to do her own oral care due to her arm injuries. Together looked POC (point of care) in the electronic medical record where NAs documented cares. For "oral hygiene," in the 15 days and 30 opportunities to complete oral care there were only 12 checkmarks indicating the level of care R13 needed for oral care, not specifically if oral care had been completed or not. Facility Activity of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would provide care and services for oral care. A resident who was not able to carry out ADLs would receive the services to maintain oral hygiene.	F0677		08/21/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement a bowel movement (BM) protocol for 1 of 1 resident (R13) reviewed for constipation. Findings include: R13's diagnosis report dated 7/16/26, included diagnoses of fractured vertebrae, fracture of right	F0684	How corrective action will be taken for those affected by the alleged deficient practice: R13 had a documented BM after administration of PRN suppository on 07/15/26. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed to ensure that no other residents were experiencing constipation and require bowel intervention. Reviewed facility standing	08/21/2026

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F0684 SS = D	Continued from page 42 radius (bone in forearm) and fracture right humerus (bone in upper arm). R13's admission Minimum Data Set (MDS) assessment dated 7/7/26, indicated intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all activities of daily living (ADLs) and did not walk. R13's physician orders dated 6/30/26, included senna (laxative) oral tablet 8.6 mg (milligrams), give three tablets by mouth as needed for constipation; three tablets two times a day as needed for constipation. In addition, orders dated 6/30/26, included: may use standing orders as signed by provider. Standing orders signed by provider 3/11/26, indicated for bowel protocol: --Milk of Magnesia (laxative) 30 cc (cubic centimeter) orally daily PRN (as needed) if no bowel movement for two days. --Dulcolax suppository (laxative), one per rectum daily PRN if no bowel movement for three days. --Fleets (brand name) or tap water enema rectally daily PRN constipation. R13's care plan dated 7/7/26, indicated an alteration in elimination related to mobility limitations and R13 would move bowels every three days or greater. R13's bowel movement task list completed by NAs, indicated R13 did not have a documented BM from 7/9/26 through the morning of 7/14/26 (six days). During an observation on 7/14/26 at 11:17 a.m., licensed practical nurse (LPN)-B spoke to R13 to ask how she was feeling. R13 reported pressure down there (hand over lower abdomen) and stated she had not had a BM for a while. After leaving the room, LPN-B accessed the electronic medical record (EMR) and saw the last documented BM for R13 had been on 7/8/26, six days ago. LPN-B had not been aware if the facility had a BM protocol or standing orders and stated she would give R13 the PRN laxative ordered for her. During an interview on 7/14/26 at 2:04 p.m., nursing assistant (NA)-D stated NAs documented resident BMs in POC (point of care) in the EMR. If a resident was independent with toileting, might not know if they had a BM unless asked. For other residents, we know if they had BM because we change their brief or take them to the bathroom. NA-D admitted a NA might forget or not have time to document cares	F0684	Continued from page 42 orders for bowel interventions. Education provided to nurses/TMAs on standing orders, BM monitoring, and facility expectations. Education provided to CNAs on facility expectations for BM documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete random Bowel Movement audits to ensure compliance twice weekly x1 week, weekly x3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0684 SS = D	Continued from page 43 including BMs, in POC. During an interview on 7/15/26 at 11:45 a.m., registered nurse (RN)-C stated R13 had no results from the PRN medication given the day before, and therefore gave R13 a suppository that morning and R13 had a BM. During an interview on 7/15/26 at 12:50 p.m., RN-C stated nursing staff were expected to monitor resident BMs via the EMR and the BM sheet the night shift staff filled out indicating residents to receive a suppository after not having a BM for three days. If a resident went more than three days without a BM, staff should start the protocol per the standing orders which indicated to start with a stool softener or Milk of Magnesia, then a suppository, then an enema. RN-C pointed to the standing orders posted on the bulletin board in the nurses' station office. RN-C confirmed by what she could see, nursing staff had not been monitoring R13’s BMs since she had gone six days without a BM and no intervention. During an interview on 7/16/26 at 8:48 a.m., the director of nursing (DON) had been informed of findings. The DON stated it was not okay for a resident to go six days without a BM. The DON stated by day three, should receive a suppository per the standing orders and that all nursing staff should know that. The DON acknowledged staff had not been monitoring and addressing R13’s BMs per the standing orders. A bowel monitoring policy was requested and not received.	F0684		08/21/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F0688	How corrective action will be taken for those affected by the alleged deficient practice: R29 and R37s ambulation programs were reviewed for appropriateness and were reflected across the medical record (physician orders, care plan, Kardex, and POC). How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with ambulation programs have the potential to be affected by the alleged deficient practice	08/21/2026

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F0688 SS = D	Continued from page 44 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. Findings include: R29's diagnosis report dated 7/16/26, included generalized osteoarthritis, diabetes, generalized muscle weakness and obesity. R29's quarterly Minimum Data Set (MDS) assessment dated 4/28/26, indicated intact cognition, clear speech, could understand and be understood. R29 required partial to moderate assistance with most ADLs including walking 150 feet. R29 used a walker and wheelchair for mobility. R29's physician orders dated 7/15/25, indicated per therapy, ensure resident is walked two times a day with staff, every day and evening shift. R29's "Therapy Alert" from PT dated 7/15/25, indicated R29 should ambulate one to two times a day with FWW (front wheeled walker) and assistance of one staff. R29's care plan dated 1/26/25, indicated R29 had an alteration in mobility related to impaired mobility and to follow PT instructions. On 7/15/25, care plan indicated to ambulate R29 two times a day with FWW and assist of one. R29's Kardex (a quick reference used by nursing assistants to inform them of a resident's care) printed on 7/16/26, indicated ambulate resident two times/day with FWW and assist of one. May progress distance as tolerated by resident. R29's documentation of ambulation in POC (point of care, where NAs document in the electronic medical record) indicated out of 28 days and 56 opportunities, documentation indicated R29 had been walked only nine times.	F0688	Continued from page 44 The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit of residents with ambulation programs was completed to ensure appropriateness and were reflected across the medical record. Reviewed Monarch's Activities of Daily Living (ADL)/Maintain Abilities policy and facility expectations for mobility. Nurses and CNAs were educated on policy and facility expectations regarding compliance with therapy recommendations for ambulation programs and documentation. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee with complete random resident walk audits to ensure compliance twice weekly x1 week, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0688 SS = D	Continued from page 45 R29's TAR (treatment administration record) completed by nursing staff, indicated: ensure R29 walked two times a day with staff every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R29 was walked 21 times. Documentation between the NA who was responsible to perform the task and documentation of the nurse who was to be informed of task completion, did not match. During an interview on 7/15/26, at 9:36 a.m., R29 had been sitting in her wheelchair in her room with walker off to the side. R29 stated she used to be on a walking program but had not walked for a while because the facility was short staffed. R13 stated she would like to walk in the hallway, so her legs stayed strong. R37's diagnosis report dated 7/16/26, included diagnoses of congestive heart failure (when the heart doesn't pump as well as it should) diabetes, generalized muscle weakness, history of falling, and obesity. R37's annual MDS assessment dated 4/15/26, indicated intact cognition, clear speech, could understand and be understood. R37 required partial to moderate assistance with ADLs, including walking 150 feet. R37 used a walker and wheelchair for mobility. R37's physician orders dated 4/13/26, indicated ensure resident ambulates one to two times per day with assist of one to manage O2 (oxygen), every day and evening shift. R37's "Therapy Alert" from PT staff dated 4/7/26, indicated ambulate resident one to two times a day with FWW and assist of one to manage O2 tubing. R37's care plan dated 4/10/24, indicated alteration in mobility related to weakness and history of falling, and to follow PT instructions. PT's walking recommendations/instructions from 4/7/26, were not included in the care plan. R37's Kardex printed on 7/16/26, did not include ambulation recommendations by PT. R37's POC had not been set up to include recommendations from PT and therefore no location in POC for NAs to document if/when they ambulated R37. R37's TAR completed by nursing staff, indicated: ensure R37 ambulates 1-2x/day with assist of 1 to	F0688		08/21/2026

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F0688 SS = D	Continued from page 46 manage O2 tubing, every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R37 was walked 27 times. However there had been no documentation by the NAs who were responsible for performing the task. During an interview on 7/15/26 at 9:30 a.m. R37 had been sitting in a wheelchair in her room with a walker off to the side. R37 stated she used to walk in the hallway but didn't anymore. R37 stated it was something she wanted to do in order to keep mobile, adding it was good for her to walk. R37 stated she used to walk to the shower room, but no longer. R37 felt she could walk if staff helped her. During an interview on 7/15/26, at 10:16 a.m., physical therapy assistant (PTA)-E, who was also the department director provided "Therapy Alert" forms for R29 and R37. PTA-E stated copies of the forms were given to the director of nursing (DON) and NAs. During an interview on 07/15/2026 1:40 p.m., nursing assistant (NA)-D stated R29 and R37 were on walking programs but admitted NAs were not always able to walk residents, including R29 and R37, due to being so busy. NA-D stated residents would usually be walked on the day and the evening shifts and sometimes that depended upon what was going on, such as an activity. NA-D stated walking was important, so residents didn't lose the ability to walk. During an interview on 7/15/26 at 4:48 p.m., with nursing assistant NA-E and NA-F, NA-E stated R29 and R37 were on a list at the desk to be walked in the morning and the afternoon. NA-E stated residents only got walked once a day due to their workload – it gets so heavy, we don't have time. NA-F agreed. NA-E stated if a resident was walked, it was charted in POC. NA-E stated sometimes the nurse would ask if they got it done and would document it too. NA-F stated most residents were in the facility for rehabilitation, and it was important they walked, adding, if you don't use it, you lose it. During an interview on 7/15/26 at 4:53 p.m., licensed practical nurse (LPN)-D stated she documented on the TAR when NAs ambulated a resident. LPN-D stated she did not always see residents being ambulated so asked the NA; if they said yes, she documented it and didn't question it. During an interview on 7/16/26 at 8:22 a.m., licensed practical nurse (LPN)-A, stated she did not know why nurses were asked to document a task	F0688		08/21/2026

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F0688 SS = D	Continued from page 47 they did not do themselves. LPN-A stated she kept track if she saw a resident being walked, or if an NA told her they walked a resident, adding she had to trust what they told her. During an interview on 7/16/26 at 8:56 a.m., the director of nursing (DON) stated resident recommendations for walking came from PT. When received, the residents name would be added to a list at the nurses' station to inform NAs which residents should be walked. The DON was asked to look in POC for documentation of R29 and R37 being walked. For R29, the DON admitted R29 had not been walked according to PT recommendation, physician order, care plan and Kardex. For R37, POC had not been set up for NAs to document her walking and couldn’t say why, or how NAs documented this task without POC. The DON stated she did not monitor whether or not residents were walked according to PT recommendations, nor did she monitor documentation. The DON stated she asked the nurses if residents were walked even though they did not perform the task. The DON stated she knew the afternoon shift struggled with walking residents due to meals, bedtime and staff breaks. The DON stated it was important to walk residents, so they didn’t lose the ability to walk, it improved breathing and prevented formation of contractures. The DON stated she had been informed by NA staff they didn’t have time to walk residents but told them they could ask nurses to help them. Facility Activities of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would ensure a resident was given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility would provide care and services including walking.	F0688		08/21/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F0880	How corrective action will be taken for those affected by the alleged deficient practice: East hall bath tub chair cushions were replaced on July 16, 2026 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who use the tub room have the potential to be affected by the alleged deficient practice	08/21/2026

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F0880 SS = D	Continued from page 48 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 48 The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: A full house audit was completed to ensure no other bath tub chair cushions needed replacement. Reviewed Monarch's Infection Prevention and Control Program policy and facility process for reporting infection control or maintenance concerns. Education provided to all staff on policy and expectations for reporting concerns of items that have been broken down and do not meet the regulatory requirements required for homelike environment or infection control. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance Director or designee with audit facility bath tub chair cushions monthly and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0880 SS = D	Continued from page 49 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to maintain reusable resident care equipment in a manner that could be effectively cleaned and disinfected by continuing to use a bathtub chair with torn and cracked cushion surfaces in the east hallway bath room. This had the potential to affect any of the 19 residents residing on the east and west hallways who used the tub room. Findings include: On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed the shower chair seat with a black vinyl cushion contained multiple tears, cracks, and openings throughout the seating surface. Portions of the vinyl covering were missing, exposing the underlying light-colored cushion material. The damaged areas created multiple irregular surfaces and openings across the seat cushion. On 7/15/26 at 12:50 p.m., nursing assistant (NA)-A stated the bathtub room was used for residents and confirmed the cracked shower chair was used. NA-A stated they placed a towel on the chair before residents use it. On 7/15/26 at 12:51 p.m., licensed practical nurse (LPN)-A stated the bathtub chair cushion was cracked and had openings and stated it "could be an infection control issue." On 7/15/26 at 12:55 p.m., maintenance director (MD)-A confirmed the bathtub chair cushion was cracked and damaged and stated they it would be expected to be replaced and stated they were not aware of the cushion's condition. On 7/15/26 at 12:59 p.m., the administrator observed the bathtub chair cushion and confirmed the cushion should not be in that condition due to infection control concerns. The administrator stated staff would not be expected to use the shower chair if the cushion was cracked. On 7/15/26 at 4:48 p.m., the director nursing (DON), also known as the infection preventionist, stated the	F0880		08/21/2026

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D F0880 SS = D	Continued from page 50 shower chair was not expected to have cracked cushions and stated the damaged cushion could present an infection control problem. The facility Infection Prevention and Control Program policy dated 11/24, indicatedPrevention of Infectioninstituting measures to avoid complicationseducating staff and ensuring that they adhere to proper techniques and procedures	F0880		08/21/2026
F F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F0732	How corrective action will be taken for those affected by the alleged deficient practice: The current nursing hours were posted, according to regulatory requirements, when the concerns were identified. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The regulation for Posted Nurse Staffing Information has been reviewed. Facility process of ensuring accuracy at the beginning and end of day and expectations were implemented. Scheduler was educated on facility expectation to ensuring accuracy and updated when there is a change to staffing levels. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will complete random audits of posted staffing information to ensure compliance 3x per week x 1, weekly x 3, monthly x 2 and will report to QAPI committee for further review and recommendations.	08/21/2026

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F0732 SS = C	Continued from page 51 (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure the posted nursing hours were updated when there was a change to staffing levels. This had the potential to affect all residents and visitors of the facility. Findings include: During an observation and interview on 3/14/26 at 10:45 a.m., the daily staffing hours were posted in the main entrance area visible to all residents and visitors but were dated 3/13/26. Licensed practical nurse (LPN)-A was observed taking out the page for 3/13/26, and inserting the new daily staffing hours for 3/14/26. Review of the daily staffing hours posted for 3/13/25, indicated the following hours: Days: one registered nurse (RN), one LPN, one trained medication aide (TMA), four nursing assistants (NAs). Evenings: two RNs, four NAs. Nights: one LPN, two NAs. Review of the daily staffing hours posted for 3/14/26, indicated the following hours: Days: two LPNs, one TMA, four NAs. Evenings: one RN, one LPN, four NAs. Nights: one LPN, two NAs.	F0732		08/21/2026

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F0732 SS = C	Continued from page 52 Review of facility schedules dated 7/13/26 and 7/14/26, indicated additional NAs on each day to assist with baths that were missed on the weekend. On 7/13/26, an additional nursing assistant was scheduled from 10:30 a.m. to 2:30 p.m., and on 7/14/26, an additional nursing assistant was scheduled from 11:00 a.m. to 2:30 p.m. There were no changes made to the daily staffing posting to reflect these changes in staffing totals. During interview on 7/14/26 at 10:45 a.m., director of nursing (DON) stated she had added extra staff to assist with making up baths from the weekend that did not get done. DON further stated she would expect the daily staff posting to be updated when there were changes to the schedule. DON confirmed the postings had not been updated to reflect accurate information on either 7/13/26 or 7/14/26. During interview on 7/16/26 at 2:45 p.m., administrator stated it was the responsibility of the TMA to update the daily staff posting in real time, but she also kept on eye on it. Administrator confirmed the updates had not been made on 7/13/26 or 7/14/26, and she would have expected them updated to reflect accurate staffing levels. A policy on daily staff postings was requested but not received.	F0732		08/21/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/13/26 to 7/16/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. NO deficiencies were cited.	20000		08/21/2026

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

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20000	Continued from page 1 H53883229C iQies # 2717031 H53883337C iQies # 3000657 H53883338C iQies # 2997280 H53883232C iQies # 2624776 H53883232C iQies # 2624512 The following complaints were reviewed with deficiencies cited at: H53883228C iQies # 2741658 with licensing order cited at 20800 H53883230C iQies # 2653216 with licensing order cited at 20915 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S	20000		08/21/2026

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LAKESHORE REHABILITATION CENTER LLC	**108 8TH STREET NORTHWEST , WASECA, Minnesota, 56093**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0 20000	Continued from page 2 PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		08/21/2026
0 20255	Quality Assessment and Assurance Committee CFR(s): MN Rule 4658.0070 A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the quality assurance and performance improvement (QAPI) committee failed to identify resident call light wait time concerns prior to survey, nor make a good faith attempt to correct the deficiency. In addition, the facility failed to develop and implement action plans, measure the success of actions and track performance, conduct a performance improvement project (PIP), and regularly review, analyze, and act on data collected. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: QAPI meeting minutes dated 3/31/25, indicated, "Call lights tend to be #1 issue." Call light response times had not been included/mentioned again in the subsequent six QAPI meeting minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn’t an issue, however there was no	20255	Corrected	08/21/2026

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20255	Continued from page 3 documentation to support this. During an interview on 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the time of the interview and that he was covering her responsibilities. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. During QAPI meetings, the facility is expected to analyze data, discuss findings, review audit results, perform root cause analyses, develop action plans, and monitor the effectiveness of interventions. VPO stated regarding call light response times, that if ongoing concerns existed, the facility should utilize call light logs to identify trends, review the information through the QAPI process, and implement corrective actions. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program. During an interview on 7/16/26 at 9:46 a.m., the administrator stated current survey findings of long call light response times had not been on her radar. The administrator admitted there had been no staff meetings where QAPI meeting activities had been communicated to employees nor were employees asked for feedback about potential concerns related to resident care. Facility QAPI Plan with review date of 1/2/26, indicated the organization used QAPI to make decisions and guide their day-to-day operations, and included all employees, all departments and all processes. Decisions were based on data which included input from caregivers, residents, families and other stakeholders. Data sources for bench making progress would include information from residents and family interviews and staff surveys. All staff would be encouraged to communicate concerns and ideas to any department manager DEVELOP AND IMPLEMENT ACTION PLANS Due to numerous sufficient staffing and long call light wait time concerns expressed by residents, family members and staff, QAPI (quality assurance and performance improvement) meeting minutes were reviewed. QAPI meeting minutes from March 2025 through June 2026, indicated the following: 3/31/25 - Minutes lacked substance. No actions or resolutions. Identified under grievances: "call lights	20255		08/21/2026

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20255	Continued from page 4 tend to be #1 issue." Not mentioned again. 6/18/25 – No documentation of minutes. 9/30/25 - Minutes lacked substance. Not able to determine actions or resolutions. 12/17/25 – No documentation of minutes. 1/14/26 – No documentation of minutes. 3/18/26 – No documentation of minutes. 6/10/26 – No documentation of minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the lack of documentation of actions or resolutions at QAPI meetings, the administrator stated their meeting discussions were mostly verbal and admitted the minutes did not reflect their discussions. The administrator stated they needed to take better notes. With regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn't an issue, however there was no documentation to support this. During an interview on 7/16/26 at 9:46 a.m., the administrator stated she set the QAPI meeting agenda, facilitated the meetings and documented the meeting minutes, and that quality measures were monitored at both a corporate level and locally. The administrator admitted the minutes lacked identification of issues, analysis, monitoring, auditing, outcomes, and acknowledged the documentation needed to be improved as the minutes did not reflect activities of the committee. During the same interview, the administrator stated a PIP for 2026, had been unplanned weight loss. The administrator stated the only data obtained had been weight loss information from the dietician, and admitted they had not conducted a root cause analysis nor considered other important data such as diet orders, food preferences, observations of residents eating, involvement of family, use of supplements, etc. The administrator admitted their work lacked all available data and did not include a comprehensive analysis, action plan or audits. During a telephone interview on 7/15/26 at 11:00 a.m., vice president of operations (VPO) stated he had not been aware of anything specific related to quality indicator concerns at the facility. If there	20255		08/21/2026

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20255	Continued from page 5 were resident concerns about call lights, he would ask specific questions, look at trends and patterns. For example, if long call lights were around the supper meal, he would expect an analysis of the situation and potentially add staff or reassign responsibilities. VPO stated he would expect QAPI minutes to identify data had been analyzed, a root cause analysis completed, action/interventions identified. For long call light wait times, circle back with residents, look at specific grievances, ask specific questions - time of day, day of week, etc. Adjust operations and business practices, monitor, audit. Call light logs should be utilized if a facility can run them, and then data presented to the QAPI committee for review. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and adhere to the facility QAPI (quality assurance and performance improvement) plan, the federal requirements for an effective QAPI committee, and educate members of the QAPI committee on the QAPI process. The administrator or designee could ensure QAPI minutes reflected the identification of problems, goals, measurements, audits, analysis and outcomes. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20255		08/21/2026
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) assessment was coded accurately for 1 of 1 resident (R50) reviewed for discharge a by inaccurately coding a planned discharge as an unplanned discharge, and failed to follow the Resident Assessment Instrument (RAI) Manual. Findings include: R50's discharge assessment - return not anticipated MDS dated 6/28/26, indicated unplanned discharge to home/community on 6/28/26, cognitive skills for	20550	corrected	08/21/2026

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20550	Continued from page 6 daily decision making: modified independence - some difficulty in new situations only; was independent with oral hygiene, toileting hygiene, dressing, personal hygiene, transfers, walking, did not use a wheelchair, diagnoses indicated hemiplegia following cerebral infarction affecting left non-dominant side (stroke-related condition where a blood clot or blockage; has caused paralysis or severe weakness on the left side of the body). R50's discharge instructions dated 6/25/26 at 1:37 p.m., licensed practical nurse (LPN)-A indicated discharge home, reason for discharge: resident request, admission date 4/28/26, came to our facility following hospitalization for CVA (stroke) with left sided weakness and left sided vision deficit. Has worked with therapy and is now independent with all cares, further the document was signed by R50 and indicated understood the medication instructions and other instructions given to me by the healthcare professional. R50's document titled notice of resident/patient transfer or discharge 6/29/26, social services (SS) director-A indicated date of anticipated discharge 6/28/26, date notice provided 6/26/26, the transfer or discharge is/was appropriate because the resident's health has/had improved sufficiently so the resident no longer needs/needed the services provided by the facility R50's provider note progress note dated 6/25/26, nurse practitioner (NP)-D indicated okay to discharge to home with current meds and treatment plan. R50's progress note dated 6/28/26 at 8:45 a.m. the director of nursing (DON) indicated R50 packed personal belongings and brought to the front door awaiting on dtr (daughter) pick up, ambulating independently w/o (without) aid, reviewed d/c medications with resident again. Understanding noted AEB (as evidenced by)resident repeating instructions, reading out loud and familiarity/awareness with names and dosing of medications, provided printed out MAR (medication administration record) for June/July so resident has 'a graph' so she can check off after taking. informed resident and dtr that writer spoke with pharmacist at pharmacy yesterday to ensure medications were ready for pick up, R50 excited to be returning home. D/C (discharge) instructions, meds and personal belongings with resident. discharged to home via private vehicle/dtr. On 7/15/26 at 10:00 a.m., the director of nursing	20550		08/21/2026

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20550	Continued from page 7 (DON) stated R50's MDS had been completed as an unplanned discharge because the timing of the discharge changed at the last minute and the facility was not prepared for the resident to leave that day. The DON stated the family situation was dysfunctional and there was uncertainty regarding transportation and whether R50 would return home with family or independently. The DON confirmed R50 was ready for discharge; however, the facility had not planned for the resident to leave on the day of discharge. The DON confirmed the discharge process was followed, a provider discharge order was obtained, all necessary discharge paperwork and education were provided to R50, and R50 did not leave AMA (against medical advice). On 7/15/26 at 11:49 a.m., registered nurse (RN)-A, the MDS coordinator, stated R50's discharge arrangements were finalized only a couple of days before discharge and the assessment was coded as an unexpected discharge because they believed that coding was consistent with the Resident Assessment Instrument (RAI) Manual. The MDS coordinator stated R50 did not leave AMA and that although the facility did not know the exact day R50 would leave until shortly before discharge, a provider discharge order had been obtained and facility discharge instructions had been completed. On 7/15/26 at 11:59 a.m., licensed practical nurse (LPN)-A stated R50 had been working toward discharge home, discharge planning discussions had occurred several days before discharge, and a provider discharge order had been obtained. The nurse stated the uncertainty involved whether R50 would return home with family or independently, not whether R50 would be discharged from the facility. On 7/15/26 at 12:22 p.m., the nurse practitioner (NP)-D stated R50's discharge was planned and was not an unexpected discharge. On 7/15/26 at 12:47 p.m., the social services (SS)-A director stated R50's discharge had been planned, a care conference had been held regarding the discharge, and the MDS would not be expected to be coded as an unplanned discharge. Review of the RAI Manual dated 10/25, indicated an unplanned discharge occurs when the discharge was unexpected, such as an acute hospitalization or the resident leaving against medical advice. Because R50's discharge planning had occurred over several days, a provider discharge order had been obtained, discharge instructions were completed, and the resident did not leave AMA, the discharge did not	20550		08/21/2026

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20550	Continued from page 8 meet the definition of an unplanned discharge. Facility Discharge Planning Policy dated 1/25, indicated at discharge the rounding provider must write an order for discharge, if the rounding provider refuses to write a discharge order and the resident insists on being discharged anyway refer to Against Medical advice policy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to Minimum Data Set (MDS) assessments, including identification of when a planned versus unplanned discharge occurred and collection of required information. The director of nursing or designee could educate staff to policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. The results of those audits could be taken to the quality assurance and performance improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20550		08/21/2026
20800	Nursing Personnel; Staffing requirements CFR(s): MN Rule 4658.0510 Subp. 1 Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide sufficient nursing staff to ensure 13 of 13 residents (R7, R4, R13, R31, R45, R35, R37, R42, R29, R35, R8, R24, R33), reviewed for sufficient staffing, received care and assistance in a timely manner. The lack of sufficient staff had the potential to affect all 42 residents who resided in the facilit Findings include: Refer to F676: Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain ral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance.	20800	Corrected	08/21/2026

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20800	Continued from page 9 Refer to F677: Based on interview and document review, the facility failed to provide oral care to 1 of 1 resident (R13) who was reviewed for assistance with activities of daily living (ADLs) and who was dependent upon staff for ADL cares. Refer to F688: Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. RESIDENT/FAMILY INTERVIEWS/ CALL LIGHT RESPONSE TIMES R7’s quarterly Minimum Data Set (MDS) assessment dated 6/26/26, indicated orthopedic aftercare for hip fracture. R7 had intact cognition, clear speech, could understand and be understood. R7 required substantial assistance or was dependent upon staff for activities of daily living (ADLs). R7 was always incontinent of bowel and did not walk. During an interview on 7/13/26 at 11:21 a.m., R7 stated the facility was chronically short-handed; he didn’t have bowel control and used his call lights to have his brief changed or to get in or out of bed. R7 stated he was frustrated with the length of time it took staff to answer his call light. R7 had 216 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 17 31-40 minutes = 6 41-50 minutes = 5 51-60 minutes = 1 61-70 minutes = 1 >70 minutes = 2 >130 minutes = 2 >150 minutes = 1 R4’s quarterly MDS assessment dated 7/17/26, indicated cardio/respiratory condition, including congestive heart failure (when the heart cannot	20800		08/21/2026

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20800	Continued from page 10 pump efficiently to meet the body's needs). R4 had intact cognition, clear speech, could understand and be understood. R4 required substantial assistance with oral hygiene, dressing, standing, sitting, toileting and walking short distances. During an interview on 7/13/26 at 10:25 a.m., R4 stated it took a long time for staff to answer her call light, "I'm at the end of the hallway and I feel pissed off; happens daily." R4 had 342 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 19 31-40 minutes = 2 41-50 minutes = 1 51-60 minutes = 2 61-70 minutes = 1 R13's admission MDS assessment dated 7/7/26, indicated orthopedic after care for fractures and other multiple trauma. R13 had intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all ADLs, was frequently incontinent of stool and did not walk. During an interview on 7/13/26 at 1:33 p.m., family member (FM)-A stated a few times when she had come into R13's room, her call light was not in reach and R13 had to yell for help. FM-A stated R13 was able to activate her call light and had waited up to 45 minutes for someone to respond. FM-A stated R13 had called her crying when no one came. FM-A stated R13 had pounded a cup on the overbed table to get the staff's attention. Observed call light on the floor behind the bedside dresser. FM-A handed it to R13. R13 had 111 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 3 31-40 minutes = 3 41-50 minutes = 2 51-60 minutes = 2	20800		08/21/2026

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20800	Continued from page 11 >80 minutes = 1 R31's quarterly MDS assessment dated 6/15/26, indicated fractures, heart failure and Alzheimer's disease. R31 had severe cognitive impairment, clear speech, could understand and be understood. R31 required substantial assistance with most ADLs, was always incontinent of bladder and bowel, and did not walk. During an interview on 7/13/26 at 2:08 p.m., R31 stated the facility was short staffed in the evening, and it took a long time for his call light to be answered. R31 stated he waited up to 45 - 60 minutes. R31 stated call lights were discussed at resident council meetings, but residents were pretty much blown off. R31 stated he used his call light to use bathroom or lay down. R31 stated staff ran and hurried and apologized, but there were not enough of them. R31 had 172 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 13 31-40 minutes = 5 41-50 minutes = 6 51-60 minutes = 1 71-80 minutes = 1 >140 minutes = 1 R45's quarterly MDS assessment dated 7/6/26, indicated stroke and heart failure. R45 had moderately impaired cognition, clear speech, could understand and be understood. R45 was always incontinent of bladder and bowel and did not walk. During an interview on 7/13/26 at 11:08 a.m., R45 stated he waited a long time for his call light to be answered. R45 stated service was better when he moved in (2024), but not now. R45 stated he had called the fire department and his sister for help in the past when no one answered his call light. R45 stated he used his call light for brief changes, get in or get out of bed. R45 had 34 call light activations dated 5/12/26-7/12/26, indicating call lights were answered in the following time frames:	20800		08/21/2026

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20800	Continued from page 12 >30 minutes = 1 >40 minutes = 2 R35's quarterly MDS assessment dated 6/19/26, indicated heart failure and diabetes. R35 had intact cognition, clear speech, could understand and be understood. R35 required substantial assistance for most all ADLs, was always incontinent of bladder and bowel and did not walk. During an interview on 7/13/26 at 3:13 p.m., R35 stated she had waited up to 1 1/2 hours for staff to answer her call light. R35 stated she used her call light for the bathroom and to go to activities. R35 stated she stayed in her wheelchair rather than recliner because it took too long for staff to come, and if in her wheelchair, was ready to go. R35 had 257 activations call light activations dated 5/12/26- 7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 19 31-40 minutes = 11 41-50 minutes = 6 51-60 minutes = 1 61-70 minutes = 4 71-80 minutes = 1 91-100 minutes = 1 R37's annual MDS assessment dated 4/15/26, indicated R42 was cognitively intact, required supervision with personal hygiene, and partial/moderate assistance with dressing and transfers, utilized a manual wheelchair and diagnoses included muscle weakness. R37's care plan dated 6/2/26, indicated fall risk related to weakness, history of falling, assistance with ADL (activity of daily living) and transferring and interventions including monitor and document on safety, reminder sign on bathroom door to call for staff assist with toileting, assist of one with toileting. On 7/13/26 at 11:30 a.m., R37 was seated in a wheelchair in their room and stated they sometimes had to wait a long time for assistance while in the bathroom. R37 stated when they were unable to	20800		08/21/2026

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20800	Continued from page 13 clean themselves after toileting, they remained in the bathroom waiting for staff assistance for approximately 30 minutes to one hour. R37 stated they would do what they could independently and return to their room without receiving assistance. R37 stated they did not like having to wait but understood staff were busy. R37 stated the delay was worse on the day shift and stated they were no longer able to clean themselves independently. Call light times dated 5/12/26-7/12/26, indicated the following : 143 activations 21-30 minutes = 8 31-40 minutes = 9 41-50 minutes = 8 51-60 minutes = 3 61-70 minutes = 1 >70 minutes = 2 R42's admission MDS dated 5/20/26, indicated cognitively intact, no rejection of care, required supervision or touching assistance with oral hygiene, diagnosis included displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture (break of the lower leg), and history of falling. R42's CAA (care area assessment) dated 5/21/26, indicated R42 had a decline in mobility following hospitalization for a fall that resulted in a right ankle fracture, in PT (physical therapy) and OT (occupational therapy) at this time, needing assistance with mobility and ADLs (activities of daily living), alert and oriented and able to make her needs known, plan to continue to provide assistance with ADLs and follow therapy recommendations. R42's care plan dated 5/15/26, indicated alternation in mobility, does not walk, assist with movement in bed and in/out bed, set up with personal hygiene. On 7/13/26 at 10:46 a.m., R42 stated they had to wait approximately 30 to 45 minutes for staff assistance with toileting needs, including urination and bowel movements. R42 stated they had not experienced accidents due to the delays but began wearing a brief because of the concern. R42 stated weekends were the worst due to short staffing and	20800		08/21/2026

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20800	Continued from page 14 stated delays also occurred during shift change and during the week. R42 stated they learned to request assistance before shift change because staff would tell them, "Sorry, we are short staffed." R42 stated there were times when they were left waiting on the commode and reported they had previously complained and cried about the delays, resulting in a room change to a different hallway. R42 stated delays continued after the move and were especially concerning when only one staff member was available when two staff members were needed for assistance. Call light times dated 5/12/26-7/12/26, indicated the following : 280 activations 21-30 minutes = 20 31-40 minutes = 11 41-50 minutes = 3 RESIDENT COUNCIL R29's quarterly MDS assessment dated 5/1/26, indicated intact cognition, use of walker and wheelchair, partial assistance with toileting, bathing, and transfers, and diagnoses of heart failure and high blood pressure. R35's quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of wheelchair, dependent with toilet use, substantial assistance with bathing, substantial assistance for transfers, and diagnoses of heart failure and kidney insufficiency. R8's admission MDS assessment dated 6/26/26, indicated intact cognition, use of walker and wheelchair, substantial assistance for toileting and dressing, independent with transfers, and diagnoses of high blood pressure and diabetes mellitus. R24's quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of walker, independent with hygiene, dressing, and transfers, and diagnoses of cancer and heart failure. R33's quarterly MDS assessment dated 6/5/26, indicated intact cognition, use of walker and wheelchair, independent with dressing, eating, and transfers, and diagnoses of high blood pressure and Parkinson's disease.	20800		08/21/2026

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20800	Continued from page 15 During resident council meeting on 7/14/26 at 1:50 p.m., the following statements were documented: R29 stated staffing was a big concern at the facility. R29 stated she waited over 30 minutes for her light to be answered and sometimes had to have her bath rescheduled. R29 further stated concerns had been brought up at resident council meetings but the council had not heard back on what had been done about staffing concerns and long call light wait times. R35 stated her call light was answered after 30 minutes and sometimes up to 90 minutes. R35 stated that was too long to wait. R35 also stated she missed her bath due to lack of staff at the facility. R8 stated she was fairly independent and did not need much help, but has heard other residents say it took a long time for their lights to be answered. R8 stated she participated in resident council meetings and staff response time and lack of staff was always a topic, but had not heard a response from the facility. R24 stated she waited over 30 minutes multiple times for her light to be answered and she thought weekends were particularly worse. R24 further stated she had missed her bath and it sometimes took three days for staff to get caught up and give her a bath. R24 stated she did not like waiting an additional three days. R33 stated 20 minutes was too long for him, and he often had to wait over 20 minutes. R33 further stated if he had to go to the bathroom and waited over 20 minutes, he would have an accident in his brief. R33 stated he had accidents due to waiting more than he would like to admit. During interview on 7/15/26 at 7:58 a.m., activities assistant (AA)-A stated she facilitated resident council meetings and took meeting minutes. AA-A stated the facility did not do a formal follow-up to resident concerns, did not have anything in writing, and did not recall how or if resident council concerns regarding staffing had been addressed. STAFF INTERVIEWS During a confidential interview, employee-C stated the unit known as the south unit, used to have three nursing assistants (NAs) and now had two. Employee-C was aware some residents complained of long call light wait times. Employee-C stated the unit had a lot of residents who required significant	20800		08/21/2026

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20800	Continued from page 16 assistance from NA staff for dressing, toileting, and two staff for transfers and/or use of mechanical lifts. In addition, employee-C stated staff were not provided walkie-talkies so spent a lot of time looking for each other. Employee C stated it was important for NA staff to be able to communicate information to the nurse quickly, and if had to go room to room looking for the nurse, valuable time could be wasted. Employee C stated many times she has had to go room to room looking for an NA. During a confidential interview, employee-F stated it was pretty common to get complaints from residents about long call light wait times and they were surprised when she got there right away. Employee-F stated the facility did not use walkie-talkies and often had to go room to room to look for a coworker. Employee F stated she had been in a situation where a resident fell, had to put a pillow under their head, and leave the room to find the nurse. Employee-F stated they had a meeting last year after State surveyors left and they brought up walkie-talkies, but nothing changed. Employee F stated a lot of things were talked about, but nothing got done. Employee-F stated currently six residents required the use of a mechanical lift which tied up two NAs for long periods. Employee F stated NAs gave baths on the evening shift which she didn't think was good because that left the other NA on the floor alone causing delays in helping with two-person assists. During a confidential interview, employee B stated she was aware some agency nurses would not return to work at the facility because staffing levels never improved. Employee B stated the south unit had 24 high-acuity residents with only two NAs, adding that was a safety concern. Employee-B stated leadership knew they were short staffed and should be doing something about it. Employee-B stated staff were afraid to speak up for fear of losing their job. Employee-B stated there were no walkie-talkies for communication, so staff had to run around to track people down. Employee-B stated the facility was not able to meet the needs of residents and was aware some families had removed their family member from the facility because of that. During a confidential interview, employee-D stated they were short staffed and used a lot of agency staff. Employee D stated they did their best but acknowledged residents sometimes waited a long time to get care. Employee D stated they did not use walkie-talkies, so often had to go up and down the hall looking for help and that caused delays.	20800		08/21/2026

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20800	Continued from page 17 On 7/13/26 at 5:00 p.m., nursing assistant (NA)-B stated there were two nursing assistants working today. NA-B stated that on the previous evening, after 6:00 p.m., they were the only nursing assistant because the agency staff member who had been scheduled to work did not report. NA-B stated the agency staff member had been scheduled to work doubles throughout the weekend but was unsure whether they had reported for any of the shifts. NA-B stated they provided evening cares and answered call lights by herself the day prior. NA-B stated it was not common to have only one nursing assistant scheduled on the east and west, due to agency staff not showing for the scheduled shift. NA-B stated there were usually two nursing assistants assigned to the south hall and estimated approximately six residents required two-person assistance. NA-B stated call light response times could be delayed depending on the how many staff were working and the needs of the residents. NA-B stated the facility does not have any tools in place to assist staff with requesting help such as walkie talkies and staff would need to yell if assistance was needed. On 7/13/26 at 5:10 p.m., licensed practical nurse (LPN)-A, stated two nursing assistants were sufficient for the east and west hallway, but if only one nursing assistant was available the nurse would need to assist. LPN-A stated it occurred more often that only one nursing assistant was available because agency staff failed to report for work. LPN-A stated when this occurred, staff attempted to call employees who were off duty and notified the director of nursing for direction. On 7/13/26 at 5:43 p.m., a call light illuminated for Room 11. NA-C was observed responding to the call light. At 5:46 p.m., another call light illuminated for Room W-2 while NA-C remained in Room 11. NA-C stated, "I can't leave this resident alone. My partner is on break." The call light remained active until 5:57 p.m. On 7/13/26 at 6:21 p.m., NA-C stated they had been asked to report early to their shift because baths scheduled over the weekend had not been completed and staff were attempting to complete the missed baths. On 7/14/26 at 8:32 a.m., the trained medication aide (TMA)-B stated it was difficult for one TMA to complete medication administration and additional help would be beneficial. The TMA stated they were the only TMA for the building. The TMA stated there were usually two NA's scheduled for east and west	20800		08/21/2026

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20800	Continued from page 18 hall but occasionally only one was available when someone called in or agency staff did not report. On 7/14/26 at 8:46 a.m., NA-A stated they were scheduled to work from 6:00 a.m. to 2:30 p.m., on 7/11/26, but remained at the facility until 6:00 p.m. because another staff member did not report. NA-A stated they were the only nursing assistant on Sunday 7/12/26, from 6:00 a.m. to 2:30 p.m. NA-A stated baths, resident weights, and ambulation were not completed because only one nursing assistant was available. NA-A stated residents experienced delays in call light response times and questioned why staff took longer to respond. NA-A stated it was not uncommon to have only one nursing assistant working on weekends. On 7/14/26 at 9:07 a.m., the social services director (SS)-A stated residents had complained about call light response times and was "not a surprise". SS-A stated when residents have concerns regarding call light response times, residents were encouraged to speak with the charge nurse and staff are educated regarding the concerns. SS-A stated concerns regarding call light response times were a known concern at the facility and stated it was not a surprise that concerns regarding resident call lights were identified during the survey. On 7/14/26 at 9:09 a.m., the administrator stated call light response times had previously been reviewed and acknowledged there were some lengthy response times. The administrator stated they could not specifically recall any exceeding 30 minutes but believed any response time over 30 minutes would be considered significant. The administrator stated R42 voiced concerns with long call light times and R42 call lights were reviewed and the administrator stated they did not remember whether there were more than two occurrences over 30 minutes. The administrator stated staff discussed the concerns with R42 and believed transferring R42 to another wing would improve response times. The administrator stated additional call light logs were not reviewed because no grievances had been filed. The administrator stated the facility does not routinely conduct call light audits. The administrator stated the last review of call light logs occurred approximately two months earlier during an investigation in which each wing was reviewed. The administrator stated concern would generally be identified if more than two or three rooms demonstrated call light response times exceeding 30 minutes. The administrator stated they did not review the call light logs provided during this survey, did not believe the facility had long call light	20800		08/21/2026

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20800	Continued from page 19 response time issues, and stated concerns would be addressed in real time rather than through the QAPI process. On 7/14/26 at 9:36 a.m., LPN-B stated call light response times on the south hall could exceed 30 minutes. LPN-B stated staff were burned out, were frequently called on their days off to pick up shifts due to staffing shortage, residents missed baths and resident ambulation was not completed occurred due to staffing shortages. LPN-B stated some residents did not receive breakfast until approximately 9:30 a.m. because morning cares were delayed. LPN-B further stated the facility did not provide walkie-talkies, requiring staff to search for coworkers when assistance was needed, which further delayed resident care and call light response. On 7/14/26 at 9:45 a.m., NA-D stated when staff members leave for breaks, only one staff member remains on the unit, resulting in residents frequently experiencing long wait times for assistance. NA-D stated when a resident requires a two-person transfer to the toilet, other residents may have to wait for assistance until additional staff are available. NA-D stated management was aware of long call light response times and that the facility's computer system tracked call light response times. NA-D stated staff had voiced concerns regarding delayed response times to management and were instructed to respond to residents more timely; however, staffing levels were not increased. NA-D stated staff responded to call lights as quickly as possible and did not have downtime but could not respond more quickly when there were not enough staff available. NA-D further stated staffing decisions were based solely on resident census. NA-D confirmed R42 had been moved to a different unit due to concerns regarding delays in receiving care. NA-D further stated overnight staff would at times assist R42 to the toilet and then leave to assist another resident, resulting in R42 waiting approximately 30 minutes for assistance before staff returned. On 7/14/26 at 2:42 p.m., nursing assistant (NA)-C stated the facility had a lot of staff who didn’t come for their shifts, especially on the weekends, particularly agency staff. NA-C further stated the facility used a star system to ensure coverage and she had to stay later than her scheduled shift often to cover for other staff who didn’t show up. NA-C stated staffing was not adjusted based on resident needs, there was always a set number of three or four nursing assistants no matter how many residents there were in the facility. NA-C stated it was hard to get help when needed and residents had	20800		08/21/2026

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20800	Continued from page 20 to wait a long time. On 7/14/26 at 2:46 p.m., NA-B stated when they were short-staffed residents had to wait a long time for help. NA-B further stated they were short-staffed a lot, especially on weekends. On 7/14/26 at 4:51 p.m., the director of nursing (DON) stated weekend staffing schedules posted in the facility were not updated in real time to reflect actual staffing. The DON stated they spent a significant portion of her day providing resident care because of staffing shortages and stated agency staff had contributed to the staffing problems and doing a disservice to the facility. On 7/15/26 at 6:38 a.m., LPN-C stated she worked the night shift and if there were 42 residents, one nurse and two NAs were adequate, but when the census rose to 47 or 48 it was not. LPN-C stated there were one NA on each floor and her, and at 1:30 a.m., and 4:30 a.m., the NA from first floor went to second floor to help, and they covered each other for breaks. LPN-C stated they used to have walkie-talkies but didn't anymore and didn't know why, so they used their personal cell phones or the house phone to contact each other. In order to know if a call light was going off, LPN-C stated staff had to be in the hallway to observe the scrolling marquee and might hear the beep (indicating a call light was activated) or you might not. On 7/15/26 at 8:49 a.m., LPN-A stated that when staffing is limited, nurses may need to assist; however, one staff member caring for approximately 21 residents is insufficient. LPN-A stated they have heard residents report staffing shortages on multiple occasions. LPN-A further stated the south wing requires three staff members and delays occur when staff must search room-to-room for assistance. LPN-A stated staff previously used walkie-talkies, but without them staff may not know another resident requires assistance. LPN-A stated they had spent significant time looking for available staff and has been told by residents they have waited up to 30 minutes for assistance. LPN-A stated the director of nursing (DON) was aware of these concerns and frequently works on the floor, where the issues should be readily apparent. LPN-A stated the facility did not provide staff with walkie-talkies. LPN-A stated this created a safety concern because if a resident fell, was bleeding, or required immediate assistance while staff were in another resident's room, they would not be able to quickly obtain help from another staff member.	20800		08/21/2026

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20800	Continued from page 21 On 7/15/26 at 9:05 a.m., maintenance director (MD)-A provided resident care unit distance measurements: first floor from beginning of the east hallway to end of the west hallway was 130 feet (equivalent to a 12-13 story building). Distance on the south unit, from first room to last room was 206 feet (more than half the distance of a football field) On 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the time of the interview and that he was covering her responsibilities. VPO stated the facility administrator was responsible for completing the facility assessment, and stated that he would expect the facility assessment to include staffing numbers and information regarding the facility's staffing levels. VPO did not identify any specific staffing concerns and stated that the facility occasionally utilizes agency staff to address staffing needs when necessary. VPO stated that the administrator would be expected to review staffing trends and patterns, ask specific questions regarding identified issues, and ensure that appropriate actions were implemented. VPO stated if concerns such as extended call light response times were identified, the administrator would be expected to investigate the issue by asking questions such as when the delays are occurring, whether they are isolated to a particular shift and what interventions were needed. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program. On 7/15/26 at 2:30 p.m., the DON stated staffing levels were determined based on resident acuity, resident census, holidays, anticipated resident needs, and hours per resident day (PPD), with a target of approximately 3.0 PPD. The DON stated resident needs were reviewed during the morning meeting, including new admissions and residents requiring additional assistance. However, when asked how resident acuity was incorporated into staffing decisions, the DON was unable to clearly explain the process or identify how staffing assignments were adjusted to meet resident care needs. The DON stated staffing assignments varied by unit, with lighter staffing on the east and west halls and staff floating to the south hall as needed. The DON stated staff were supposed to carry pagers to receive call light notifications but acknowledged the pagers were missing and stated, "Maybe they're lost." The DON further stated staff would have to	20800		08/21/2026

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20800	Continued from page 22 leave a resident's room to view the scrolling call light display at the end of the hallway. The DON stated the facility had purchased walkie-talkies approximately one month earlier but had not implemented their use. After discussion regarding delayed staff response, the DON stated walkie-talkies could be implemented that evening to improve communication. When asked how the facility determined staffing was adequate, the DON stated residents were cared for, there were no odors, pressure ulcers were not worsening, residents were happy, and meals were provided. However, the DON was unable to identify specific monitoring processes to ensure resident oral care, bathing, and other activities of daily living (ADLs) were consistently completed. The DON acknowledged managers, including the DON, frequently provided direct resident care because of staffing shortages and stated the facility did not have enough staff to add additional personnel. The DON further stated nursing assistant documentation was poor because some staff lacked electronic medical record (EMR) access, documentation was lost, agency staff lost documentation, and staff did not have time to complete documentation. When informed that multiple residents and staff independently reported delays in care and prolonged call light response times, the DON stated there was no explanation for why this was occurring. On 7/15/26 at 3:03 p.m., the administrator stated daily staffing decisions were based on resident census, resident acuity, and PPD following discussion of admissions, discharges, and resident needs during the daily stand-up meeting. The administrator stated staffing adequacy was evaluated by the absence of wounds, falls, odors, resident complaints, and whether residents were coming to the nurses' station. The administrator acknowledged the facility did not routinely monitor call light response times and stated the last review of call light data occurred approximately two weeks earlier for a single resident concern rather than reviewing facility-wide trends. The administrator stated staffing was adjusted for resident acuity, including hospice residents, residents requiring mechanical lifts, extensive wounds, and psychosocial needs. However, the administrator acknowledged staff communication regarding resident call lights was not functioning as expected. The administrator believed staff carried pagers but acknowledged only one working pager was available at each end of the building and stated staff would have to leave a resident's room to obtain assistance or holler for help because no established communication process was in place. The administrator further stated staff	20800		08/21/2026

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20800	Continued from page 23 were expected to complete documentation throughout the shift "when they have a minute", however no time is dedicated to documentation. On 7/15/26 at 3:41 p.m., RN-C, known as the regional nurse consultant, stated staffing levels were based on PPD and resident acuity, with staffing increased when residents required additional care. RN-C stated the facility was budgeted for a specific PPD and staffing adjustments required clinical justification. However, RN-C acknowledged resident care was not consistently being completed and specifically identified oral care not being completed, resident ambulation needs not being met, and prolonged call light response times. RN-C stated two nursing assistants assigned to the south hall were "probably not enough." RN-C further stated there had been no documented staff meetings or documented follow-up regarding staffing concerns and would have expected documentation of education and corrective actions related to identified staffing issues. On 7/16/26 at 8:20 a.m., NA-E stated the facility needed four or more nursing assistants during the day and evening because of the floor plan of the facility, especially during busy times. NA-E stated they put on a lot of steps each day and covered a lot of area. NA-E stated it was hard to get everything done on time and baths got missed and pushed off to other days. On 7/16/26 at 8:22 a.m., NA-A stated it was hard to get her work done on time, especially because there was no way to communicate with other staff. NA-A stated when she needed assistance she would have to search for another staff member and that took up extra time. Review of the facility assessment dated 6/1/26, indicated the following: Direct Care Staffing Plan: To ensure an adequate amount of staff at Lakeshore Rehabilitation Center at all times, the resident population, CMI, and census is taken into account daily to determine sufficient staffing needs. Lakeshore's IDT reviews census on the daily census template sent out daily by Health Information to determine the needs on each unit. Any admission and discharges planned also factor in and assist in determining the staffing needs for each day on each unit. Individual assignments for continuity of care for residents and across staff assignments is determined by the DON, Nurse Management, Charge Nurse, Unit Nurse in that order of hierarchy.	20800		08/21/2026

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20800	Continued from page 24 During interview on 7/15/26 at 2:34 p.m., administrator stated staffing should be based off the facility assessment, but the facility assessment was lacking any indication of how many staff were needed at the facility. Administrator further stated she did not have a specific algorithm for determining staffing levels and making necessary adjustments. A staffing policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could work with the administrator to develop a system to ensure staffing levels are adequate to meet resident care needs. The facility could develop auditing tools to ensure the required resident care is being provided consistently and timely and report results to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20800		08/21/2026
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement a bowel movement (BM) protocol for 1 of 1 resident (R13) reviewed for constipation. Findings include: R13's diagnosis report dated 7/16/26, included diagnoses of fractured vertebrae, fracture of right radius (bone in forearm) and fracture right humerus (bone in upper arm). R13's admission Minimum Data Set (MDS) assessment dated 7/7/26, indicated intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all activities of daily living (ADLs) and did not walk. R13's physician orders dated 6/30/26, included senna (laxative) oral tablet 8.6 mg (milligrams), give	20875	Corrected	08/21/2026

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20875	Continued from page 25 three tablets by mouth as needed for constipation; three tablets two times a day as needed for constipation. In addition, orders dated 6/30/26, included: may use standing orders as signed by provider. Standing orders signed by provider 3/11/26, indicated for bowel protocol: --Milk of Magnesia (laxative) 30 cc (cubic centimeter) orally daily PRN (as needed) if no bowel movement for two days. --Dulcolax suppository (laxative), one per rectum daily PRN if no bowel movement for three days. --Fleets (brand name) or tap water enema rectally daily PRN constipation. R13's care plan dated 7/7/26, indicated an alteration in elimination related to mobility limitations and R13 would move bowels every three days or greater. R13's bowel movement task list completed by NAs, indicated R13 did not have a documented BM from 7/9/26 through the morning of 7/14/26 (six days). During an observation on 7/14/26 at 11:17 a.m., licensed practical nurse (LPN)-B spoke to R13 to ask how she was feeling. R13 reported pressure down there (hand over lower abdomen) and stated she had not had a BM for a while. After leaving the room, LPN-B accessed the electronic medical record (EMR) and saw the last documented BM for R13 had been on 7/8/26, six days ago. LPN-B had not been aware if the facility had a BM protocol or standing orders and stated she would give R13 the PRN laxative ordered for her. During an interview on 7/14/26 at 2:04 p.m., nursing assistant (NA)-D stated NAs documented resident BMs in POC (point of care) in the EMR. If a resident was independent with toileting, might not know if they had a BM unless asked. For other residents, we know if they had BM because we change their brief or take them to the bathroom. NA-D admitted a NA might forget or not have time to document cares including BMs, in POC. During an interview on 7/15/26 at 11:45 a.m., registered nurse (RN)-C stated R13 had no results from the PRN medication given the day before, and therefore gave R13 a suppository that morning and R13 had a BM. During an interview on 7/15/26 at 12:50 p.m., RN-C stated nursing staff were expected to monitor resident BMs via the EMR and the BM sheet the	20875		08/21/2026

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20875	Continued from page 26 night shift staff filled out indicating residents to receive a suppository after not having a BM for three days. If a resident went more than three days without a BM, staff should start the protocol per the standing orders which indicated to start with a stool softener or Milk of Magnesia, then a suppository, then an enema. RN-C pointed to the standing orders posted on the bulletin board in the nurses' station office. RN-C confirmed by what she could see, nursing staff had not been monitoring R13's BMs since she had gone six days without a BM and no intervention. During an interview on 7/16/26 at 8:48 a.m., the director of nursing (DON) had been informed of findings. The DON stated it was not okay for a resident to go six days without a BM. The DON stated by day three, should receive a suppository per the standing orders and that all nursing staff should know that. The DON acknowledged staff had not been monitoring and addressing R13's BMs per the standing orders. A bowel monitoring policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise policies and procedures if necessary, regarding monitoring resident bowel movements, carrying out standing orders, and re-educating staff on the expected procedures. In addition, the DON or designee could determine a specific timeframe to conduct monitoring audits to ensure compliance. The DON or designee could take the results of the education and audits to the quality assurance and performance improvement (QAPI) committee to ensure appropriate oversight and/or the need to continue monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20875		08/21/2026
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	20895	Corrected	08/21/2026

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20895	Continued from page 27 B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. Findings include: R29's diagnosis report dated 7/16/26, included generalized osteoarthritis, diabetes, generalized muscle weakness and obesity. R29's quarterly Minimum Data Set (MDS) assessment dated 4/28/26, indicated intact cognition, clear speech, could understand and be understood. R29 required partial to moderate assistance with most ADLs including walking 150 feet. R29 used a walker and wheelchair for mobility. R29's physician orders dated 7/15/25, indicated per therapy, ensure resident is walked two times a day with staff, every day and evening shift. R29's "Therapy Alert" from PT dated 7/15/25, indicated R29 should ambulate one to two times a day with FWW (front wheeled walker) and assistance of one staff. R29's care plan dated 1/26/25, indicated R29 had an alteration in mobility related to impaired mobility and to follow PT instructions. On 7/15/25, care plan indicated to ambulate R29 two times a day with FWW and assist of one. R29's Kardex (a quick reference used by nursing assistants to inform them of a resident's care) printed on 7/16/26, indicated ambulate resident two times/day with FWW and assist of one. May progress distance as tolerated by resident. R29's documentation of ambulation in POC (point of care, where NAs document in the electronic medical record) indicated out of 28 days and 56 opportunities, documentation indicated R29 had been walked only nine times.	20895		08/21/2026

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20895	Continued from page 28 R29's TAR (treatment administration record) completed by nursing staff, indicated: ensure R29 walked two times a day with staff every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R29 was walked 21 times. Documentation between the NA who was responsible to perform the task and documentation of the nurse who was to be informed of task completion, did not match. During an interview on 7/15/26, at 9:36 a.m., R29 had been sitting in her wheelchair in her room with walker off to the side. R29 stated she used to be on a walking program but had not walked for a while because the facility was short staffed. R13 stated she would like to walk in the hallway, so her legs stayed strong. R37's diagnosis report dated 7/16/26, included diagnoses of congestive heart failure (when the heart doesn't pump as well as it should) diabetes, generalized muscle weakness, history of falling, and obesity. R37's annual MDS assessment dated 4/15/26, indicated intact cognition, clear speech, could understand and be understood. R37 required partial to moderate assistance with ADLs, including walking 150 feet. R37 used a walker and wheelchair for mobility. R37's physician orders dated 4/13/26, indicated ensure resident ambulates one to two times per day with assist of one to manage O2 (oxygen), every day and evening shift. R37's "Therapy Alert" from PT staff dated 4/7/26, indicated ambulate resident one to two times a day with FWW and assist of one to manage O2 tubing. R37's care plan dated 4/10/24, indicated alteration in mobility related to weakness and history of falling, and to follow PT instructions. PT's walking recommendations/instructions from 4/7/26, were not included in the care plan. R37's Kardex printed on 7/16/26, did not include ambulation recommendations by PT. R37's POC had not been set up to include recommendations from PT and therefore no location in POC for NAs to document if/when they ambulated R37. R37's TAR completed by nursing staff, indicated: ensure R37 ambulates 1-2x/day with assist of 1 to	20895		08/21/2026

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20895	Continued from page 29 manage O2 tubing, every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R37 was walked 27 times. However there had been no documentation by the NAs who were responsible for performing the task. During an interview on 7/15/26 at 9:30 a.m. R37 had been sitting in a wheelchair in her room with a walker off to the side. R37 stated she used to walk in the hallway but didn't anymore. R37 stated it was something she wanted to do in order to keep mobile, adding it was good for her to walk. R37 stated she used to walk to the shower room, but no longer. R37 felt she could walk if staff helped her. During an interview on 7/15/26, at 10:16 a.m., physical therapy assistant (PTA)-E, who was also the department director provided "Therapy Alert" forms for R29 and R37. PTA-E stated copies of the forms were given to the director of nursing (DON) and NAs. During an interview on 07/15/2026 1:40 p.m., nursing assistant (NA)-D stated R29 and R37 were on walking programs but admitted NAs were not always able to walk residents, including R29 and R37, due to being so busy. NA-D stated residents would usually be walked on the day and the evening shifts and sometimes that depended upon what was going on, such as an activity. NA-D stated walking was important, so residents didn't lose the ability to walk. During an interview on 7/15/26 at 4:48 p.m., with nursing assistant NA-E and NA-F, NA-E stated R29 and R37 were on a list at the desk to be walked in the morning and the afternoon. NA-E stated residents only got walked once a day due to their workload – it gets so heavy, we don't have time. NA-F agreed. NA-E stated if a resident was walked, it was charted in POC. NA-E stated sometimes the nurse would ask if they got it done and would document it too. NA-F stated most residents were in the facility for rehabilitation, and it was important they walked, adding, if you don't use it, you lose it. During an interview on 7/15/26 at 4:53 p.m., licensed practical nurse (LPN)-D stated she documented on the TAR when NAs ambulated a resident. LPN-D stated she did not always see residents being ambulated so asked the NA; if they said yes, she documented it and didn't question it. During an interview on 7/16/26 at 8:22 a.m., licensed practical nurse (LPN)-A, stated she did not know why nurses were asked to document a task	20895		08/21/2026

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20895	Continued from page 30 they did not do themselves. LPN-A stated she kept track if she saw a resident being walked, or if an NA told her they walked a resident, adding she had to trust what they told her. During an interview on 7/16/26 at 8:56 a.m., the director of nursing (DON) stated resident recommendations for walking came from PT. When received, the residents name would be added to a list at the nurses' station to inform NAs which residents should be walked. The DON was asked to look in POC for documentation of R29 and R37 being walked. For R29, the DON admitted R29 had not been walked according to PT recommendation, physician order, care plan and Kardex. For R37, POC had not been set up for NAs to document her walking and couldn’t say why, or how NAs documented this task without POC. The DON stated she did not monitor whether or not residents were walked according to PT recommendations, nor did she monitor documentation. The DON stated she asked the nurses if residents were walked even though they did not perform the task. The DON stated she knew the afternoon shift struggled with walking residents due to meals, bedtime and staff breaks. The DON stated it was important to walk residents, so they didn’t lose the ability to walk, it improved breathing and prevented formation of contractures. The DON stated she had been informed by NA staff they didn’t have time to walk residents but told them they could ask nurses to help them. Facility Activities of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would ensure a resident was given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility would provide care and services including walking. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise policies and procedures if necessary, and re-educate staff on expectations for carrying out physician orders for residents on a walking program. The DON or designee could determine a specific timeframe to conduct monitoring audits to ensure compliance. The DON or designee could take the results of the education and audits to the quality assurance and performance improvement (QAPI) committee to ensure appropriate oversight and/or the need to continue monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		08/21/2026

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20915	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 A Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain oral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance. Findings include: R42's admission Minimum Data Set (MDS) dated 5/20/26, indicated cognitively intact, no rejection of care, required supervision or touching assistance with oral hygiene, diagnosis included displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture (break of the lower leg), and history of falling. R42's CAA (care area assessment) dated 5/21/26, indicated R42 had a decline in mobility following hospitalization for a fall that resulted in a right ankle fracture, in PT (physical therapy) and OT (occupational therapy) at this time, needing assistance with mobility and ADLs (activities of daily living), alert and oriented and able to make her needs known, plan to continue to provide assistance with ADLs and follow therapy recommendations. R42's care plan dated 5/15/26, indicated alternation in mobility, does not walk, assist with movement in	20915	Corrected	08/21/2026

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20915	Continued from page 32 bed and in/out bed, set up with personal hygiene. R42's task: personal hygiene the ability to use suitable items to clean teeth, dated 6/16/26-7/14/26, indicated the following data that R42 was provided setup assistance, partial assistance, or independent 6/19/26 6/20/26 6/22/26 6/24/26 6/26/26 6/27/26 6/28/26 6/29/26 6/30/26 67/1/26 7/2/26 7/3/26 7/5/26 7/7/26 7/9/26 7/13/26 The data provided failed to indicate R42 was provided daily set up assistance with oral care. R42's treatment administration record (TAR) dated 7/1/26-7/30/26, indicated start date 5/14/26, NWB (non-weight bearing) rt (right) leg every shift, CAM boot; wea with all activities including sleeping. May remove for skin hygiene, icing and ankle ROM every shift for right ankle fracture On 7/13/26 at 10:51 a.m., R42 was observed seated in a recliner wearing a black orthopedic boot on the right lower leg. R42 stated she was non-weight bearing due to a fractured leg and required staff assistance to obtain her toothbrush, toothpaste, a	20915		08/21/2026

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20915	Continued from page 33 cup of water, and assistance to empty the water after brushing her teeth. R42 stated she did not receive assistance with morning oral care every day. R42 stated she frequently requested assistance; however, staff told her they did not have time because they were assisting other residents. R42 stated she stopped asking because she did not want another resident to have to wait for care. R42 stated she had been moved from another area of the facility because she was told the current hallway was less busy and she would receive timelier assistance. On 7/14/26 at 8:18 a.m., R42 stated she had not yet received morning care. She stated she preferred to eat breakfast before receiving assistance to wash up. R42 also stated she previously experienced long call light response times and had been instructed to call the facility's main telephone number when her call light was not answered. On 7/14/26 at 8:51 a.m., nursing assistant (NA)-A stated there were times staff did not have enough time to assist R42 with obtaining the supplies needed to brush her teeth and acknowledged assistance could be delayed until approximately 1:00 p.m. NA-A confirmed there were occasions when R42 requested assistance and they told R42 they were too busy. NA-A further stated R42 required assistance to obtain a glass of water and to empty the cup after brushing her teeth. On 7/14/26 at 9:00 a.m., the social services director (SS)-A stated R42 had previously been moved to another hallway due to concerns regarding long call light response times. SS-A confirmed review of call light logs identified response times exceeding 25 minutes for R42. Staff were educated regarding timely responses, and R42 was provided the front desk telephone number if assistance was not received. SS-A acknowledged R42 should not have to call the front desk to obtain assistance. On 7/14/26 at 9:09 a.m., the administrator confirmed R42 had expressed concerns regarding long call light response times and that the call light logs had been reviewed. The administrator stated she did not recall response times greater than 30 minutes and considered call light response times exceeding 30 minutes to be significant. The adminstrator stated R42 to was moved to a "less busy hallway". On 7/14/26 at 12:37 p.m., R42 stated her teeth had been brushed that day; however, she reported she was not routinely offered assistance with brushing her teeth on weekend mornings.	20915		08/21/2026

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LAKESHORE REHABILITATION CENTER LLC	**108 8TH STREET NORTHWEST , WASECA, Minnesota, 56093**

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20915	Continued from page 34 On 7/15/26 at 8:19 a.m., NA-A confirmed they did not have sufficient time to provide all required care to R42 on Saturday, 7/11/26, including oral care. On 7/15/26 at 8:49 a.m., licensed practical nurse (LPN)-A stated staff were expected to provide R42 with assistance to set up for teeth brushing. LPN-A stated nursing assistants were expected to notify the nurse if they were unable to provide the required assistance. LPN-A acknowledged R42 was particular about her oral hygiene. LPN-A further acknowledged staffing shortages could delay care, stating there were not enough staff to care for all residents, staff frequently had difficulty locating assistance, residents had reported waiting up to 30 minutes for assistance, and the director of nursing (DON) was aware of these concerns. On 7/15/26 at 10:20 a.m., the DON stated staff were expected to provide R42 with daily assistance to set up for tooth brushing and document the care provided. The DON stated staff were expected to complete ADL (activity of daily living) documentation before leaving their shift. The DON confirmed R42's documentation did not identify oral care was completed daily. Facility Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary are and services to ensure that a resident's abilities in activities of daily living do not diminish.... 3. The facility will provide care and services for the following activities of daily living a. hygiene-bathing, dressing, grooming, and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise policies and procedures if necessary, and re-educate staff on expectations for providing oral care to dependent residents. The DON or designee could determine a specific timeframe to conduct monitoring audits to ensure compliance. The DON or designee could take the results of the education and audits to the quality assurance performance improvement (QAPI) committee to ensure appropriate oversight and/or the need to continue monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20915		08/21/2026

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21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to maintain reusable resident care equipment in a manner that could be effectively cleaned and disinfected by continuing to use a bathtub chair with torn and cracked cushion surfaces in the east hallway bath room. This had the potential to affect any of the 19 residents residing on the east and west hallways who used the tub room Findings include: On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed the shower chair seat with a black vinyl cushion contained multiple tears, cracks, and openings throughout the seating surface. Portions of the vinyl covering were missing, exposing the underlying light-colored cushion material. The damaged areas created multiple irregular surfaces and openings across the seat cushion. On 7/15/26 at 12:50 p.m., nursing assistant (NA)-A stated the bathtub room was used for residents and confirmed the cracked shower chair was used. NA-A stated they placed a towel on the chair before residents use it. On 7/15/26 at 12:51 p.m., licensed practical nurse (LPN)-A stated the bathtub chair cushion was cracked and had openings and stated it "could be an infection control issue." On 7/15/26 at 12:55 p.m., maintenance director (MD)-A confirmed the bathtub chair cushion was cracked and damaged and stated they it would be expected to be replaced and stated they were not aware of the cushion's condition. On 7/15/26 at 12:59 p.m., the administrator observed the bathtub chair cushion and confirmed the cushion should not be in that condition due to infection control concerns. The administrator stated staff would not be expected to use the shower chair if the cushion was cracked. On 7/15/26 at 4:48 p.m., the director nursing (DON),	21385	Corrected	08/21/2026

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21385	Continued from page 36 also known as the infection preventionist, stated the shower chair was not expected to have cracked cushions and stated the damaged cushion could present an infection control problem. The facility Infection Prevention and Control Program policy dated 11/24, indicatedPrevention of Infectioninstituting measures to avoid complicationseducating staff and ensuring that they adhere to proper techniques and proceduresSUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure the infection control program developed to accurately reflect ongoing preventative maintenance of equipment that would pose a infection control risk on a scheduled or needed in the facility on a routine basis. The DON or designee could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The DON or designee could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		08/21/2026
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment for residents residing in East and West hallways resulting in large dark stains, fraying and worn carpet throughout the hallway and damaged, cracked, sagging, and discolored ceiling tiles in the east hallway bath tub room. Findings Include: On 7/13/26 at 5:09 p.m., observation of the east hallway outside resident rooms identified a discolored dark stain on the flooring measuring approximately 1½ feet by 6 inches, irregularly shaped with darkened edges and concentrated areas of discoloration. The stains were distributed throughout the hallway and were readily visible from a distance due to the contrast between the stained areas and the surrounding carpet. The	21665	Corrected	08/21/2026

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21665	Continued from page 37 carpeting appeared worn and soiled. On 7/13/26 at 5:21 p.m., the licensed practical nurse (LPN)-A stated the hallway carpeting was stained and frayed, and further stated the carpet was not securely attached at the seams. LPN-A stated the carpet had been shampooed the previous week; however, the stains remained because the carpeting was old. On 7/13/26 at 5:53 p.m., the environmental services manager (EVSM)-C stated the flooring had been scrubbed multiple times without improvement and that requests for replacement flooring had been ongoing for an extended period. EVSM-C stated the ripped carpet and stained flooring were maintenance issues, described the condition as "embarrassing" and "unfair to the residents," and confirmed the concerns were included in weekly reports submitted to environmental management. EVSM-C stated the carpeting was a concern and reported attempts had been made to clean the carpet; however, the staining worsened during humid conditions. On 7/14/26 at 10:04 a.m., the maintenance director (MD)-A and administrator confirmed the carpeting was not secure and frayed and stated "anything could be tripped on." They stated the carpet had been glued previously at the seams and replacement had been discussed; however, no replacement date had been established. The administrator acknowledged residents would not be expected to live with frayed carpeting or holes in the carpet as it is not a homelike environment. The administrator stated the carpet condition was a known concern and acknowledged the stains remained despite shampooing. The administrator stated the carpeting "does not look good or homelike," confirmed awareness of the condition. The administrator confirmed the carpets on the East and West halls did not provide a homelike environment. On 7/14/26 at 12:23 p.m., observation of the east hallway identified multiple areas where the carpeting was worn through with the carpet backing visible. Several carpet seams were frayed and separated, creating raised edges. Numerous irregularly shaped dark brown and black discolored areas of varying sizes were present throughout the hallway carpeting. On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed a ceiling tile surrounding the sprinkler head with a large circular brown discolored area measuring approximately 18 to 24 inches in diameter, with a darker brown ring around the outer edge and a lighter-colored center. An adjacent ceiling tile had	21665		08/21/2026

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21665	Continued from page 38 an additional irregularly shaped brown discolored area extending across the edge of the tile. Additional ceiling tiles were observed to be cracked, broken, and sagging, with visible deterioration to the tile surfacesOn 7/15/26 at 12:55 p.m., MD-A while observing the ceiling confirmed the ceiling tile in the bathroom was stained and stated the facility has a flat roof. MD-A further stated the ceiling tile was "busted." On 7/15/26 at 12:59 p.m., the administrator observed the condition of the ceiling and confirmed they would expect the stained and cracked ceiling tiles to be replaced. The Facility document The Revisor of Statues dated 2007, indicatedA nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongs to the extent possible. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure cleanliness of carpets and and preventative maintenance program developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The administrator, maintenance supervisor, or designee could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The administrator, maintenance supervisor, or designee could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		08/21/2026
21880	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 20 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility	21880	Corrected	08/21/2026

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21880	Continued from page 39 Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident concerns identified at resident council meetings were addressed and residents notified of a resolution or ongoing measures to ensure compliance. This affected all 9 residents (R8, R24, R25, R28, R29, R30, R33, R35, and R36) who attended resident council Findings include: R29's quarterly Minimum Data Set (MDS) assessment dated 5/1/26, indicated intact cognition, use of walker and wheelchair, partial assistance with toileting, bathing, and transfers, and diagnoses of heart failure and high blood pressure. R35's quarterly MDS assessment dated 6/19/26, indicated intact cognition, use of wheelchair, dependent with toilet use, substantial assistance with bathing, substantial assistance for transfers, and diagnoses of heart failure and kidney insufficiency. Review of the resident council minutes dated 7/6/26, 6/10/26, 3/26/26, and 3/11/26, indicated concerns with wheelchair maintenance, toilet leaking, missing socks, mealtime service delays, food quality and	21880		08/21/2026

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21880	Continued from page 40 temperature, and long call light times. The meeting minutes did not include follow-up or explanations of how or when the concerns would be addressed, or if they were ever addressed. During resident council interview on 7/14/26 at 1:50 p.m., R29 stated staffing was a big concern at the facility and she sometimes waited over 30 minutes for her call light to be answered. R29 further stated she had brought those concerns up at resident council but had never gotten any answer from facility staff whether her concern was addressed. R29 stated the council brought things up at meetings but didn't hear back and nothing was ever done about it. R20 stated she didn't know the council was supposed to get a response to their concerns. During resident council interview on 7/14/26 at 1:50 p.m., R35 stated she was unaware of any follow-up on resident council concerns and had never heard any solutions to concerns brought up at resident council. During interview on 7/15/26 at 7:58 a.m., activities assistant (AA)-A stated she helped facilitate the resident council meetings and typed the minutes. AA-A stated she was unable to find any evidence of replies to resident council concerns but was sure they were addressed verbally. AA-A stated she was not aware a formal response in written form should be given to the resident council and would have to start documenting follow-up for resident concerns. During interview on 7/15/26 at 1:40 p.m., administrator stated she would expect the resident council to receive responses from leadership addressing their concerns. Administrator further stated she was unaware concerns were not being addressed or documented. Administrator stated she would expect staff to follow federal regulations. A facility policy on responses to grievances and resident council concerns was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies pertaining to handling resident council concerns, educate staff on these policies and perform audits to ensure each resident council concern has been addressed by the facility. The results of those audits could be taken to the quality assurance and performance improvement (QAPI) committee to determine compliance or the need for further monitoring.	21880		08/21/2026

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21880	Continued from page 41 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		08/21/2026