Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 21, 2025

Administrator
Lakeshore Rehabilitation Center LLC
108 8th Street Northwest
Waseca, MN 56093

RE: CCN: 245388
Cycle Start Date: March 27, 2025

Dear Administrator:

On May 13, 2025, the Minnesota Departments 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 17, 2025

Administrator
Lakeshore Rehabilitation Center LLC
108 8th Street Northwest
Waseca, MN 56093

RE: CCN: 245388
Cycle Start Date: March 27, 2025

Dear Administrator:

On March 27, 2025, 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 June 27, 2025 (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 September 27, 2025 (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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE REHABILITATION CENTER LLC	108 8TH STREET NORTHWEST WASECA, MN 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
F 000	INITIAL COMMENTS On 3/24/25 to 3/27/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R35) reviewed for self-administration of medications. Findings include:	F 554	F554 (D) Self Administration of meds Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R35) reviewed for self-administration of medications.	5/1/25

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

Electronically Signed | 04/25/2025

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

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F 554	Continued From page 1 R35's admission Minimum Data Set (MDS) assessment dated 1/25/25, identified R35 had intact cognition and required assistance with all activities of daily living (ADL)'s. R35's diagnoses included atrial fibrillation, heart failure, hypertension, renal failure, diabetes mellitus, thyroid disorder and arthritis. MDS indicated R35 required substantial/maximal assistance with personal hygiene. R3's physician orders included order for Ipratropium-Albuterol inhalation solution 0.5-2.5% (3) mg (milligram)/3 ml (milliliter) - inhale one vial orally three times a day related to respiratory syncytial virus as the cause of diseases classified elsewhere. During interview and observation on 3/24/25 at 1:56 p.m., R35 was sitting in a wheelchair in her room. Nebulizer mask and canister was laying on the over the bed table with solution remaining in the canister. R35 stated she completes the nebulizer herself after the nurse sets it up. During observation on 3/25/25 at 1:15 p.m., R35 was sitting in her wheelchair holding the nebulizer mask to her face. Nebulizer cup contained a clear solution and nebulizer machine was running with no staff present in room. R35's record identified neither a self-administration of medication assessment was completed or an order for self-administration. During interview on 3/27/25 at 8:42 a.m., trained medication aide (TMA)-A stated if a resident was able to self-administer medications, it would be displayed in the resident's electronic health record (EHR). TMA-A confirmed R35 did not have	F 554	R35 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to regulatory requirements. Regulation: 483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by 483.21(b)(2)(ii), has determined that this practice is clinically appropriate. How corrective action will be taken for those affected by the alleged deficient practice: R35 was assessed for self-administration of medications on 04/01/25 and was determined to be safe with self-administration of nebulizers after set up. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who self-administer nebulizers after set up have the potential to be affected. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Full house audit completed to identify like residents with nebulizer orders. Residents were assessed for ability to self-administer nebulizers and, if appropriate, orders were obtained. Nurses and TMAs were educated on Monarch's Self Administration of Medications policy and facility expectations.	

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F 554	Continued From page 2 an order to self-administer medications which included nebulizer treatments. TMA-A stated she sets the nebulizer machine up placed the solution in the canister and will leave the room and come back in 10-15 minutes to ensure treatment is completed and shut the nebulizer machine off. During interview on 3/27/25 at 8:42 a.m., licensed practical nurse (LPN)-B stated the TMA's administers the nebulizer treatments. LPN-B stated if a resident was able to self-administer medications, it would be displayed in the resident's EHR. LPN-B confirmed R35 did not have a self-administration of medications order. During interview on 3/27/25 at 9:53 a.m., nursing assistant (NA)-A stated if we notice R35 does not have the nebulizer mask on, we go into her room and assist her with reapplying the mask. NA-A stated this morning, R35 had the mask on her face however, it was not correct and NA-A had to help R35 readjust the mask. During interview on 3/27/25 at 11:08 a.m., director of nursing (DON) stated she completes the self-administration of medications assessments. DON stated TMA's administer the nebulizer by placing the medication in the canister and places the mask on the resident's face and will go back later to ensure treatment is complete and shut off the machine. DON confirmed a self-administration of medications assessment was not completed and confirmed there was no order in place for R35 to self-administer her medications. DON stated it was important for the resident to be assessed for self-administration of medications as the medication would not be effective if R35 removed the mask.	F 554	Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete audits to ensure compliance 3 times weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further recommendations. Completion date: 5/1/25	

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F 554	Continued From page 3 The facility Self-Administration of Medications policy, dated 2/24, identified residents have the right to self-administer medication if the interdisciplinary team (IDT) has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.	F 554		
F 677 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 observation, interview, and record review the facility failed to provide assistance with facial hair removal for 1 of 1 resident (R35) reviewed for activities of daily living (ADL')s . Findings include: R35's admission Minimum Data Set (MDS) assessment dated 1/25/25, identified R35 had intact cognition and required assistance with activities of daily living (ADL)'s. R35's diagnoses included diabetes mellitus, and arthritis. MDS indicated R35 required substantial/maximal assistance with personal hygiene. R35's care plan lacked evidence of resident's shaving preferences. During observation and interview on 3/24/25 at	F 677	F677 (D) ADL Care Provided Based on observation, interview, and record review the facility failed to provide assistance with facial hair removal for 1 of 1 resident (R35) reviewed for activities of daily living (ADL')s . R35 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to regulatory requirements. Regulation: 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.	5/1/25

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F 677	Continued From page 4 1:46 p.m., R35 had white facial hair on chin approximately 1 inch long. R35 stated staff has assisted before and would like to be shaved. During observation on 3/25/25 at 10:47 a.m., R35 continued to have facial hair on chin. During observation on 3/26/25 at 7:12 a.m., R35 continued to have facial hair on chin. During observation on 3/27/25 at 9:22 a.m., R35 continued to have facial hair on chin. During interview on 3/27/25 at 9:53 a.m., nursing assistant (NA)-A stated if a resident had facial hair, she would ask the resident if they would like to be shaved. If resident stated they would like to be shaved, NA-A would go and find a shaver and assist resident with shaving. NA-A stated she has not asked or shaved R35. During interview on 3/27/25 at 10:36 a.m., NA-B stated they are supposed to shave residents if facial hair is noticed. NA-B stated she assisted R35 with morning cares and stated she noticed chin hairs but stated she did not shave R35. During interview on 3/27/25 at 10:39 a.m., licensed practical nurse (LPN)-B stated nursing assistants perform shaving when doing morning cares with residents, but it should be addressed on the resident's bath days. LPN-B stated R35's scheduled bath occurs Monday evenings. LPN-B confirmed R35 had facial hair and should have been shaved. During interview on 3/27/25 at 11:08 a.m., director of nursing (DON) indicated staff are to shave resident's facial hairs if seen, women especially.	F 677	How corrective action will be taken for those affected by the alleged deficient practice: R35's facial hair was removed on 03/27/25. 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. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Full house audit completed to identify like residents needing assistance with facial hair removal. Residents were assisted with facial hair removal, per their preference. Nurses, TMAs, and nursing assistants were educated on Monarch's Activities of Daily Living (ADLs) Maintain Abilities policy and facility expectations. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete audits to ensure compliance 3 times weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further recommendations. Completion date: 5/1/25	

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F 677	Continued From page 5 DON stated facility has razors to use if family members do not provide one. DON stated staff should have asked R35 if she would like to be shaved. DON stated it was important for the resident to be shaved for dignity of the resident. The facility Activities of Daily Living Policy, dated 3/31/23, indicated the facility is to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.	F 677		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		5/1/25

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F 758	Continued From page 6 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures for 3 of 3 residents (R7, R8, and R32) and failed to ensure residents were routinely assessed for side effects who received physician ordered antipsychotic medications for 1 of 5 residents (R8), reviewed for unnecessary medications.	F 758	F758 (D) Free from unnecessary Psychotropic Med Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures for 3 of 3 residents (R7, R8, and R32) and failed to ensure residents were routinely assessed for side effects who received physician ordered antipsychotic	

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F 758	Continued From page 7 Findings include: R7's quarterly Minimum Data Set (MDS) assessment dated 2/20/25, identified R7 had intact cognition and required assistance with all activities of daily living (ADL)'s. R7's diagnoses included orthostatic hypotension, depression, bipolar disorder, secondary Parkinsonism, mild cognitive impairment of uncertain or unknown etiology, and insomnia. R7's physician orders included Aripiprazole (antipsychotic) 10 milligram (mg) by mouth in the morning for bipolar disorder and Olanzapine (antipsychotic) 5 mg by mouth at bedtime for bipolar disorder. R7's medical record lacked evidence orthostatic blood pressures had not been obtained three out of six months for R7 with use of an antipsychotic medication. R7's care plan indicated R7 had a potential for psychotropic drug adverse drug reactions related to daily use of psychotropic medication for diagnosis of bipolar disorder. Goal was for resident to not experience adverse drug reactions to current psychotropic drug medication regimen and have interventions of monthly orthostatic blood pressures. R8 R8's annual Minimum Data Set (MDS) assessment dated 1/31/25, identified R8 had intact cognition and required assistance with all activities of daily living (ADL)'s. R8's diagnoses included hypertension, anxiety disorder, depression, and schizophrenia.	F 758	medications for 1 of 5 residents (R8), reviewed for unnecessary medications. R7, R8, R32 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Regulation: 483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- 483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; 483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and 483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate	

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F 758	Continued From page 8 R8's physician orders included orders for Aripiprazole (antipsychotic) 10 milligram (mg) by mouth in the morning for bipolar disorder and Olanzapine (antipsychotic) 5 mg by mouth at bedtime for bipolar disorder. R8's medical record lacked any evidence orthostatic blood pressures had been obtained for R8 in the past six months. R8's had Abnormal Involuntary Movement Scale (AIMS) assessment (measures involuntary movements of tardive dyskinesia (TD)) completed on 8/1/24 . R8's care plan indicated R8 had a potential for psychotropic drug adverse drug reactions related to daily use of psychotropic medication for diagnosis of bipolar disorder. Goal was for resident to not experience and adverse drug reactions to current psychotropic drug medication regimen and have interventions of monthly orthostatic blood pressures and TD screening or AIMS per protocol. During interview on 3/26/25 at 10:22 p.m., consultant pharmacist (CP) stated any resident on an antipsychotic medication should have orthostatic blood pressures checked monthly and AIMS assessment should be initiated within 30 days of admission or upon start of an antipsychotic medication and be reassessed at least every six months. CP stated orthostatic blood pressures and AIMS assessment were important to monitor for side effects and for orthostatic blood pressures. During interview on 3/27/25 at 11:08 a.m., director of nursing (DON) stated monitoring for antipsychotic medications consisted of orthostatic blood pressures and a baseline AIMS	F 758	for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the How corrective action will be taken for those affected by the alleged deficient practice: Orthostatic blood pressures were obtained for R7, R8, and R32. A Dyskinesia Identification System Evaluation form was completed for R8 on 03/25/25. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who receive antipsychotic medications have the potential to be affected. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Full house audit completed to identify like residents who receive physician ordered antipsychotic medications. Residents were reviewed for completion of monthly orthostatic blood pressures and routine side effect monitoring. Any missing documentation was collected and reviewed. Nurses and TMAs were educated on Monarch's Psychotropic Medication Use policy and facility expectations. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing or designee will complete audits to ensure compliance	

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F 758	Continued From page 9 assessment. DON stated orthostatic blood pressures should be obtained monthly and orthostatic blood pressures are important to see if the resident is displaying side effects of the antipsychotic medication and could increase risks for falls. DON confirmed the finding for R7 and R8 . DON stated AIMS assessments should be completed every six months and R8 should have had an AIMS assessment completed in February and confirmed last assessment was on 8/1/24. DON stated it was important to assess for TD to see if resident is having any symptoms of TD as the resident may need dosage of their antipsychotic medication changed. R 32 R32's Quarterly MDS dated 2/27/25, indicated cognitively intact with no behaviors. No limitations to upper and lower extremities, substantial assist for toileting and activities of daily living (ADL's) and was continent of bowels and occasionally incontinent of urine. R32's diagnoses list included psychotic disorder with delusions, mood disorder, anxiety disorder, and major depressive disorder. R32's provider orders included Aripiprazole (medication to treat psychiatric/mood disorders) 5 mg twice a day with a start date 9/3/2024, monitor orthostatic blood pressure while resident is receiving antipsychotic medications every day shift starting on the 7th of every month starting 10/7/24. R32's care plan included potential for psychotropic drug ADR's (adverse drug reactions) related to daily use of psychotropic medication.	F 758	weekly x4 weeks, monthly x2 months, and will review with QA committee for further recommendations. Completion date: 5/1/25	

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F 758	Continued From page 10 Interventions included monthly orthostasis blood pressure. A mobility care plan indicated R32 was an extensive assist of 1-2 with movement in bed and in/out of bed and "extensive assist of 1-2 with transfers; use sit to stand lift [a machine used to assist residents to a standing position] when resident is tired. R32's medication administration indicated R32 received Aripiprazole October 2024- March 2025. Orthostatic blood pressure documentation was as follows: 10/7/24: Lying-118/66, Sitting-114/60, standing-"NA" 11/7/24: Lying-106/56, sitting-110/71, standing-143/67 12/7/24: lying-137/73, sitting-156/84, standing-indicated "9" 1/7/25: Lying-108/50, Sitting- 117/51, standing-[left blank] 2/7/25: lying, sitting, and standing were left blank 3/7/25 lying, sitting, and standing were left blank. Progress notes dated 9/3/24-3/25/25 lacked documentation resident refused orthostatic blood pressures or orthostatic blood pressures were rescheduled. During interview on 3/26/25 at 9:58 a.m., nursing assistant (NA)-A stated R32 can stand and ambulate short distances with staff assistance. A sit to stand lift is used for transfers when R32 is feeling weak. During interview on 3/27/25 at 8:24 a.m., licensed practical nurse (LPN)-A stated residents on antipsychotic medications are monitored for side effects, orthostatic hypotension once a month,	F 758		

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F 758	Continued From page 11 and extrapyramidal symptoms (uncontrolled muscle movements related to antipsychotic medication use). LPN-A stated R32 can stand and "probably could stand long enough to get standing blood pressures because they walk [R32]" During interview on 3/27/2025 at 9:59 a.m., the director of nursing (DON) stated orthostatic blood pressures are monitored monthly for residents who receive antipsychotic medications. If a resident is unable to stand safely, staff check a lying and sitting blood pressure only. The DON stated staff are expected to document a behavior note indicating a resident refused and attempt the blood pressures later. The DON stated orthostatic blood pressures are scheduled the entire day so staff can attempt on a different shift if there is a refusal. If a resident continues to refuse, the DON stated she "would hope" she is updated. The DON stated R32 does tire easily however, can stand and do a pivot transfer. The DON confirmed the MAR lacked documentation of orthostatic blood pressure or refusals for February and March 2025. The facility Psychotropic Medication use policy, dated 1/25, indicated with initiation of an antipsychotic medication, residents will have an orthostatic blood pressure performed on a monthly basis, unless otherwise indicated by provider. AIMS will be performed on residents receiving antipsychotic medications to screen for tardive dyskinesia at baseline, semi-annually, and after discontinuation every month x 3.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		5/1/25

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F 812	Continued From page 12 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in 1 of 1 walk-in freezers, failed to ensure food stored in the refrigerators and dry storage were labeled, dated and discarded properly. This deficient practice had the potential to affect all 48 residents, staff and visitors who received food from facility kitchen. Findings include: Freezer During the initial kitchen tour on 3/24/25 at 12:50 p.m., a walk-in commercial freezer had a cooling fan mounted to the top of the unit which had visible ice built up on numerous places along the unit. The ceiling of freezer had ice built up, thick	F 812	F812 (F) Food Procurement Based on observation, interview, and document review, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in 1 of 1 walk-in freezers, failed to ensure food stored in the refrigerators and dry storage were labeled, dated and discarded properly. This deficient practice had the potential to affect all 48 residents, staff and visitors who received food from facility kitchen Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in	

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F 812	Continued From page 13 in some areas and in frozen droplet forms in other areas, that went from the back wall of the freezer towards the front of the freezer cover two-thirds of the ceiling on the left side. The back wall of the freezer had ice build-up with the thickest of the ice towards the bottom with a mound of ice on the floor. Brown substance, approximately 5-inch diameter, was melted into the mound of ice. The floor of the freezer and the metallic shelving used also had ice build-up present . Approximately, one-third of the floor was covered with thick ice build-up. The metallic shelving units were used to hold food and sat parallel with the walls of the freezer from the front wall to the back wall of the freezer. Immediately to the right of the cooling unit, there were several food items stored in boxes. Boxes were cardboard which were soft and somewhat mushy feeling to touch. Several boxes had visible ice buildup covering them. A gauge present measured the unit at -4 degrees Fahrenheit (F). During a subsequent visit to the kitchen on 3/27/25 at 10:15 a.m., ice continued to be present in the freezer. During interview on 3/27/25 at 10:23 a.m., culinary services director (CSD) confirmed ice buildup in the freezer's wall, ceiling, shelves and boxes. CSD stated the fan in the freezer was blocked and was not working. CSD stated maintenance looked at the fan yesterday and fixed it. CSD stated it has been an on-going process to get the ice out of the freezer since she started several months ago. CSD stated the ice buildup could be a concern as it could contaminate food, cause freezer burn on food or could cause food to rot from the mushy boxes that food is being store in.	F 812	response to the regulatory requirements. Regulation: 483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Education: The Culinary department staff have been informed and understand the Freezer-upright or chest policy and regulation on food procurement, Store/Prepare/Serve- Sanitary. How corrective action will be taken for those affected by the alleged deficient practice: The facility has removed ice buildup in the walk- in freezer and has properly labeled and dated all items. 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	

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F 812	Continued From page 14 During interview on 3/27/25 at 12:30 p.m., administrator stated she was not aware of the ice buildup in the freezer. Administrator stated she would expect staff to notify her if there was ice buildup in the freezer. Administrator confirmed ice buildup was a concern on the last annual survey but to her knowledge it was addressed and taken care of. Administrator stated the ice buildup could impact food quality and overall functionality of the freezer. Label, cover and date of foods: During an observation and interview on 3/24/25 at 12:20 p.m., CSD confirmed the following food items were observed in the prep cooler in the kitchen that were not labeled or dated: -Jar of opened salsa that did not have an opened date on container. - Opened plastic storage bag with Hot dogs were dated 3/15/25. CSD stated they were expired. -Container of opened cottage cheese that did not have an opened date on container. - Container of opened egg salad that did not have an opened date on container and had an expiration date of 3/22/25. CSD stated it was expired. During observation and interview on 3/24/25 at 12:58 p.m., CSD confirmed the following food items were observed in the walk-in cooler were not labeled or dated: - Opened bag of lettuce had brown slime that did not have an opened date. - Opened plastic storage bag with sliced American cheese that had several slices that were dried out. Bag did not have an opened date. - Opened plastic storage bag with sliced white cheese that did not have an opened date. - Container of opened sour cream that did not	F 812	the problem will be corrected and will not occur: • The freezer has been properly cleaned & all items are labeled • Education of how to properly clean the freezer & the regulation has taken place with the culinary department as well as the food receiving and storage policy Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Culinary director or designee will complete audits to ensure compliance 3 times weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further recommendations. Completion date: 5/1/25	

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F 812	Continued From page 15 have an opened date on container. During an interview on 3/24/25 at 1:12 p.m., CSD verified all items should be labeled, covered and dated as soon as food is removed from its original container. The CSD stated it was important to label and date food items to know when food items are fresh. During an interview on 3/27/25 at 10:15 a.m., cook stated when food is opened, they are to label and date before putting it away. Cook stated it was important to complete to know if a food was expired or should be thrown away. During an interview on 3/27/25 at 10:20 a.m., culinary aide (CA)-A stated when food is opened it needed to be labeled and dated so you know when it was opened or expired. The facilities Freezer policy, dated 9/12, indicated cleaning procedure of freezer which consisted of: 1. All items should be removed from freezer and transferred to another freezer. 2. Let all ice melt and unit warm up. 3. Wash out inside of freezer with warm soapy water. Rinse well. 4. Wipe out with weak solution of baking soda and water. Rinse well. 5. Dry inside with soft cloth. Let air dry. 6. Plug in unit and let freezer return to proper temperature. 7. Wash shelves with soapy water. Rinse, dry and replace in freezer. 8. Replace frozen food. 9. Clean per cleaning schedule of facility. The facility Food Storage policy, dated 9/12, indicated facility would maintain sanitary	F 812		

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F 812	Continued From page 16 techniques in non-perishable food storage in order to protect the health of those dependent on the service. The remaining contents of opened food packages will be stored in plastic containers with tight-fitting lids or plastic zip lock bags. All containers will be properly labeled and dated as to contents.	F 812		
F 867 SS=C	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §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 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	F 867		5/1/25

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F 867	Continued From page 17 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. §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	F 867		

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F 867	Continued From page 18 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	F 867		

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LAKESHORE REHABILITATION CENTER LLC	108 8TH STREET NORTHWEST WASECA, MN 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
F 867	Continued From page 19 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: Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identify, investigate, analyze and respond to freezer maintenance (i.e., prevent ice buildup) by developing and implementing action plans for the process improvement identified to be a current concern with past identified non compliancy. This had potential to affect all 45 residents, staff and visitors who consumed food at the care center. Findings include: Facilities QAPI (Quality Assessment and Performance Improvement) Plan, identified the purpose of QA (Quality Assessment) would be to take a proactive approach to continually improve the way we provide care, with each employee to participate in the ongoing QAPI efforts. The facility QA plan outlined the facility would review data from areas defined by the facility as high risk or problem prone areas; and it outlined a process for how Performance Improvement Projects (PIP) would be completed. The QA team "will determine what information is needed for the project and how to obtain it. A root cause analysis will be completed to assure the problem is identified. The team will develop an action plan for the improvement and the QA committee will require reporting of the project effectiveness." Facilities last three recertification surveys dated 6/24/21, 6/7/23, and 5/30/24 identified F-tag	F 867	F867 (C) QAPI Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identify, investigate, analyze and respond to freezer maintenance (i.e., prevent ice buildup) by developing and implementing action plans for the process improvement identified to be a current concern with past identified non compliancy. This had the potential to affect all 45 residents, staff and visitors who consumed food at the care center. Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Regulation: 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 resident representatives, including how such information will be	

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F 867	Continued From page 20 812-Food Procurement, Store/Prepare/Serve Sanitary was cited each time with similar concerns including: the facility failed to label opened containers of food, not sanitize a deep fat fryer in storage, or kitchen commercial can opener; the facility failed to mark/date opened containers of food stored in one kitchen refrigerators and freezer; and failed to ensure expired/damaged food were identified and removed; the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in walk-in freezers. See F812 for further details of the kitchen tour. During an interview on 03/27/25 at 10:23 a.m., dietary manager (DM) stated the fan in the freezer was blocked and was not working, however maintenance looked at it the day before and fixed the fan. DM stated the ice buildup has been there for several weeks. The DM stated ice buildup could be a concern as it could contaminate food, causing freezer burn on food or cause food to rot from mushy boxes the food is being stored in and said it was not appropriate. During an interview on 3/27/25 at 12:30 p.m., the administrator stated she was not aware of ice buildup in the freezer and would expect the DM to have notified her. The administrator confirmed the concern was identified during the last recertification and the plan of corrections was to replace the draping in the freezer. The administrator confirmed the freezer did not currently have any draping and stated ice buildup was a problem because it could impact food quality and overall functionality of the freezer. The administrator stated the QA team met monthly and explained the current facility's PIP's	F 867	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	

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F 867	Continued From page 21 included various projects, with all current goals for them being met. The administrator stated the QA team included members from clinical care services, culinary, activities, maintenance, housekeeping, and administration. The QA focus may extend to any one of these service areas. The administrator reviewed the QAPI meeting minutes and confirmed the committee did not identify any current or previous issues with the freezer. The administrator confirmed monitoring of the last years recertification was not performed.	F 867	safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. 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	

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F 867	Continued From page 22	F 867	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. How corrective action will be taken for those affected by the alleged deficient practice: All residents have the potential to be affected by this alleged deficiency. Facility has initiated education with Culinary Manager on our QAPI process and reviewing freezer operational status and the labeling and dating food process. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: • Education of how to properly clean the freezer and food storage policy & the regulations have taken place with the culinary department Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: The culinary director or designee will complete the freezer ice buildup audits and the food storage audit to ensure compliance 3 times weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further	

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F 867	Continued From page 23	F 867	recommendations. Completion date: 5/1/25	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/25/2025. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. 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	K 000		

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K 000	Continued From page 2 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 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 45 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		5/1/25

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K 353	Continued From page 3 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.4, 5.1.1, 5.2.1, 5.2.1.1.1, 5.2.1.1.2(2)(5), 5.3.2, 7.3, 13.5.1 NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section(s), 6.2.7, 6.2.7.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/25/2025 between 9:00 AM and 12:30 PM, it was revealed by observation in the Kitchen & Dishwashing areas that sprinkler head(s) exhibited signs of oxidation and debris loading. 2. On 03/25/2025 between 9:00 AM and 12:30 PM, it was revealed by observation that in Resident RM S2 that a sprinkler head assembly was missing an escutcheon cover. 3. On 03/25/2025 between 9:00 AM and 12:30 PM, it was revealed by observation and a review of available documentation, that the most recent	K 353	K353 (F) Sprinkler System Based on observation, a review of documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of WaterBased Fire Protection Systems, section(s), 4.4, 5.1.1, 5.2.1, 5.2.1.1.1, 5.2.1.1.2(2)(5), 5.3.2, 7.3, 13.5.1 NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section(s), 6.2.7, 6.2.7.2 These deficient findings could have a widespread impact on the residents within the facility. Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Regulation: Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	

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K 353	Continued From page 4 5-yr sprinkler inspection was last completed on 01/13/2020. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Education: Education has been done with the maintenance supervisor on the importance of ensuring the routine maintenance and inspections on the sprinkler system are completed How corrective action will be taken for those affected by the alleged deficient practice: • Facility has called Olympic Fire and they performed the 5-year sprinkler inspection on 4/7/2025. They also replaced the sprinkler head with oxidation and cleaned the heads with debris. They also replaced the escutcheon cover in room S2 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 administrator and director of maintenance will complete monthly audits of the sprinkler system to insure it is maintained properly. Quality Assurance plans to monitor facility	

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K 353	Continued From page 5	K 353	performance to make sure that corrections are achieved and are permanent: • The maintenance director will report on any unresolved issues to QAPI on a quarterly basis. Completion date: 5/1/25	
K 374 SS=F	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 REQUIREMENT 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 03/25/2025 between 9:00 AM and 12:30 PM, it was revealed by observation that the Dining	K 374	K 374 (F) Smoke barrier 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. Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not	5/1/25

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K 374	Continued From page 6 Room smoke barrier door assembly exhibited and air-gap greater that 1/8 inch, allowing the movement and passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Regulation: 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 Education: Education has been done with the maintenance supervisor on the importance of ensuring the doors in the smoke barriers do not have an air gap greater then 1/8th inch. How corrective action will be taken for those affected by the alleged deficient practice: • Facility has replaced the door brush sweep in order to ensure there is not gap larger than 1/8th of an inch 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 administrator and director of maintenance will complete monthly audits of the hallway to ensure it is maintained properly.	

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LAKESHORE REHABILITATION CENTER LLC	**108 8TH STREET NORTHWEST** **WASECA, MN 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
K 374	Continued From page 7	K 374	Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: • The maintenance director will report on any unresolved issues to QAPI on a quarterly basis. Completion date: 5/1/25	