Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 2, 2026

Administrator
Sauer Health Care
1635 WEST SERVICE DRIVE
WINONA, MN 55987

RE: CCN: 245102
Cycle Start Date: March 19, 2026

Dear Administrator:

On March 19, 2026, a survey was completed at your facility by the Minnesota Department of Health, 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 19, 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 September 19, 2026 (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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 2, 2026

Administrator
Sauer Health Care
1635 WEST SERVICE DRIVE
WINONA, MN 55987

Re: State Nursing Home Licensing Orders
Event ID: 1F4FA3-H1

Dear Administrator:

The above facility survey was completed on March 19, 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:

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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.

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April 2, 2026

Administrator
Sauer Health Care
1635 WEST SERVICE DRIVE
WINONA, MN 55987

RE: CCN: 245102
Cycle Start Date: March 19, 2026

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April 2, 2026

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Event ID: 1F4FA3-H1

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Office: 651-201-4384 | Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 24, 2026

Administrator
Sauer Health Care
1635 WEST SERVICE DRIVE
WINONA, MN 55987

RE: CCN: 245102
Cycle Start Date: March 19, 2026

Dear Administrator:

On June 12, 2026, the Minnesota Department of Health 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2026

Administrator
Sauer Health Care
1635 WEST SERVICE DRIVE
WINONA, MN 55987

Re: Reinspection Results
Event ID: 1F4FA3-H3

Dear Administrator:

On June 12, 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 March 19, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 24, 2026

Administrator
Sauer Health Care
1635 WEST SERVICE DRIVE
WINONA, MN 55987

RE: CCN: 245102
Cycle Start Date: March 19, 2026

Dear Administrator:

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Feel free to contact me if you have questions.

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June 24, 2026

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1635 WEST SERVICE DRIVE
WINONA, MN 55987

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Dear Administrator:

On June 12, 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 March 19, 2026. At this time these correction orders were found corrected.

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 27, 2026

Administrator
Sauer Health Care
1635 West Service Drive
Winona, MN 55987

RE: CCN: 245102
Cycle Start Date: March 19, 2026

Dear Administrator:

On April 2, 2026, we informed you that we may impose enforcement remedies.

On May 12, 2026, the Minnesota Department of Health completed a revisit, and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

F0725: Sufficient Nursing Staff

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 19, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 19, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 19, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 19, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Sauer Health Care will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 19, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 19, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245102	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sauer Health Care	**1635 WEST SERVICE DRIVE , WINONA, Minnesota, 55987**

(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
F0000	INITIAL COMMENTS On 5/7/26, 5/8/26, and 5/12/26, an offsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited on 3/19/26. The facility was NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following tags were recited: F725. 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		06/05/2026
F0725 SS = D	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	F0725	PLAN OF CORRECTION – F0725 Sufficient Nursing Staffing 1. How the deficient practice was corrected for residents affected Residents identified during the survey were assessed to ensure their needs were met timely. Nursing leadership immediately reviewed staffing assignments, resident acuity, and call light response processes with licensed nurses and nursing assistants. Staff members received education regarding expectations for prompt call light response and resident rounding. 2. How the facility identified other residents who may be affected All residents residing in the facility have the potential to be affected by this deficient practice. The facility conducted a review of call light response patterns, staffing schedules, resident complaints, grievances, and satisfaction concerns related to	06/05/2026

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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F0725 SS = D	Continued from page 1 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: Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet resident needs for 3 of 3 residents (R4, R10, R11) resulting in a pattern of delayed call light responses and care for R4, R10, R11. Findings include: Findings include: R4's face sheet dated 5/12/26, identified diagnoses cerebral infarction (stroke), hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) of left side, muscle weakness, and repeated falls. R4's Quarterly Minimum Data Set (MDS) dated 4/2/26, indicated R4's cognition was intact, needed substantial/maximum assistance for toilet transfer and chair/bed to chair transfer. R4's Activities of Daily Living (ADL) focus care plan dated 11/20/20, identified R4 had a self-care deficit related to stroke, left hemiparesis, weakness, impaired balance, limited mobility, impaired vision, history of falls, potential for pain. Interventions as follows: -Toileting needs that R4 needed substantial/maximum assistance of one staff, frequently incontinent of bladder, occasionally to frequently incontinent of bowel. R4 needed assistance with hygiene after a bowel movement. -Transfers: R4 needed substantial/maximum assistance with toilet transfers from one staff with a sit to stand mechanical lift.	F0725	Continued from page 1 response times. No recent grievances related to call light wait times. Areas identified as needing improvement were addressed immediately through staff coaching and assignment adjustments. Root cause analysis was completed, and the peak times of concern related to medication administration. Coaching completed with TMAs to assist on the floor during these times as well. 3. Measures put in place to ensure the deficient practice does not recur The facility has implemented the following systemic changes: Increased licensed nurse and certified nursing assistant staffing levels through the addition of nursing FTEs based on resident acuity and care needs. Reviewed and adjusted staffing schedules to improve coverage during peak call light usage times. Educated licensed nurses and nursing assistants to verify competency on expectations related to timely call light response, resident-centered care, accountability, and escalation procedures. 5/14/2026 Mandatory staff in-service completed. Implemented daily call light response audits Monday through Friday conducted by nursing leadership. Implemented weekend call light response audits with findings reviewed and follow-up coaching completed on the next business day when indicated. Staff identified as not meeting expectations receive immediate coaching, counseling, and corrective action as appropriate in accordance with facility policy. Nursing leadership monitors staffing effectiveness and adjusts assignments as needed to meet resident care needs. 4. Monitoring to ensure ongoing compliance	06/05/2026

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F0725 SS = D	Continued from page 2 During an interview on 5/8/26 at 1:28 p.m., R4 stated his call lights were not being answered timely, and he had to wait for a long time to go to the bathroom. “When I have to wait to use the bathroom, I just fill my drawers, and staff have to clean me up and that just pisses me off.” R4’s call light log report was reviewed from 4/10/26 to 5/7/26, identified that R4’s call light was activated for over 20 minutes on sixteen occasions. The longest delay in response was 1 hour, 1 minute and 58 seconds. R4's Call Light Events with wait times over 20 Minutes: Tuesday, 4/12/26: -9:20 a.m., for a total response time of 40 min and 41 seconds. -12:28 p.m., for a total response time of 30 min and 18 seconds. Wednesday, 4/13/26: -12:37 p.m., for a total response time of 38 minutes and 38 seconds. Friday, 4/17/26: -5:58 a.m., for a total response time of 30 minutes and 18 seconds. -5:28 p.m., for a total response time of 25 minutes and 32 seconds. -7:14 p.m., for a total response time of 20 minutes and 10 seconds. Wednesday, 4/22/26: -9:42 a.m., for a total response time of 24 minutes and 10 seconds. Saturday, 4/25/26: -12:10 p.m., for a response time of 26 minutes and 9 seconds. Sunday, 4/26/26:	F0725	Continued from page 2 The Director of Nursing or designee will conduct call light response audits by review of call light reports, cameras, and resident interviews. DON or designee will audit bi- weekly x 4 weeks and monthly x 2 months call light report for call light wait times. DON or designee will conduct direct observation on all three shifts of call lights being answered and needs addressed bi-weekly x 4 weeks and weekly x 1 month. DON or designee will conduct direct observation to ensure direct care staff are carrying a walkie talkie bi-weekly x 4 weeks and weekly x 1 month. Audit results will be reviewed weekly by nursing leadership for trends and opportunities for improvement. Staff requiring additional intervention will receive documented coaching and/or corrective action. A summary of audit findings, staffing effectiveness, and corrective actions was reported at the 5/12/2026 QAPI meeting and will be reported to the facility Quality Assurance and Performance Improvement (QAPI) Committee bi-monthly. The QAPI Committee will review results bi-monthly for three months and determine whether additional monitoring or interventions are necessary to ensure sustained compliance. Completion Date: Compliance with this plan of correction will be achieved on 6/5/2026 Director of Nursing: Cindy Kaehler, RN, DON Administrator: Jessi Muras, RN, LNHA	06/05/2026

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F0725 SS = D	Continued from page 3 -6:18 p.m., for a response time of 25 minutes and 17 seconds. Monday, 4/27/26: -8:48 a.m., for a response time of 30 minutes and 3 seconds. Tuesday, 4/28/26: -6:08 a.m., for a response time of 43 minutes. Monday, 5/4/26: -8:49 a.m., for a response time of 22 minutes and 13 seconds. Wednesday, 5/6/26: -6:42 a.m., for a response time of 25 minutes and 6 seconds. Thursday, 5/7/26: -6:02 a.m., for a response time of 1 hour, 1 minute and 58 seconds. -9:46 a.m., for a response time of 25 minutes and 6 seconds. -3:16 p.m., for a response time of 20 minutes and 10 seconds. Friday, 5/8/26: -6:43 a.m., for a response time of 25 minutes and 5 seconds. R10’s face sheet dated 5/12/26, identified diagnoses of cancer of the prostate, chronic kidney disease, osteoarthritis, and unsteadiness of the feet. R10’s Quarterly MDS dated 4/10/26, identified R10 had moderate cognitive impairment, needed substantial/maximum assistance for toilet/chair transfer. Review of R10’s call light log report was reviewed	F0725		06/05/2026

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F0725 SS = D	Continued from page 4 from 5/1/26 through 5/8/26, identified R10's call light was activated for over 20 minutes on six occasions. The longest delay was 44 minutes. R10's Call Light Events with wait times over 20 minutes: Thursday, 5/6/26: -9:31 a.m., with a response time of 40 minutes and 36 seconds. Friday, 5/7/26: -4:44 a.m., with a response time of 23 min and 25 seconds. -5:48 a.m., with a response time of 44 minutes. -7:16 a.m., with a response time of 31 min and 21 seconds. -9:07 a.m., with a response time of 29 min and 20 seconds. -7:58 p.m., with a response time of 33 minutes and 10 seconds. R11's face sheet dated 5/12/26, identified diagnoses of weakness, heart failure, essential tremor, and hemiplegia (paralysis on one side) and hemiparesis (weakness on one side). R11's Quarterly MDS dated 3/19/26, identified R11's cognition was intact and needed moderate assistance for chair/toilet transfers. Review of R11's call light log was reviewed from 5/1/26 through 5/8/26, identified R11's call light was activated for over 20 minutes on three occasions. The longest delay was 40 minutes. R11's Call Light Events with wait times over 20 minutes: Saturday, 5/2/26: -7:04 a.m., with a response time of 40 minutes and Monday, 5/4/26: -6:54 p.m., with a response time of 28 minutes and 50 seconds.	F0725		06/05/2026

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F0725 SS = D	Continued from page 5 Tuesday, 5/7/26: -9:17 a.m., with a response time of 27 minutes and 32 seconds. During an interview on 5/8/26 at 1:20 p.m., nursing assistant (NA)-M stated R4 will propel himself back to his room after mealtimes and has to wait for extended periods of time to get his call light answered due to staff in the dining room assisting other residents. NA-M further explained all staff carry a walkie talkie to be able to hear the call lights go off to assist with answering them, and the nurses were busy as well so could not assist in answering the call lights. During an interview on 5/12/26 at 9:39 a.m., director of nursing (DON) stated she had been aware R4 continued to have extended call light times even after she had adjusted staffing schedules to have staff arrive at various times during a shift. DON explained she believed R4's call light not being responded to in a timely manner was due to staff being busy at the times R4 puts his call light on, however, it should be the responsibility of all the staff to attempt to assist the residents to meet their needs. The consequences of not answering a call light timely could lead things like falls, choking, not identifying a change in condition. DON further explained that the acuity of the residents residing in the facility is much higher than it had before, however, the staffing had not changed to adjust this. DON stated she is going to be adding an extra staff member on some of the shifts, but they have not been put on the schedule yet. Review of the facility's Quality Care and Services Policy dated 1/29/26, identified the goal of the facility will work to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, consistent with the resident's comprehensive assessment and plan of care and the resident or their representative's choices ensuring that residents receive treatment and care in accordance with professional standards of practice. Policy: Ensure call light device is always in reach of resident. All staff are responsible for answering call lights.	F0725		06/05/2026

Minnesota Department of Health

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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 5/7/26, 5/8/26, and 5/12/26, an offsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 3/19/26 by the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a	20000		06/05/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		06/05/2026