

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Lakeshore Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 8th Street Northwest Waseca, MN 56093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide sufficient nursing staff to ensure 13 of 13 residents (R7, R4, R13, R31, R45, R35, R37, R42, R29, R35, R8, R24, R33), reviewed for sufficient staffing, received care and assistance in a timely manner. The lack of sufficient staff had the potential to affect all 42 residents who resided in the facility. Findings include: Refer to F676: Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain oral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance. Refer to F677: Based on interview and document review, the facility failed to provide oral care to 1 of 1 resident (R13) who was reviewed for assistance with activities of daily living (ADLs) and who was dependent upon staff for ADL cares. Refer to F688: Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. RESIDENT/FAMILY INTERVIEWS/ CALL LIGHT RESPONSE TIMES R7's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated orthopedic aftercare for hip fracture. R7 had intact cognition, clear speech, could understand and be understood. R7 required substantial assistance or was dependent upon staff for activities of daily living (ADLs). R7 was always incontinent of bowel and did not walk. During an interview on 7/13/26 at 11:21 a.m., R7 stated the facility was chronically short-handed; he didn't have bowel control and used his call lights to have his brief changed or to get in or out of bed. R7 stated he was frustrated with the length of time it took staff to answer his call light. R7 had 216 call light activations dated 5/12/26- 7/12/26, indicating call lights were answered in the following time frames: (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	21-30 minutes = 17 31-40 minutes = 6 41-50 minutes = 5 51-60 minutes = 1 61-70 minutes = 1 >70 minutes = 2 >130 minutes = 2 >150 minutes = 1 R4's quarterly MDS assessment dated [DATE], indicated cardio/respiratory condition, including congestive heart failure (when the heart cannot pump efficiently to meet the body's needs). R4 had intact cognition, clear speech, could understand and be understood. R4 required substantial assistance with oral hygiene, dressing, standing, sitting, toileting and walking short distances. During an interview on 7/13/26 at 10:25 a.m., R4 stated it took a long time for staff to answer her call light, I'm at the end of the hallway and I feel pissed off; happens daily. R4 had 342 call light activations dated 5/12/26- 7/12/26, indicating call lights were answered in the following time frames: 21-30 minutes = 19 31-40 minutes = 2 41-50 minutes = 1 51-60 minutes = 2 61-70 minutes = 1 R13's admission MDS assessment dated [DATE], indicated orthopedic after care for fractures and other multiple trauma. R13 had intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all ADLs, was frequently incontinent of stool and did not walk. During an interview on 7/13/26 at 1:33 p.m., family member (FM)-A stated a few times when she had come into R13's room, her call light was not in reach and R13 had to yell for help. FM-A stated R13 was able to activate her call light and had waited up to 45 minutes for someone to respond. FM-A stated R13 had called her crying when no one came. FM-A stated R13 had pounded a cup on the (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unit had 24 high-acuity residents with only two NAs, adding that was a safety concern. Employee-B stated leadership knew they were short staffed and should be doing something about it. Employee-B stated staff were afraid to speak up for fear of losing their job. Employee-B stated there were no walkie-talkies for communication, so staff had to run around to track people down. Employee-B stated the facility was not able to meet the needs of residents and was aware some families had removed their family member from the facility because of that. During a confidential interview, employee-D stated they were short staffed and used a lot of agency staff. Employee D stated they did their best but acknowledged residents sometimes waited a long time to get care. Employee D stated they did not use walkie-talkies, so often had to go up and down the hall looking for help and that caused delays. On 7/13/26 at 5:00 p.m., nursing assistant (NA)-B stated there were two nursing assistants working today. NA-B stated that on the previous evening, after 6:00 p.m., they were the only nursing assistant because the agency staff member who had been scheduled to work did not report. NA-B stated the agency staff member had been scheduled to work doubles throughout the weekend but was unsure whether they had reported for any of the shifts. NA-B stated they provided evening cares and answered call lights by herself the day prior. NA-B stated it was not common to have only one nursing assistant scheduled on the east and west, due to agency staff not showing for the scheduled shift. NA-B stated there were usually two nursing assistants assigned to the south hall and estimated approximately six residents required two-person assistance. NA-B stated call light response times could be delayed depending on the how many staff were working and the needs of the residents. NA-B stated the facility does not have any tools in place to assist staff with requesting help such as walkie talkies and staff would need to yell if assistance was needed. On 7/13/26 at 5:10 p.m., licensed practical nurse (LPN)-A, stated two nursing assistants were sufficient for the east and west hallway, but if only one nursing assistant was available the nurse would need to assist. LPN-A stated it occurred more often that only one nursing assistant was available because agency staff failed to report for work. LPN-A stated when this occurred, staff attempted to call employees who were off duty and notified the director of nursing for direction. On 7/13/26 at 5:43 p.m., a call light illuminated for room [ROOM NUMBER]. NA-C was observed responding to the call light. At 5:46 p.m., another call light illuminated for Room W-2 while NA-C remained in room [ROOM NUMBER]. NA-C stated, I can't leave this resident alone. My partner is on break. The call light remained active until 5:57 p.m. On 7/13/26 at 6:21 p.m., NA-C stated they had been asked to report early to their shift because baths scheduled over the weekend had not been completed and staff were attempting to complete the missed baths. On 7/14/26 at 8:32 a.m., the trained medication aide (TMA)-B stated it was difficult for one TMA to complete medication administration and additional help would be beneficial. The TMA stated they were the only TMA for the building. The TMA stated there were usually two NA's scheduled for east and west hall but occasionally only one was available when someone called in or agency staff did not report. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	instructed to respond to residents more timely; however, staffing levels were not increased. NA-D stated staff responded to call lights as quickly as possible and did not have downtime but could not respond more quickly when there were not enough staff available. NA-D further stated staffing decisions were based solely on resident census. NA-D confirmed R42 had been moved to a different unit due to concerns regarding delays in receiving care. NA-D further stated overnight staff would at times assist R42 to the toilet and then leave to assist another resident, resulting in R42 waiting approximately 30 minutes for assistance before staff returned. On 7/14/26 at 2:42 p.m., nursing assistant (NA)-C stated the facility had a lot of staff who didn't come for their shifts, especially on the weekends, particularly agency staff. NA-C further stated the facility used a star system to ensure coverage and she had to stay later than her scheduled shift often to cover for other staff who didn't show up. NA-C stated staffing was not adjusted based on resident needs, there was always a set number of three or four nursing assistants no matter how many residents there were in the facility. NA-C stated it was hard to get help when needed and residents had to wait a long time. On 7/14/26 at 2:46 p.m., NA-B stated when they were short-staffed residents had to wait a long time for help. NA-B further stated they were short-staffed a lot, especially on weekends. On 7/14/26 at 4:51 p.m., the director of nursing (DON) stated weekend staffing schedules posted in the facility were not updated in real time to reflect actual staffing. The DON stated they spent a significant portion of her day providing resident care because of staffing shortages and stated agency staff had contributed to the staffing problems and doing a disservice to the facility. On 7/15/26 at 6:38 a.m., LPN-C stated she worked the night shift and if there were 42 residents, one nurse and two NAs were adequate, but when the census rose to 47 or 48 it was not. LPN-C stated there were one NA on each floor and her, and at 1:30 a.m., and 4:30 a.m., the NA from first floor went to second floor to help, and they covered each other for breaks. LPN-C stated they used to have walkie-talkies but didn't anymore and didn't know why, so they used their personal cell phones or the house phone to contact each other. In order to know if a call light was going off, LPN-C stated staff had to be in the hallway to observe the scrolling marquee and might hear the beep (indicating a call light was activated) or you might not. On 7/15/26 at 8:49 a.m., LPN-A stated that when staffing is limited, nurses may need to assist; however, one staff member caring for approximately 21 residents is insufficient. LPN-A stated they have heard residents report staffing shortages on multiple occasions. LPN-A further stated the south wing requires three staff members and delays occur when staff must search room-to-room for assistance. LPN-A stated staff previously used walkie-talkies, but without them staff may not know another resident requires assistance. LPN-A stated they had spent significant time looking for available staff and has been told by residents they have waited up to 30 minutes for assistance. LPN-A stated the director of nursing (DON) was aware of these concerns and frequently works on the floor, where the issues should be readily apparent. LPN-A stated the facility did not provide staff with walkie-talkies. LPN-A stated this created a safety concern because if a resident fell, was bleeding, or required immediate assistance while staff were in another resident's room, they would not be able to quickly obtain help from another staff member. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/15/26 at 9:05 a.m., maintenance director (MD)-A provided resident care unit distance measurements: first floor from beginning of the east hallway to end of the west hallway was 130 feet (equivalent to a 12-13 story building). Distance on the south unit, from first room to last room was 206 feet (more than half the distance of a football field) On 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the time of the interview and that he was covering her responsibilities. VPO stated the facility administrator was responsible for completing the facility assessment, and stated that he would expect the facility assessment to include staffing numbers and information regarding the facility's staffing levels. VPO did not identify any specific staffing concerns and stated that the facility occasionally utilizes agency staff to address staffing needs when necessary. VPO stated that the administrator would be expected to review staffing trends and patterns, ask specific questions regarding identified issues, and ensure that appropriate actions were implemented. VPO stated if concerns such as extended call light response times were identified, the administrator would be expected to investigate the issue by asking questions such as when the delays are occurring, whether they are isolated to a particular shift and what interventions were needed. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program. On 7/15/26 at 2:30 p.m., the DON stated staffing levels were determined based on resident acuity, resident census, holidays, anticipated resident needs, and hours per resident day (PPD), with a target of approximately 3.0 PPD. The DON stated resident needs were reviewed during the morning meeting, including new admissions and residents requiring additional assistance. However, when asked how resident acuity was incorporated into staffing decisions, the DON was unable to clearly explain the process or identify how staffing assignments were adjusted to meet resident care needs. The DON stated staffing assignments varied by unit, with lighter staffing on the east and west halls and staff floating to the south hall as needed. The DON stated staff were supposed to carry pagers to receive call light notifications but acknowledged the pagers were missing and stated, Maybe they're lost. The DON further stated staff would have to leave a resident's room to view the scrolling call light display at the end of the hallway. The DON stated the facility had purchased walkie-talkies approximately one month earlier but had not implemented their use. After discussion regarding delayed staff response, the DON stated walkie-talkies could be implemented that evening to improve communication. When asked how the facility determined staffing was adequate, the DON stated residents were cared for, there were no odors, pressure ulcers were not worsening, residents were happy, and meals were provided. However, the DON was unable to identify specific monitoring processes to ensure resident oral care, bathing, and other activities of daily living (ADLs) were consistently completed. The DON acknowledged managers, including the DON, frequently provided direct resident care because of staffing shortages and stated the facility did not have enough staff to add additional personnel. The DON further stated nursing assistant documentation was poor because some staff lacked electronic medical record (EMR) access, documentation was lost, agency staff lost documentation, and staff did not have time to complete documentation. When informed that multiple residents and staff independently reported delays in care and prolonged call light response times, the DON stated there was no explanation for why this was occurring. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/15/26 at 3:03 p.m., the administrator stated daily staffing decisions were based on resident census, resident acuity, and PPD following discussion of admissions, discharges, and resident needs during the daily stand-up meeting. The administrator stated staffing adequacy was evaluated by the absence of wounds, falls, odors, resident complaints, and whether residents were coming to the nurses' station. The administrator acknowledged the facility did not routinely monitor call light response times and stated the last review of call light data occurred approximately two weeks earlier for a single resident concern rather than reviewing facility-wide trends. The administrator stated staffing was adjusted for resident acuity, including hospice residents, residents requiring mechanical lifts, extensive wounds, and psychosocial needs. However, the administrator acknowledged staff communication regarding resident call lights was not functioning as expected. The administrator believed staff carried pagers but acknowledged only one working pager was available at each end of the building and stated staff would have to leave a resident's room to obtain assistance or holler for help because no established communication process was in place. The administrator further stated staff were expected to complete documentation throughout the shift when they have a minute, however no time is dedicated to documentation. On 7/15/26 at 3:41 p.m., RN-C, known as the regional nurse consultant, stated staffing levels were based on PPD and resident acuity, with staffing increased when residents required additional care. RN-C stated the facility was budgeted for a specific PPD and staffing adjustments required clinical justification. However, RN-C acknowledged resident care was not consistently being completed and specif		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and document review, the facility failed to ensure the Facility Assessment included information on staffing levels needed for specific shifts. This deficient practice had the potential to affect all 42 residents who resided in the facility. Findings include: Review of Facility assessment dated 6/2026, indicated the following: Section 3. Facility resources needed to provide competent support and care for our resident population every day and during emergencies: 3.2 & 3.3. Direct Care Staffing Plan: To ensure an adequate amount of staff at Lakeshore Rehabilitation Center at all times, the resident population, case mix index (CMI), and census if taken into account daily to determine sufficient staffing needs. Lakeshore's interdisciplinary team (IDT) reviews census on the daily census template sent out daily by Health Information to determine the needs on each unit. Any admissions and discharges planned also factor in and assist in determining the staffing needs for each day on each unit. Individual staff assignments for continuity of care for residents and across staff assignments is determined by the director of nursing (DON), nurse management, charge nurse, unit nurse in that order of hierarchy. The facility assessment did not include information on staffing levels needed for specific shifts, such as day, evening, and night and adjusted as necessary based on changes to resident population. During interview on 7/14/26 at 3:37 p.m., when confirming the provided facility assessment was correct, administrator stated she gave the state agency (SA) the correct and most current version and she would not put specific information in the facility assessment about staff requirements for each shift because staffing fluctuates so much. During interview on 7/15/26 at 8:02 a.m., administrator stated she was aware specific staffing date should be in the facility assessment, and she must have accidentally deleted the staffing information. Administrator stated she reached out to corporate for an updated version. Administrator further confirmed the facility did not use the daily census template to review staffing needs as directed in the facility assessment, but the IDT did talk about census daily. Administrator also stated the facility did not have a specific algorithm they used to determine needed staffing levels and would refer to their facility assessment to determine staff needed to meet resident's needs. A facility document titled Staffing Levels Per Patient Day (PPD) Compliant undated, indicated staffing levels were based on resident census numbers. A facility policy on facility assessment requirements was requested but not received.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the quality assurance and performance improvement (QAPI) committee failed to identify resident call light wait time concerns prior to survey, nor make a good faith attempt to correct the deficiency. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: QAPI meeting minutes dated 3/31/25, indicated, Call lights tend to be #1 issue. Call light response times had not been included/mentioned again in the subsequent six QAPI meeting minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn't an issue, however there was no documentation to support this. During an interview on 7/15/26 at 11:00 a.m., the vice president of operations (VPO) stated that Interim Regional Operations Director was on vacation at the time of the interview and that he was covering her responsibilities. VPO stated that the organization uses a standardized QAPI meeting format across all facilities. During QAPI meetings, the facility is expected to analyze data, discuss findings, review audit results, perform root cause analyses, develop action plans, and monitor the effectiveness of interventions. VPO stated regarding call light response times, that if ongoing concerns existed, the facility should utilize call light logs to identify trends, review the information through the QAPI process, and implement corrective actions. VPO stated that the facility should monitor call light response times, evaluate whether staffing adjustments are necessary, and address any identified concerns through the QAPI program. During an interview on 7/16/26 at 9:46 a.m., the administrator stated current survey findings of long call light response times had not been on her radar. The administrator admitted there had been no staff meetings where QAPI meeting activities had been communicated to employees nor were employees asked for feedback about potential concerns related to resident care. Facility QAPI Plan with review date of 1/2/26, indicated the organization used QAPI to make decisions and guide their day-to-day operations, and included all employees, all departments and all processes. Decisions were based on data which included input from caregivers, residents, families and other stakeholders. Data sources for bench making progress would include information from residents and family interviews and staff surveys. All staff would be encouraged to communicate concerns and ideas to any department manager.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to develop and implement action plans, measure the success of actions and track performance, conduct a performance improvement project (PIP), and regularly review, analyze, and act on data collected. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: Due to numerous sufficient staffing and long call light wait time concerns expressed by residents, family members and staff, QAPI (quality assurance and performance improvement) meeting minutes were reviewed. QAPI meeting minutes from March 2025 through June 2026, indicated the following: 3/31/25 - Minutes lacked substance. No actions or resolutions. Identified under grievances: call lights tend to be #1 issue. Not mentioned again. 6/18/25 - No documentation of minutes. 9/30/25 - Minutes lacked substance. Not able to determine actions or resolutions. 12/17/25 - No documentation of minutes. 1/14/26 - No documentation of minutes. 3/18/26 - No documentation of minutes. 6/10/26 - No documentation of minutes. During an interview on 7/14/26, 11:07 a.m., with regard to the lack of documentation of actions or resolutions at QAPI meetings, the administrator stated their meeting discussions were mostly verbal and admitted the minutes did not reflect their discussions. The administrator stated they needed to take better notes. With regard to the 3/31/25, meeting minutes about call lights being the number one issue, the administrator stated she assumed they (QAPI committee) had conducted follow-up related to concerns about call light wait times, did an audit and determined it wasn't an issue, however there was no documentation to support this. During an interview on 7/16/26 at 9:46 a.m., the administrator stated she set the QAPI meeting agenda, facilitated the meetings and documented the meeting minutes, and that quality measures were monitored at both a corporate level and locally. The administrator admitted the minutes lacked identification of issues, analysis, monitoring, auditing, outcomes, and acknowledged the documentation needed to be improved as the minutes did not reflect activities of the committee. During the same interview, the administrator stated a PIP for 2026, had been unplanned weight loss. The administrator stated the only data obtained had been weight loss information from the dietician, and admitted they had not conducted a root cause analysis nor considered other important data such as diet orders, food preferences, observations of residents eating, involvement of family, use of supplements, etc. The administrator admitted their work lacked all available data and did not include a comprehensive analysis, action plan or audits. During a telephone interview on 7/15/26 at 11:00 a.m., vice president of operations (VPO) stated he had not been aware of anything specific related to quality indicator concerns at the facility. If there were resident concerns about call lights, he would ask specific questions, look at trends and patterns. For example, if long call lights were around the supper meal, he would expect an analysis of the situation and potentially add staff or reassign responsibilities. VPO stated he would expect QAPI minutes to identify data had been analyzed, a root cause analysis completed, action/interventions identified. For long call light wait times, circle back with residents, look at specific grievances, ask specific questions - time of day, day of week, etc. Adjust operations and business practices, monitor, audit. Call light logs should be utilized if a facility can run them, and then data presented to the QAPI committee for review.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident concerns identified at resident council meetings were addressed and residents notified of a resolution or ongoing measures to ensure compliance. This affected all 9 residents (R8, R24, R25, R28, R29, R30, R33, R35, and R36) who attended resident council. Findings include: R29's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, use of walker and wheelchair, partial assistance with toileting, bathing, and transfers, and diagnoses of heart failure and high blood pressure. R35's quarterly MDS assessment dated [DATE], indicated intact cognition, use of wheelchair, dependent with toilet use, substantial assistance with bathing, substantial assistance for transfers, and diagnoses of heart failure and kidney insufficiency. Review of the resident council minutes dated 7/6/26, 6/10/26, 3/26/26, and 3/11/26, indicated concerns with wheelchair maintenance, toilet leaking, missing socks, mealtime service delays, food quality and temperature, and long call light times. The meeting minutes did not include follow-up or explanations of how or when the concerns would be addressed, or if they were ever addressed. During resident council interview on 7/14/26 at 1:50 p.m., R29 stated staffing was a big concern at the facility and she sometimes waited over 30 minutes for her call light to be answered. R29 further stated she had brought those concerns up at resident council but had never gotten any answer from facility staff whether her concern was addressed. R29 stated the council brought things up at meetings but didn't hear back and nothing was ever done about it. R20 stated she didn't know the council was supposed to get a response to their concerns. During resident council interview on 7/14/26 at 1:50 p.m., R35 stated she was unaware of any follow-up on resident council concerns and had never heard any solutions to concerns brought up at resident council. During interview on 7/15/26 at 7:58 a.m., activities assistant (AA)-A stated she helped facilitate the resident council meetings and typed the minutes. AA-A stated she was unable to find any evidence of replies to resident council concerns but was sure they were addressed verbally. AA-A stated she was not aware a formal response in written form should be given to the resident council and would have to start documenting follow-up for resident concerns. During interview on 7/15/26 at 1:40 p.m., administrator stated she would expect the resident council to receive responses from leadership addressing their concerns. Administrator further stated she was unaware concerns were not being addressed or documented. Administrator stated she would expect staff to follow federal regulations. A facility policy on responses to grievances and resident council concerns was requested but not received.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment for residents residing in East and [NAME] hallways resulting in large dark stains, fraying and worn carpet throughout the hallway and damaged, cracked, sagging, and discolored ceiling tiles in the east hallway bath tub room. Findings Include: On 7/13/26 at 5:09 p.m., observation of the east hallway outside resident rooms identified a discolored dark stain on the flooring measuring approximately 11/2 feet by 6 inches, irregularly shaped with darkened edges and concentrated areas of discoloration. The stains were distributed throughout the hallway and were readily visible from a distance due to the contrast between the stained areas and the surrounding carpet. The carpeting appeared worn and soiled. On 7/13/26 at 5:21 p.m., the licensed practical nurse (LPN)-A stated the hallway carpeting was stained and frayed, and further stated the carpet was not securely attached at the seams. LPN-A stated the carpet had been shampooed the previous week; however, the stains remained because the carpeting was old. On 7/13/26 at 5:53 p.m., the environmental services manager (EVSM)-C stated the flooring had been scrubbed multiple times without improvement and that requests for replacement flooring had been ongoing for an extended period. EVSM-C stated the ripped carpet and stained flooring were maintenance issues, described the condition as embarrassing and unfair to the residents, and confirmed the concerns were included in weekly reports submitted to environmental management. EVSM-C stated the carpeting was a concern and reported attempts had been made to clean the carpet; however, the staining worsened during humid conditions. On 7/14/26 at 10:04 a.m., the maintenance director (MD)-A and administrator confirmed the carpeting was not secure and frayed and stated anything could be tripped on. They stated the carpet had been glued previously at the seams and replacement had been discussed; however, no replacement date had been established. The administrator acknowledged residents would not be expected to live with frayed carpeting or holes in the carpet as it is not a homelike environment. The administrator stated the carpet condition was a known concern and acknowledged the stains remained despite shampooing. The administrator stated the carpeting does not look good or homelike, confirmed awareness of the condition. The administrator confirmed the carpets on the East and [NAME] halls did not provide a homelike environment. On 7/14/26 at 12:23 p.m., observation of the east hallway identified multiple areas where the carpeting was worn through with the carpet backing visible. Several carpet seams were frayed and separated, creating raised edges. Numerous irregularly shaped dark brown and black discolored areas of varying sizes were present throughout the hallway carpeting. On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed a ceiling tile surrounding the sprinkler head with a large circular brown discolored area measuring approximately 18 to 24 inches in diameter, with a darker brown ring around the outer edge and a lighter-colored center. An adjacent ceiling tile had an additional irregularly shaped brown discolored area extending across the edge of the tile. Additional ceiling tiles were observed to be cracked, broken, and sagging, with visible deterioration to the tile surfaces. On 7/15/26 at 12:55 p.m., MD-A while observing the ceiling confirmed the ceiling tile in the bathroom was stained and stated the facility has a flat roof. MD-A further stated the ceiling tile was busted. On 7/15/26 at 12:59 p.m., the administrator observed the condition of the ceiling and confirmed they would expect the stained and cracked ceiling tiles to be replaced. The Facility document The Revisor of Statutes dated 2007, indicated A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongs to the extent possible.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) assessment was coded accurately for 1 of 1 resident (R50) reviewed for discharge a by inaccurately coding a planned discharge as an unplanned discharge, and failed to follow the Resident Assessment Instrument (RAI) Manual. Findings include: R50's discharge assessment - return not anticipated MDS dated [DATE], indicated unplanned discharge to home/community on 6/28/26, cognitive skills for daily decision making: modified independence - some difficulty in new situations only; was independent with oral hygiene, toileting hygiene, dressing, personal hygiene, transfers, walking, did not use a wheelchair, diagnoses indicated hemiplegia following cerebral infarction affecting left non-dominant side (stroke-related condition where a blood clot or blockage; has caused paralysis or severe weakness on the left side of the body). R50's discharge instructions dated 6/25/26 at 1:37 p.m., licensed practical nurse (LPN)-A indicated discharge home, reason for discharge: resident request, admission date 4/28/26, came to our facility following hospitalization for CVA (stroke) with left sided weakness and left sided vision deficit. Has worked with therapy and is now independent with all cares, further the document was signed by R50 and indicated understood the medication instructions and other instructions given to me by the healthcare professional. R50's document titled notice of resident/patient transfer or discharge 6/29/26, social services (SS) director-A indicated date of anticipated discharge 6/28/26, date notice provided 6/26/26, the transfer or discharge is/was appropriate because the resident's health has/had improved sufficiently so the resident no longer needs/needed the services provided by the facility. R50's provider note progress note dated 6/25/26, nurse practitioner (NP)-D indicated okay to discharge to home with current meds and treatment plan. R50's progress note dated 6/28/26 at 8:45 a.m. the director of nursing (DON) indicated R50 packed personal belongings and brought to the front door awaiting on dtr (daughter) pick up, ambulating independently w/o (without) aid, reviewed d/c medications with resident again. Understanding noted AEB (as evidenced by) resident repeating instructions, reading out loud and familiarity/awareness with names and dosing of medications, provided printed out MAR (medication administration record) for June/July so resident has 'a graph' so she can check off after taking. informed resident and dtr that writer spoke with pharmacist at pharmacy yesterday to ensure medications were ready for pick up, R50 excited to be returning home. D/C (discharge) instructions, meds and personal belongings with resident. discharged to home via private vehicle/dtr. On 7/15/26 at 10:00 a.m., the director of nursing (DON) stated R50's MDS had been completed as an unplanned discharge because the timing of the discharge changed at the last minute and the facility was not prepared for the resident to leave that day. The DON stated the family situation was dysfunctional and there was uncertainty regarding transportation and whether R50 would return home with family or independently. The DON confirmed R50 was ready for discharge; however, the facility had not planned for the resident to leave on the day of discharge. The DON confirmed the discharge process was followed, a provider discharge order was obtained, all necessary discharge paperwork and education were provided to R50, and R50 did not leave AMA (against medical advice). On 7/15/26 at 11:49 a.m., registered nurse (RN)-A, the MDS coordinator, stated R50's discharge arrangements were finalized only a couple of days before discharge and the assessment was coded as an unexpected discharge because they believed that coding was consistent with the Resident Assessment Instrument (RAI) Manual. The MDS coordinator stated R50 did not leave AMA and that although the facility did not know the exact day R50 would leave until shortly before discharge, a provider discharge order had (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been obtained and facility discharge instructions had been completed. On 7/15/26 at 11:59 a.m., licensed practical nurse (LPN)-A stated R50 had been working toward discharge home, discharge planning discussions had occurred several days before discharge, and a provider discharge order had been obtained. The nurse stated the uncertainty involved whether R50 would return home with family or independently, not whether R50 would be discharged from the facility. On 7/15/26 at 12:22 p.m., the nurse practitioner (NP)-D stated R50's discharge was planned and was not an unexpected discharge. On 7/15/26 at 12:47 p.m., the social services (SS)-A director stated R50's discharge had been planned, a care conference had been held regarding the discharge, and the MDS would not be expected to be coded as an unplanned discharge. Review of the RAI Manual dated 10/25, indicated an unplanned discharge occurs when the discharge was unexpected, such as an acute hospitalization or the resident leaving against medical advice. Because R50's discharge planning had occurred over several days, a provider discharge order had been obtained, discharge instructions were completed, and the resident did not leave AMA, the discharge did not meet the definition of an unplanned discharge. Facility Discharge Planning Policy dated 1/25, indicated at discharge the rounding provider must write an order for discharge, if the rounding provider refuses to write a discharge order and the resident insists on being discharged anyway refer to Against Medical advice policy.		

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NAME OF PROVIDER OR SUPPLIER Lakeshore Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 108 8th Street Northwest Waseca, MN 56093	
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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain oral hygiene for 1 of 2 residents (R42) reviewed for ADL assistance. Findings include: R42's admission Minimum Data Set (MDS) dated [DATE], indicated cognitively intact, no rejection of care, required supervision or touching assistance with oral hygiene, diagnosis included displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture (break of the lower leg), and history of falling. R42's CAA (care area assessment) dated 5/21/26, indicated R42 had a decline in mobility following hospitalization for a fall that resulted in a right ankle fracture, in PT (physical therapy) and OT (occupational therapy) at this time, needing assistance with mobility and ADLs (activities of daily living), alert and oriented and able to make her needs known, plan to continue to provide assistance with ADLs and follow therapy recommendations. R42's care plan dated 5/15/26, indicated alternation in mobility, does not walk, assist with movement in bed and in/out bed, set up with personal hygiene. R42's task: personal hygiene the ability to use suitable items to clean teeth, dated 6/16/26-7/14/26, indicated the following data that R42 was provided setup assistance, partial assistance, or independent 6/19/26-6/20/26/22/26/24/26/26/26/27/26/28/26/29/26/30/26/31/26/2/26/3/26/5/26/7/7 data provided failed to indicate R42 was provided daily set up assistance with oral care. R42's treatment administration record (TAR) dated 7/1/26-7/30/26, indicated start date 5/14/26, NWB (non-weight bearing) rt (right) leg every shift, CAM boot; wea with all activities including sleeping. May remove for skin hygiene, icing and ankle ROM every shift for right ankle fracture. On 7/13/26 at 10:51 a.m., R42 was observed seated in a recliner wearing a black orthopedic boot on the right lower leg. R42 stated she was non-weight bearing due to a fractured leg and required staff assistance to obtain her toothbrush, toothpaste, a cup of water, and assistance to empty the water after brushing her teeth. R42 stated she did not receive assistance with morning oral care every day. R42 stated she frequently requested assistance; however, staff told her they did not have time because they were assisting other residents. R42 stated she stopped asking because she did not want another resident to have to wait for care. R42 stated she had been moved from another area of the facility because she was told the current hallway was less busy and she would receive timelier assistance. On 7/14/26 at 8:18 a.m., R42 stated she had not yet received morning care. She stated she preferred to eat breakfast before receiving assistance to wash up. R42 also stated she previously experienced long call light response times and had been instructed to call the facility's main telephone number when her call light was not answered. On 7/14/26 at 8:51 a.m., nursing assistant (NA)-A stated there were times staff did not have enough time to assist R42 with obtaining the supplies needed to brush her teeth and acknowledged assistance could be delayed until approximately 1:00 p.m. NA-A confirmed there were occasions when R42 requested assistance and they told R42 they were too busy. NA-A further stated R42 required assistance to obtain a glass of water and to empty the cup after brushing her teeth. On 7/14/26 at 9:00 a.m., the social services director (SS)-A stated R42 had previously been moved to another hallway due to concerns regarding long call light response times. SS-A confirmed review of call light logs identified response times exceeding 25 minutes for R42. Staff were educated regarding timely responses, and R42 was provided the front desk telephone number if assistance was not received. SS-A acknowledged R42 should not have to call the front desk to obtain assistance. On 7/14/26 at 9:09 a.m., the administrator confirmed R42 had expressed concerns regarding long call (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	light response times and that the call light logs had been reviewed. The administrator stated she did not recall response times greater than 30 minutes and considered call light response times exceeding 30 minutes to be significant. The administrator stated R42 to was moved to a less busy hallway. On 7/14/26 at 12:37 p.m., R42 stated her teeth had been brushed that day; however, she reported she was not routinely offered assistance with brushing her teeth on weekend mornings. On 7/15/26 at 8:19 a.m., NA-A confirmed they did not have sufficient time to provide all required care to R42 on Saturday, 7/11/26, including oral care. On 7/15/26 at 8:49 a.m., licensed practical nurse (LPN)-A stated staff were expected to provide R42 with assistance to set up for teeth brushing. LPN-A stated nursing assistants were expected to notify the nurse if they were unable to provide the required assistance. LPN-A acknowledged R42 was particular about her oral hygiene. LPN-A further acknowledged staffing shortages could delay care, stating there were not enough staff to care for all residents, staff frequently had difficulty locating assistance, residents had reported waiting up to 30 minutes for assistance, and the director of nursing (DON) was aware of these concerns. On 7/15/26 at 10:20 a.m., the DON stated staff were expected to provide R42 with daily assistance to set up for tooth brushing and document the care provided. The DON stated staff were expected to complete ADL (activity of daily living) documentation before leaving their shift. The DON confirmed R42's documentation did not identify oral care was completed daily. Facility Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish. 3. The facility will provide care and services for the following activities of daily living a. hygiene-bathing, dressing, grooming, and oral care.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide oral care to 1 of 1 resident (R13) who was reviewed for assistance with activities of daily living (ADLs) and who was dependent upon staff for ADL cares. Findings include: R13's diagnosis report dated 7/16/26, included diagnoses of fractured vertebrae, fracture of right radius (bone in forearm) and fracture right humerus (bone in upper arm). R13's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all ADLs, including oral hygiene. R13 did not walk. R13's care plan dated 7/7/26, indicated self-care deficient related to impaired mobility and right arm fractures. Staff would assist with dental hygiene for upper denture and lower partial. During an interview on 7/13/26 at 1:43 p.m., family member (FM)-A stated staff had not been cleaning R13's dentures, a full upper and partial on the bottom. R13 stated the same, that staff did not clean her dentures. FM-A stated R13 slept with her dentures in and when FM-A removed them to clean them, they would have food and white material on them. During an interview on 7/15/26 at 10:55 a.m., nursing assistant (NA)-G stated R13 had her own teeth (R13 had upper dentures and lower partial) and admitted she had not provided oral care that morning. NA-G stated she probably should have and could have done it when R13 was sitting up in the wheelchair earlier. During an interview on 7/15/26 at 1:20 p.m., both R13 and family member (FM)-A stated R13's dentures and teeth had not been cleaned yet. During an interview on 7/15/26 at 1:35 p.m., NA-G stated she still had not cleaned R13's dentures/teeth, adding that it had been busy. NA-G stated it was important to clean a resident's teeth for their overall health. During an interview on 7/16/26 at 8:48 a.m., the director of nursing (DON) was informed of findings and stated oral care was the responsibility of NAs and would expect it to be done at least twice a day. The DON stated R13 was not able to do her own oral care due to her arm injuries. Together looked POC (point of care) in the electronic medical record where NAs documented cares. For oral hygiene, in the 15 days and 30 opportunities to complete oral care there were only 12 checkmarks indicating the level of care R13 needed for oral care, not specifically if oral care had been completed or not. Facility Activity of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would provide care and services for oral care. A resident who was not able to carry out ADLs would receive the services to maintain oral hygiene.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement a bowel movement (BM) protocol for 1 of 1 resident (R13) reviewed for constipation. Findings include: R13's diagnosis report dated 7/16/26, included diagnoses of fractured vertebrae, fracture of right radius (bone in forearm) and fracture right humerus (bone in upper arm). R13's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R13 was dependent on staff for most all activities of daily living (ADLs) and did not walk. R13's physician orders dated 6/30/26, included senna (laxative) oral tablet 8.6 mg (milligrams), give three tablets by mouth as needed for constipation; three tablets two times a day as needed for constipation. In addition, orders dated 6/30/26, included: may use standing orders as signed by provider. Standing orders signed by provider 3/11/26, indicated for bowel protocol:--Milk of Magnesia (laxative) 30 cc (cubic centimeter) orally daily PRN (as needed) if no bowel movement for two days.--Dulcolax suppository (laxative), one per rectum daily PRN if no bowel movement for three days.--Fleets (brand name) or tap water enema rectally daily PRN constipation. R13's care plan dated 7/7/26, indicated an alteration in elimination related to mobility limitations and R13 would move bowels every three days or greater. R13's bowel movement task list completed by NAs, indicated R13 did not have a documented BM from 7/9/26 through the morning of 7/14/26 (six days). During an observation on 7/14/26 at 11:17 a.m., licensed practical nurse (LPN)-B spoke to R13 to ask how she was feeling. R13 reported pressure down there (hand over lower abdomen) and stated she had not had a BM for a while. After leaving the room, LPN-B accessed the electronic medical record (EMR) and saw the last documented BM for R13 had been on 7/8/26, six days ago. LPN-B had not been aware if the facility had a BM protocol or standing orders and stated she would give R13 the PRN laxative ordered for her. During an interview on 7/14/26 at 2:04 p.m., nursing assistant (NA)-D stated NAs documented resident BMs in POC (point of care) in the EMR. If a resident was independent with toileting, might not know if they had a BM unless asked. For other residents, we know if they had BM because we change their brief or take them to the bathroom. NA-D admitted a NA might forget or not have time to document cares including BMs, in POC. During an interview on 7/15/26 at 11:45 a.m., registered nurse (RN)-C stated R13 had no results from the PRN medication given the day before, and therefore gave R13 a suppository that morning and R13 had a BM. During an interview on 7/15/26 at 12:50 p.m., RN-C stated nursing staff were expected to monitor resident BMs via the EMR and the BM sheet the night shift staff filled out indicating residents to receive a suppository after not having a BM for three days. If a resident went more than three days without a BM, staff should start the protocol per the standing orders which indicated to start with a stool softener or Milk of Magnesia, then a suppository, then an enema. RN-C pointed to the standing orders posted on the bulletin board in the nurses' station office. RN-C confirmed by what she could see, nursing staff had not been monitoring R13's BMs since she had gone six days without a BM and no intervention. During an interview on 7/16/26 at 8:48 a.m., the director of nursing (DON) had been informed of findings. The DON stated it was not okay for a resident to go six days without a BM. The DON stated by day three, should receive a suppository per the standing orders and that all nursing staff should know that. The DON acknowledged staff had not been monitoring and addressing R13's BMs per the standing orders. A bowel monitoring policy was requested and not received.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to maintain, restore or improve the functional ability for 2 of 2 residents (R29, R37) reviewed for ADLs, when the facility failed to ensure residents were walked according to physical therapy (PT) instructions and physician orders. Findings include: R29's diagnosis report dated 7/16/26, included generalized osteoarthritis, diabetes, generalized muscle weakness and obesity. R29's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R29 required partial to moderate assistance with most ADLs including walking 150 feet. R29 used a walker and wheelchair for mobility. R29's physician orders dated 7/15/25, indicated per therapy, ensure resident is walked two times a day with staff, every day and evening shift. R29's Therapy Alert from PT dated 7/15/25, indicated R29 should ambulate one to two times a day with FWW (front wheeled walker) and assistance of one staff. R29's care plan dated 1/26/25, indicated R29 had an alteration in mobility related to impaired mobility and to follow PT instructions. On 7/15/25, care plan indicated to ambulate R29 two times a day with FWW and assist of one. R29's Kardex (a quick reference used by nursing assistants to inform them of a resident's care) printed on 7/16/26, indicated ambulate resident two times/day with FWW and assist of one. May progress distance as tolerated by resident. R29's documentation of ambulation in POC (point of care, where NAs document in the electronic medical record) indicated out of 28 days and 56 opportunities, documentation indicated R29 had been walked only nine times. R29's TAR (treatment administration record) completed by nursing staff, indicated: ensure R29 walked two times a day with staff every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R29 was walked 21 times. Documentation between the NA who was responsible to perform the task and documentation of the nurse who was to be informed of task completion, did not match. During an interview on 7/15/26, at 9:36 a.m., R29 had been sitting in her wheelchair in her room with walker off to the side. R29 stated she used to be on a walking program but had not walked for a while because the facility was short staffed. R13 stated she would like to walk in the hallway, so her legs stayed strong. R37's diagnosis report dated 7/16/26, included diagnoses of congestive heart failure (when the heart doesn't pump as well as it should) diabetes, generalized muscle weakness, history of falling, and obesity. R37's annual MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R37 required partial to moderate assistance with ADLs, including walking 150 feet. R37 used a walker and wheelchair for mobility. R37's physician orders dated 4/13/26, indicated ensure resident ambulates one to two times per day with assist of one to manage O2 (oxygen), every day and evening shift. R37's Therapy Alert from PT staff dated 4/7/26, indicated ambulate resident one to two times a day with FWW and assist of one to manage O2 tubing. R37's care plan dated 4/10/24, indicated alteration in mobility related to weakness and history of falling, and to follow PT instructions. PT's walking recommendations/instructions from 4/7/26, were not included in the care plan. R37's Kardex printed on 7/16/26, did not include ambulation recommendations by PT. R37's POC had not been set up to include recommendations from PT and therefore no location in POC for NAs to document if/when they ambulated R37. R37's TAR completed by nursing staff, indicated: ensure R37 ambulates 1-2x/day with assist of 1 to manage O2 tubing, every day and evening shift. Since 7/1/26, documentation indicated out of 15 days and 30 opportunities, R37 was walked 27 times. However there had been no documentation by the NAs who were responsible for performing the task. During an (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 7/15/26 at 9:30 a.m. R37 had been sitting in a wheelchair in her room with a walker off to the side. R37 stated she used to walk in the hallway but didn't anymore. R37 stated it was something she wanted to do in order to keep mobile, adding it was good for her to walk. R37 stated she used to walk to the shower room, but no longer. R37 felt she could walk if staff helped her. During an interview on 7/15/26, at 10:16 a.m., physical therapy assistant (PTA)-E, who was also the department director provided Therapy Alert forms for R29 and R37. PTA-E stated copies of the forms were given to the director of nursing (DON) and NAs. During an interview on 07/15/2026 1:40 p.m., nursing assistant (NA)-D stated R29 and R37 were on walking programs but admitted NAs were not always able to walk residents, including R29 and R37, due to being so busy. NA-D stated residents would usually be walked on the day and the evening shifts and sometimes that depended upon what was going on, such as an activity. NA-D stated walking was important, so residents didn't lose the ability to walk. During an interview on 7/15/26 at 4:48 p.m., with nursing assistant NA-E and NA-F, NA-E stated R29 and R37 were on a list at the desk to be walked in the morning and the afternoon. NA-E stated residents only got walked once a day due to their workload - it gets so heavy, we don't have time. NA-F agreed. NA-E stated if a resident was walked, it was charted in POC. NA-E stated sometimes the nurse would ask if they got it done and would document it too. NA-F stated most residents were in the facility for rehabilitation, and it was important they walked, adding, if you don't use it, you lose it. During an interview on 7/15/26 at 4:53 p.m., licensed practical nurse (LPN)-D stated she documented on the TAR when NAs ambulated a resident. LPN-D stated she did not always see residents being ambulated so asked the NA; if they said yes, she documented it and didn't question it. During an interview on 7/16/26 at 8:22 a.m., licensed practical nurse (LPN)-A, stated she did not know why nurses were asked to document a task they did not do themselves. LPN-A stated she kept track if she saw a resident being walked, or if an NA told her they walked a resident, adding she had to trust what they told her. During an interview on 7/16/26 at 8:56 a.m., the director of nursing (DON) stated resident recommendations for walking came from PT. When received, the residents name would be added to a list at the nurses' station to inform NAs which residents should be walked. The DON was asked to look in POC for documentation of R29 and R37 being walked. For R29, the DON admitted R29 had not been walked according to PT recommendation, physician order, care plan and Kardex. For R37, POC had not been set up for NAs to document her walking and couldn't say why, or how NAs documented this task without POC. The DON stated she did not monitor whether or not residents were walked according to PT recommendations, nor did she monitor documentation. The DON stated she asked the nurses if residents were walked even though they did not perform the task. The DON stated she knew the afternoon shift struggled with walking residents due to meals, bedtime and staff breaks. The DON stated it was important to walk residents, so they didn't lose the ability to walk, it improved breathing and prevented formation of contractures. The DON stated she had been informed by NA staff they didn't have time to walk residents but told them they could ask nurses to help them. Facility Activities of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would ensure a resident was given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility would provide care and services including walking.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and document review the facility failed to maintain reusable resident care equipment in a manner that could be effectively cleaned and disinfected by continuing to use a bathtub chair with torn and cracked cushion surfaces in the east hallway bath room. This had the potential to affect any of the 19 residents residing on the east and west hallways who used the tub room. Findings include: On 7/15/26 at 7:13 a.m., observation of the bath tub room on the east hallway revealed the shower chair seat with a black vinyl cushion contained multiple tears, cracks, and openings throughout the seating surface. Portions of the vinyl covering were missing, exposing the underlying light-colored cushion material. The damaged areas created multiple irregular surfaces and openings across the seat cushion. On 7/15/26 at 12:50 p.m., nursing assistant (NA)-A stated the bathtub room was used for residents and confirmed the cracked shower chair was used. NA-A stated they placed a towel on the chair before residents use it. On 7/15/26 at 12:51 p.m., licensed practical nurse (LPN)-A stated the bathtub chair cushion was cracked and had openings and stated it could be an infection control issue. On 7/15/26 at 12:55 p.m., maintenance director (MD)-A confirmed the bathtub chair cushion was cracked and damaged and stated they it would be expected to be replaced and stated they were not aware of the cushion's condition. On 7/15/26 at 12:59 p.m., the administrator observed the bathtub chair cushion and confirmed the cushion should not be in that condition due to infection control concerns. The administrator stated staff would not be expected to use the shower chair if the cushion was cracked. On 7/15/26 at 4:48 p.m., the director nursing (DON), also known as the infection preventionist, stated the shower chair was not expected to have cracked cushions and stated the damaged cushion could present an infection control problem. The facility Infection Prevention and Control Program policy dated 11/24, indicated Prevention of Infection instituting measures to avoid complications educating staff and ensuring that they adhere to proper techniques and procedures		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review the facility failed to ensure the posted nursing hours were updated when there was a change to staffing levels. This had the potential to affect all residents and visitors of the facility. Findings include: During an observation and interview on 3/14/26 at 10:45 a.m., the daily staffing hours were posted in the main entrance area visible to all residents and visitors but were dated 3/13/26. Licensed practical nurse (LPN)-A was observed taking out the page for 3/13/26, and inserting the new daily staffing hours for 3/14/26. Review of the daily staffing hours posted for 3/13/25, indicated the following hours: Days: one registered nurse (RN), one LPN, one trained medication aide (TMA), four nursing assistants (NAs). Evenings: two RNs, four NAs. Nights: one LPN, two NAs. Review of the daily staffing hours posted for 3/14/26, indicated the following hours: Days: two LPNs, one TMA, four NAs. Evenings: one RN, one LPN, four NAs. Nights: one LPN, two NAs. Review of facility schedules dated 7/13/26 and 7/14/26, indicated additional NAs on each day to assist with baths that were missed on the weekend. On 7/13/26, an additional nursing assistant was scheduled from 10:30 a.m. to 2:30 p.m., and on 7/14/26, an additional nursing assistant was scheduled from 11:00 a.m. to 2:30 p.m. There were no changes made to the daily staffing posting to reflect these changes in staffing totals. During interview on 7/14/26 at 10:45 a.m., director of nursing (DON) stated she had added extra staff to assist with making up baths from the weekend that did not get done. DON further stated she would expect the daily staff posting to be updated when there were changes to the schedule. DON confirmed the postings had not been updated to reflect accurate information on either 7/13/26 or 7/14/26. During interview on 7/16/26 at 2:45 p.m., administrator stated it was the responsibility of the TMA to update the daily staff posting in real time, but she also kept on eye on it. Administrator confirmed the updates had not been made on 7/13/26 or 7/14/26, and she would have expected them updated to reflect accurate staffing levels. A policy on daily staff postings was requested but not received.		