Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 18, 2025

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: January 29, 2025

Dear Administrator:

On January 29, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 29, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 29, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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E 000	Initial Comments On 1/27/25-1/29/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E 039		3/11/25

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

Electronically Signed | 02/27/2025

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

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E 039	Continued From page 1 (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not	E 039		

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E 039	Continued From page 2 accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 3 based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 4 (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional	E 039		

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E 039	Continued From page 5 exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 6 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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E 039	Continued From page 7 a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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E 039	Continued From page 8 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,	E 039		

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E 039	Continued From page 9 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a full-scale community based exercise to test their emergency preparedness program (EPP) in response to an actual emergency event. This deficient practice had the potential to affect all 59 clients residing in the facility, along with staff who work in the facility. Findings include: Review of the facilities EPP revised on 1/24/24, lacked a community based exercise in the last year, to test their EPP. On 2/7/24 at 3:32 p.m., the administrator and maintenance director (M)-A, also identified as EPP coordinator, confirmed only one table top exercise was completed. The administrator and M-A confirmed a community drill had not been completed in the past year. M-A indicated he just started in the role a few months ago. Facility policy titled Emergency Operations Plan reviewed 1/24/24, indicated education training, including drills and exercise are utilized in this facility achieve proficiency during emergency response. In compliance with stated and federal regulations... A disaster drill is held bi-annually	E 039	All residents living in the facility have the potential to be impacted by the alleged practice. Review of policy was completed by the interdisciplinary team and a tabletop exercise was completed. The Executive Director or Designee provided education to the interdisciplinary team on completing emergency drills and recording these as they occur. Monthly audits will be completed by the Executive Director or designee for the next year. Audits will be brought to Quality Assessment Process Improvement for review.	

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E 039	Continued From page 10 one which will be community based.	E 039		
F 000	INITIAL COMMENTS On 1/27/25 through 1/29/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H51845945C (MN00109640), H51845944C (MN00109113), H51845946C (MN00107826), H51846241C (MN00110243). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 554	Based on observation, interview and	3/11/25

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F 554	Continued From page 11 review, the facility failed to ensure 2 of 2 residents (R6, R49) who were observed to have medications in their rooms, had been appropriately assessed and deemed safe to self-administer medications. Findings include: R6's facesheet printed on 1/28/25, included diagnoses of rheumatoid arthritis and dementia. R6's annual Minimum Data Set (MDS) assessment dated 11/22/24, indicated R6 had moderately impaired cognition, clear speech, could understand and be understood. R6 required assistance of staff for most activities of daily living (ADL). R6 did not ambulate. R6's physician orders dated 10/28/24, included Voltaren (treats joint and muscle pain) external gel 1%. Apply 2 g (grams) to knees topically as needed for pain four times a day. Orders did not include authorization for self-administration of medication. R6's care plan dated 12/5/23, indicated R6 had pain in her knees related to arthritis and to administer pain medications per physician orders. The care plan did not include self-administration of medication. No assessment for safe self-administration of medication was noted in the electronic medical record (EMR). During an observation and interview on 1/27/25 at 3:39 p.m., observed a large tube of Voltaren, 3.53 ounces on bedside dresser on the vacant side of the room. R6 stated she did not put it on herself,	F 554	document review, the facility allegedly failed to ensure 2 of 2 residents (R6, and R49) who were observed to have medications in their rooms, had been appropriately assessed and deemed safe to self-administer medications. Affected residents (R6 and R49) will be assessed with the medication self-administration assessment. If the assessment shows they are appropriate for medication self-administration a provider□s order will be placed to allow them to keep the appropriately assessed medications in their room. If they do not pass the assessment, they will have all their medications kept in the medication cart and the reason why will be explained to them. Like residents, which are those that are in house and request to self-administer medications. audited to ensure self-administration of medication assessment and care plan in place are current. Director of nursing or designee provided re-education on self-administration of medication, assessment, and care plan, to nurses and CNAs. Director of Nursing or designee will complete audits three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement	

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F 554	Continued From page 12 adding "They do sometimes." R49 R49's facesheet printed on 1/28/25, included diagnoses of stroke, type 1 diabetes and dementia. R49's quarterly MDS assessment dated 12/25/24, indicated moderately impaired cognition, clear speech, could understand and be understood. R49 was independent with ADL's and ambulatory with a walker. R49 physician orders dated 6/17/24, included glucose oral tablet chewable, give 4 gram by mouth as needed for low blood sugar. Give if blood sugar less than 70 mg (milligrams) wait 15 minutes, recheck blood sugar level. If still less than 70 take an additional 4 gm tablet. Repeat until blood sugar above 70. R49's orders did not include aspirin, iron or an order for self-administration of medications. R49's care plan dated 6/18/24, did not include self- administration of medication. No assessment for safe self-administration of medication was noted in the EMR. During an observation and interview on 1/27/25 at 1:52 p.m., observed the following medications in R49's room: --Chewable glucose tablets, three large bottles, 50 tablets in each bottle, observed on a bookcase --Aspirin 325 mg, one bottle of 500 tablets observed on the bedside dresser --Iron 65 mg, one bottle of 365 tablets observed on a tall dresser R49 stated he brought the medications from	F 554	committee for review and recommendations.¿¿¿	

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F 554	Continued From page 13 home, but didn't use them anymore. During an interview and observation on 1/28/25 at 11:30 a.m., along with the director of nursing (DON) went to R6 and R49's rooms. In R6's room, the Voltaren had been moved to the bedside table next to R6's bed. The DON removed it, stating it could not be left in R6's room unless she had a self-administration order and didn't think she did. In R49's room, and with R49's permission observed the aspirin and iron bottles had been moved to the top drawer of his bedside dresser. The glucose tablets remained on the bookcase. The DON stated R49 did not have a self- administration order and the medications should not be in his room. The DON did not know why staff had not observed the medications that were in plain sight -- adding they should have caught that. During an interview on 1/29/25 at 7:43 a.m., licensed practical nurse (LPN)-A stated a resident couldn't have medications in their room without a self- administration order and it also needed to be care planned. LPN-A stated she was not aware R6 had a tube of Voltaren in her room -- she had not seen that. LPN-A stated R49 did have an order for self-administration of glucose tablets - she had personally sent a message to the provider to request it. LPN-A looked in the EMR and acknowledged there was no order, nor was it care planned. The facility Medication Self-Administration policy dated 6/1/17, indicated residents were not permitted to administer or retain any medication in his or her room unless their attending physician wrote an order for self-administration of the medication and resident was assessed.	F 554		

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		3/11/25

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F 580	Continued From page 15 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify resident representatives following falls with subsequent transfer to the hospital for 2 of 2 residents (R20, R164) reviewed for falls. Findings include: R20's facesheet printed on 1/29/25, included diagnoses of chronic kidney disease with heart failure, dependence on renal dialysis, recent femur fracture, morbid obesity and diabetes. R20's significant change Minimum Data Set (MDS) assessment dated 1/16/25, indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 was independent with some activities of daily living (ADL) including eating, toileting, and self-propelling in her wheelchair. R20 was dependent upon staff for dressing, showering and transferring in and out of bed. R20's care plan dated 3/25/18, indicated a history of falls. Care plan dated 12/28/24, indicated R20 had pain and impaired mobility related to recent femur fracture with surgical repair.	F 580	Based on interview and document review, the facility allegedly failed to notify resident representatives following a fall with subsequent transfer to the hospital for 2 of 2 residents (R20, R164) reviewed for falls. Residents R164 and R20 re-education on notification completed. Like residents have the potential to be impacted by this practice. Re-education provided to nursing staff on notification process when changes may occur with a resident. Director of nursing or designee provided re-education to direct care nursing staff about proper notifications when sending someone to the hospital. Director of Nursing or designee will complete audits three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality	

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F 580	Continued From page 16 During an interview on 1/27/25 at 5:12 p.m., R20 stated on 12/28/24, she was standing in the bathroom when her knees gave out, causing her to fall and fracture her left femur. Incident report dated 12/28/24 at 7:07 p.m., for R20's unwitnessed fall, under a heading titled: Agencies / People Notified -- indicated a statement: No notifications found. A progress note dated 12/28/24 at 9:52 p.m., indicated R20 was found on the floor in her room with left knee and calf shifted laterally. Paramedics were called; R20 was inconsolable. R20 left the facility around 7:30 p.m., and the director of nursing and nurse manager were notified. A progress note dated 12/28/2024, at 10:48 p.m., indicated family member (FM)-A called the facility to inform them R20 would be admitted to the hospital and taken to surgery the next morning to reduce a fracture of her left femur. FM-A expressed dissatisfaction and was upset no staff had called to notify her of the fall and transfer to the emergency department (ED). During a telephone interview on 1/28/25 at 3:11 p.m., FM-A stated she found out about R20's fall and subsequent transfer to the ED when R20 called her from the ED. FM-A stated she was R20's emergency contact and the facility had been informed previously to notify FM-A if R20 was sent to the ED --- which R20 had requested too. FM-A stated the fall happened around 6:30 p.m. on 12/28/24, and R20 was not able to contact her until between 8:30 p.m., and 9:00 p.m. FM-A stated she worried for R20 being alone	F 580	Assurance/Performance Improvement committee for review and recommendations.	

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F 580	Continued From page 17 because R20 liked her to be present to ask questions and give her opinion. FM-A stated she talked to the administrator about it and voiced her concerns. FM-A stated the administrator informed her that R20 was her own person and FM-A didn't need to be notified. FM-A stated she informed the administrator that she was listed as R20's emergency contact and the administrator told her she didn't see that listed in R20's care plan. FM-A then spoke to the business office manager (BOM)-D who was very apologetic and found right away that FM-A was listed as R20's emergency contact on R20's facesheet. During an interview on 1/29/25 at 10:57 a.m., the administrator stated she went to see R20 in the hospital and R20 told her FM-A was upset she wasn't notified when R20 was transferred to the hospital on 12/28/24. The administrator then called FM-A and told her R20 was her own person, and therefore it would have been up to R20 to notify FM-A. The administrator acknowledged FM-A was listed as R20's emergency contact on R20's facesheet in the electronic medical record (EMR). Administrator was aware facility policy indicated to notify the resident representative when there was an accident involving injury to a resident. During an interview on 1/29/25 at 11:22 a.m., R20 stated before she left the facility to go to the hospital on 12/28/24, she told staff to call FM-A, but they did not. R20 stated she contacted FM-A from the hospital, who then came right away. R20 stated she looked to FM-A when she went to the hospital to help speak on her behalf. During an interview on 1/29/25 at 11:34 a.m. the director of nursing (DON) stated she was aware	F 580		

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F 580	Continued From page 18 FM-A had not been notified of R20's fall and subsequent transfer to the hospital on 12/28/24. The DON stated R20 was her own person so R20 would need to contact FM-A herself. The DON admitted R20 was not likely in a position to contact FM-A herself as she had fractured her femur and according to the staff was in considerable pain. R164's facesheet printed on 1/29/25, included diagnoses of post-op orthopedic after care for neck surgery, mild cognitive impairment, and lack of coordination. R164's admission MDS assessment dated 1/27/25, indicated R164 had moderately impaired cognition, clear speech, usually understood and could usually understand. R164 needed assistance with ADLs and did not walk. He had two or more falls since admission. R164's care plan dated 1/22/25, indicated risk of falls due to impaired mobility. During an interview on 1/27/25 at 4:31 p.m., FM-B stated R164 had two falls that she was aware of since admission on 1/21/25. FM-B stated after the second fall (she wasn't sure of the date), R164 had been sent to the ED. FM-B stated no one from the facility contacted her to inform her he had fallen and was being sent to the ED. FM-B stated the first she knew about it was when the ED called her and by that time he had already been returned to the facility. FM-B was worried about R164 being by himself at the hospital because he is not able to communicate well and had been experiencing confusion. FM-B stated she lived close by and could have gone to the hospital.	F 580		

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F 580	Continued From page 19 Progress notes in the EMR and/or indecent reports indicated R164 had three falls since admission: 1. 1/22/25 2. 1/24/25, and R164 was sent to the ED. A progress note at the time of the transfer indicated: notified the situation to resident's family. 3. 1/26/25, and R164 was sent to the ED. A progress note at the time of the transfer did not indicate FM-B was notified. The incident report for this fall indicated: emergency contact was called; not currently answering; nurse will attempt to contact them again. During an interview on 1/29/25 at 11:52 a.m., the DON was informed of FM-B's concern about not being informed of R164's fall with transfer to the ED on 1/26/25. The DON was informed the incident report indicated there was an attempt to contact FM-B, but there was no answer. The DON stated, "it's not one and done" -- staff need to attempt again and/or ask the next shift to try. The facility Change in Condition policy with revised date of 10/10/24, indicated a facility would immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an	F 580		

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F 580	Continued From page 20 existing form of treatment due to adverse consequences, or to commence a new form of treatment). Notify resident's family/responsible party as applicable and in accordance with resident's wishes. Documentation should include notification of responsible party - include date, time, what was conveyed, any comments (each time notified).	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph	F 655		3/11/25

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F 655	Continued From page 21 (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a baseline care plan for 1 of 2 residents (R164) reviewed who was newly admitted to the facility. Findings include: R164's facesheet printed on 1/29/25, indicated R164 had been admitted on 1/21/25; diagnoses included post-op orthopedic after-care for neck surgery. R164's admission Minimum Data Set (MDS) assessment dated 1/27/25, indicated R164 had moderate impaired cognition, clear speech, was usually understood and could usually understand. R164 needed assistance with ADLs and did not walk independently. During an interview on 1/27/25 at 4:29 p.m., family member (FM)-B stated neither she nor R164 had received a copy of a care plan after he	F 655	Based on interview and document review, the facility allegedly failed to complete a baseline care plan on 1 of 2 residents (R164) reviewed that was newly admitted to the facility. Affected resident (R164) was given a baseline care plan to review and sign on 3/4/2025. Unit Manager met and reviewed the baseline care plan with him. New admission residents have the ability to be affected by alleged practice, IDT reviewed admission in last 30 days to ensure Baseline care in place and up to date on new admissions. Director of nursing or designee provided re-education on baseline care plans to nursing staff and Interdisciplinary team who would complete the care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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F 655	Continued From page 22 was admitted on 1/21/25. FM-B looked through a folder of all the paperwork she had received from the facility and a baseline care plan was not among them. During review of R164's electronic medical record (EMR), a baseline care plan was not found. During review of R164's paper chart, observed a two-page, carbonless form (a white and yellow copy) titled Baseline Care Plan Summary. R164's name and room number had been filled in by hand, but the rest of the form was blank. During an interview on 1/28/25 at 12:33 p.m., the director of nursing (DON) was provided with the carbonless form from R164's paper chart. The DON stated it was the correct form for documentation of a baseline care plan. The DON acknowledged it had R164's name and room number on it, that it was blank and therefore had not been completed. The DON stated she would have expected it to have been completed and a copy given to the resident and/or resident representative. The facility Comprehensive Care Plan policy with revised date of 9/23/22, did not include language about a baseline care plan to be developed and summary given to a residents and/or resident representative.	F 655	Re-education included the need for a baseline care plan, reviewing the baseline care plan form used at the facility, and the need for the resident or their representative to sign the baseline care plan form and a copy be provided to the resident or representative. Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		3/11/25

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F 656	Continued From page 23 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656		

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F 656	Continued From page 24 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 2 residents (R163) reviewed for urinary catheter. Findings include: R163's facesheet printed on 1/29/25, included a diagnoses of urinary retention. R163's discharge assessment/return anticipated Minimum Data Set (MDS) assessment dated 1/24/25, indicated R163 was dependent upon staff for most activities of daily living (ADL) and had an indwelling urinary catheter. R163's physician orders dated 1/27/25, indicated indwelling Foley catheter (drains urine from bladder). R163's care plan dated 1/27/25, did not include R163's urinary retention, use of an indwelling Foley catheter, leg bag, or urinary drainage bag. During an interview on 1/29/25 at 9:02 a.m., registered nurse (RN)-C who was also the MDS nurse stated she added focus areas to resident care plans, as did the nurse manager and director of nursing (DON). RN-C was informed R163's care plan did not include urinary retention or urinary catheter. RN-C looked in R163's electronic medical record (EMR) and confirmed it did not. RN-C stated she had just been in R163's record yesterday to update it and missed the urinary catheter. RN-C stated it was a mistake	F 656	Based on observations, interviews, and document review, the facility allegedly failed to develop a comprehensive care plan for 1 of 2 residents (R163). Effected resident (R163) is no longer in the building. Like residents, which are those residents that are new admissions or readmissions, will be audited on admission to ensure proper comprehensive care plans are completed within the appropriate timeframe. Director of Nursing or designee provided re-education to staff regarding need and reasons for comprehensive care plans, with specific focus as they relate to urinary catheters and leg wraps. Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 656	Continued From page 25 and she would correct it right away. During an interview on 1/29/25 at 11:43 a.m., the DON was informed R163's urinary retention and urinary catheter had not been care planned. The DON stated she expected it to be care planned so staff would know what cares to provide pertaining to R163's catheter, leg bag and urinary drainage bag. The facility Comprehensive Care Plan policy with revised date of 9/23/22, indicated it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that were identified in the residents comprehensive assessment. The comprehensive care plan would describe, at a minimum, services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Staff responsible for carrying out interventions specified in the care plan would be notified of their roles and responsibilities for carrying out the interventions, initially and when changes were made.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		3/11/25

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F 684	Continued From page 26 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide ongoing treatment for edema for 1 of 2 residents (R5) who required leg wraps to prevent and treat edema. Findings include: R5's face sheet printed 1/29/25, included diagnoses of pneumonia, urinary tract infection, Alzheimer's disease, traumatic arthropathy (inflammation of joint) left ankle and foot, and patent foramen ovale (flap-valve opening in the heart from right to left of the top two heart chambers which generally closes at birth, causing abnormal flow of blood). R5's significant change Minimum Data Set (MDS) assessment dated 1/15/25, indicated R5 understands and is understood, has moderately impaired cognition, requires moderate to substantial and maximal assist with transfers and walking and has impaired range of motion in both lower extremities. R5 has had multiple falls without major injury and takes anticoagulant, diuretic and opioid medications. R5's provider orders dated 10/21/24, included Right leg: Low stretch compression wraps from toes to knee. Left Leg: Low stretch compression wraps from toes to thigh, both one time a day for edema and remove per schedule. R5's plan of care dated 8/23/21, with revision on 11/10/24, included R5 had impaired	F 684	Based on observations, interviews, and document review, the facility allegedly failed to comprehensively assess and provide ongoing treatment for edema for 1 of 2 residents (R5) who require compression wraps to prevent and treat edema. Review of resident□s (R5) chart completed to make sure that treatment orders are current, and supplies are available. Like residents have the potential to be impacted by the alleged practice. These residents have been identified, and orders are current, and appropriate supplies are available to nursing staff to implement treatment orders. The Director of Nursing or designee provided re-education to staff regarding reasons for compression wraps and need to apply them as ordered by provider. Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 684	Continued From page 27	F 684		

cardiovascular status related to high blood pressure with interventions including elevate lower extremities as indicated, and Right Leg: Low stretch compression wraps from toes to knee. Left Leg: Low stretch compression wraps from toes to thigh. Apply in a.m., and remove at bedtime.

Review of the electronic medical record (EMR) for January 2025 included right and left legs compression wraps were not applied 6 times due to resident sleeping, 3 times for other reasons/see progress notes, which were reviewed and lacked documentation as to why. R5 refused 10 times to have ace wraps applied. No reattempts were documented.

During observation and interview on 1/27/25 at 3:39 p.m., R5 was in his wheelchair roaming the hallways asking where his shoes were. R5 had gripper socks on both feet and no compression wraps present on bilateral legs. R5 was unsure were he was and repeatedly asked for his socks and shoes and roamed into other residents rooms.

During interview on 1/27/25 at 4:55 p.m. family member (FM)-D stated R5 should have both his legs ace wrapped daily due to swelling but it doesn't happen. FM-D indicated his left knee and ankle have had a lot more swelling due to previous injury, so the left leg is wrapped from the thigh down. FM-D added they (staff) are supposed to massage legs, put lotion on before applying wraps but I can see how dry his legs are so I know that isn't happening.

During interview and observation on 1/28/25 at 11:27 a.m., FM-D was at bedside. R5 was sitting

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F 684	Continued From page 28	F 684		

in his wheelchair in his room with legs down and no ace wraps present. Swelling was present per FM-D and stated "its getting worse". FM-D opened the bedside drawer and pointed at the ace wraps present and stated a request was made for one of the nursing assistants (NA) this morning to put them on and she indicated the nurse has to do that but not one has come to wrap his legs yet.

During observation and interview on 1/28/25 at 1:49 p.m., R5 was lying in bed. No ace wraps were present on either leg. NA-C and NA-D stated they were unsure if R5 was supposed to have ace wraps on his legs as R5 just moved to floor yesterday. NA-C further added the NA role can put compression stockings on, but it is the nurses responsibility to do compression wraps or ace wraps.

During interview on 1/28/25 at 2:28 p.m., registered nurse (RN)-D indicated R5 should have leg wraps applied in the morning and taken off at bedtime. RN-D indicated per charting, R5 refused them at 6:00 a.m. this morning. RN-D indicated especially on the memory care unit, staff should reproach a minimum of 3 times to attempt to provide cares like compression stockings that are ordered. RN-D was not aware R5 did not have his legs wrapped and indicated she just started her shift at 2:00 p.m.

During interview on 1/28/25 at 2:30 p.m., licensed practical nurse (LPN)-B indicated she was not sure if R5 required ace wraps as he was new to the floor. LPN-B indicated NA's can apply ace wraps.

During observation 1/28/25 at 3:45 p.m. R5 had

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F 684	Continued From page 29	F 684		

his feet out of the bed, attempting to stand up at bedside. No ace wraps were present on lower legs.

During observation 1/29/25 at 8:00 a.m., R5 was lying in his bed, awake attempting to get out of bed. No ace wraps were present on lower legs.

During observation and interview on 1/29/25 at 8:28 a.m., NA- E and NA-C transferred R5 from bed to wheelchair using stand assist device and brought R5 to the dining room. NA-E and NA-C stated the wraps are put on by the nursing staff. NA-C added only the nurses can do, but NA's can apply compression stockings.

During interview 1/29/25 at 8:01 a.m., trained medication aide (TMA)-A stated she hasn't worked with R5 before and is unsure if he should have wraps on his legs. TMA-A indicated the nurse on 1st floor is covering for treatments on this floor and she would be the one to put them on.

During interview 1/29/25 at 9:28 a.m., registered nurse (RN)-E, covering nurse for R5's floor indicated R5 is supposed to wear wraps up to thigh on left leg and right leg is compression socks. RN-E was unaware the wraps were not present on R5 and stated they should be put on by night shift.

Documentation review 1/29/25 at 9:40 a.m., of the medication administration record for January 2025 indicated compression wraps were applied 1/29/25.

During interview 1/29/25 at 9:53 a.m., the director of nursing (DON) confirmed there was an order

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F 684	Continued From page 30 present for bilateral leg wraps for R5. The DON stated I would expect staff to put them on daily and take them off at bedtime. The DON indicated if residents refused, they should be reproached a minimum of three times. The DON added only one TMA is trained to apply wraps, otherwise it is the nurses responsibility. A policy on edema prevention and treatment was requested but not received.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate causal factors for a fall and failed to ensure interventions were implemented to reduce the risk of falls for 2 of 2 (R5, R164) who were reviewed for accidents. Findings include: R5's facesheet printed 1/29/25, included diagnoses of pneumonia, urinary tract infection, Alzheimer's disease, traumatic arthropathy (inflammation of joint) left ankle and foot, and patent foramen ovale (flap-valve opening in the heart from right to left of the top two heart	F 689	Based on observation, interview, and documentation review, the facility allegedly failed to assess and evaluate causal factors for a fall and allegedly failed to ensure interventions were implemented to reduce risk of falls for 2 of 2 residents (R5, R164). The identified residents (R5, R164) care plans have been reviewed, and appropriate interventions have been implemented to reduce risk of falls. Like residents (those who have had a fall in the last 30 days, and those that fall in the future), charts were reviewed for	3/11/25

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	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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F 689	Continued From page 31 chambers which generally closes at birth, causing abnormal flow of blood). R5's significant change Minimum Data Set (MDS) assessment dated 1/15/25, indicated R5 understands and is understood, has moderately impaired cognition, requires moderate to substantial and maximal assist with transfers and walking and has impaired range of motion in both lower extremities. R5 had more than 2 falls without major injury and takes anticoagulant, diuretic and opioid medications. A Care Area Assessment (CAA) dated 1/15/25, included assist as needed with activities of daily living. R5 able to make needs known. Has had several falls, with no injury. Has use of wheelchair and walker. No pressure ulcers. Is assisted with toileting and skin care needs. Is reminded to call and wait for assist. Care plan reviewed and up to date. Continue with plan of care. R5's plan of care last revised 11/10/24, included R5 is at risk for falls related to history of falls and chronic knee pain. Interventions included call do not fall sign in room, commonly used items to be placed within resident's reach, education for resident on fall prevention measures, ensure all daily necessitates are within reach, ensure proper footwear, ensure wheelchair is close to bed with brakes locked while resident is in bed and follow therapy recommendations for transfers, mobility and ambulation. An admission Fall Risk Assessment dated 10/21/24, indicated R5 was a low risk for falls. A Fall Risk Assessment completed 1/19/25,	F 689	appropriate falls interventions. Interventions for each resident were assessed to ensure it had been implemented or was no longer needed, if no longer needed it was discontinued. Like residents have the potential to be affected by this alleged practice. The interdisciplinary team will complete an in-depth review of falls as they arise, and the care plan will be updated with appropriate interventions. Re-Education on Accidents and Hazards completed with employees. Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 689	Continued From page 32	F 689		

indicated R5 remained a low risk for falls.

R5 had 7 falls between 10/30/24 and 1/25/25. Falls included:

-An Event report dated 10/30/24 at 3:45 p.m. indicated R5 was sitting up on floor head facing the bathroom door. Resident then laid flat on floor, short of breath and confused. Resident indicated he needed to use the toilet. R5 was sent to the hospital. No injury was identified. Interdisciplinary team (IDT) meeting 10/31/24, indicated root cause as self-transfer with confusion. Intervention included: call do not fall sign in room.

-Event report dated 11/14/24 at 6:45 p.m., indicated R5 was found in between bed and nightstand. Resident was confused and sitting up right. R5 stated he slipped out of bed and the television was on and was trying to turn that off. No injuries observed. An added note on 11/15/24 at 9:40 a.m., indicated confusion was root cause and fall mat placed next to the bed.

- Event report dated 11/19/24 at 5:30 p.m., indicated resident was found on the floor with no injury. Resident was unable to relay preceding events that led to fall. No injuries observed. IDT meeting 11/20/24, indicated root cause as attempting to self-transfer to go to bed. Intervention included to toilet him after meals.

-Event report dated 12/6/24 at 2:45 a.m., indicated R5 was found sitting on the floor next to his bed. Stated he was trying to stand up to grab a brief from his closet and slipped and fell. IDT team review 12/6/24 9:59 a.m., indicated fall was related to resident needing incontinent brief with

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F 689	Continued From page 33	F 689		

intervention to move incontinent briefs to a drawer in his night stand for easier access.

-Event report dated 12/14/24 at 9:04 a.m., indicated call light was on and found R5 sitting on the floor next to resident's bed. R5 stated he slid down on the floor while he was trying to get to the wheelchair. IDT team review 12/15/24 at 1:16 p.m., indicated root case of self-transferring from bed to wheelchair. Intervention included ensure wheelchair is close to bed with wheels locked while resident is in bed.

-Event report dated 12/21/24 at 3:30 p.m., indicated resident was found sitting on the floor next to his wheelchair and leaning against the bed. He stated he was trying to reach for the bed remote and slid off the bed. The resident had on grip socks and call light was within reach but not on. Two hour safety checks initiated. The record lacked root cause analysis and review by IDT team or any new interventions.

-Event report 1/19/25 at 3:30 p.m., R5 was found on the floor. R5 stated he was trying to sit on the wheelchair after coming from the bathroom and the chair slid away and he fell. No injuries noted at time of incident. Frequent 15 minutes checks initiated. Provider notified with request to check for urinary tract infection. IDT met 1/20/25 at 10:06 a.m., with confusion and self-transferring as root cause. Intervention is to have him evaluated by the provider.

During observation on 1/27/25 at 3:39 p.m., R5 was seated in his wheelchair with grippy socks on both feet. R5 was in the hallway entering other resident's rooms looking for his shoes and socks. R5 came out of another resident's room with one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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F 689	Continued From page 34	F 689		

slipper, 2 pairs of socks and a blue incontinent pad in his lap. At 3:54 p.m., nursing assistant (NA)-F approached R5 in the hallway and began to take him back to his room when she noted names on the items in R5's lap. NA-F then took items from R5, placed back in the correct residents room and took R5 back to his room. R5 self-propelled himself back out of room and continued to wheel self up and down the hallway in his wheelchair. No call don't fall sign was present in R5's room.

During interview on 1/27/25 at 5:07 p.m., family member (FM)-D stated R5 has had multiple falls since he was hospitalized in October 2024 but none with injury. FM-D indicated R5 hasn't worn shoes since last April 2024 due to swelling issues in his feet. FM-D stated she doesn't know if the facility is doing anything to prevent falls or injury.

During interview and observation 1/28/25 at 11:27 a.m., FM-D was present at the bedside with R5 sitting in his wheelchair in his room. There was no call don't fall sign present in his room. Call light way lying on the bed. FM-D indicated R5 is less confused than the previous 4 or 5 days and is much calmer today.

During observation on 1/28/25 at 3:45 p.m., R5 was sitting on the edge of bed attempting to get feet on the floor. R5's wheelchair was parked out of reach of resident, call light was on the floor under the bed. Upon request for assistance, staff came and transferred R5 to his wheelchair.

During observation and interview 1/29/25 8:08 a.m., R5 was lying with feet over the side of the bed, attempting to pull his shirt off. There was no call don't fall sign present in the room. The call

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	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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F 689	Continued From page 35	F 689		

light was on the floor, wheelchair was out of reach and no bedside table was present next to the bed. R5's bedside table was located towards the foot of R5's bed which had personal items present on top but not within R5's reach. R5 requested assistance and staff were notified. NA-G entered the room and stated she can't assist with cares as she is currently on light duty but will get others to assist. NA-G indicated R5 was previously on 1st floor and was not a fall risk at that time so doesn't believe R5 is a high fall risk. NA-G is unsure if R5 has had previous falls. NA-C and NA-E arrived into room at 8:28 a.m. and assisted R5 with morning cares. Incontinent pads were in bottom drawer of bedside stand. A stand lift was used to transfer R5 to his wheelchair. NA-E indicated staff informed her in report this morning to use the stand as R5 has been very unsteady on his feet since moving to this floor 2 days ago. NA-E and NA-C were unsure if R5 was a high fall risk or not and confirmed there was no call don't fall sign in the room.

During interview on 1/29/25 at 8:01 a.m., trained medication aide (TMA)-A indicated she hasn't worked with R5 in the past and is unsure if he is a fall risk or not and confirmed there is no call don't fall sign in his room.

During interview on 1/29/25 at 9:28 a.m., registered nurse (RN)-E indicated R5 has been declining lately and got moved from 1st floor to 3rd floor 2 days ago. RN-E stated R5 is a high fall risk and had fallen when he was on 1st floor. RN-E indicated communication from the IDT meetings and of new interventions implemented aren't always communicated to the staff after a fall event. RN-E indicated they should be alerted

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ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 689	Continued From page 36 to any changes right away. During interview 1/29/25 at 9:53 a.m., the director of nursing (DON) confirmed R5 is a high fall risk and has been since he was hospitalized in October 2024 for pneumonia. The DON stated she would expect staff to follow the plan of care with all interventions. The DON indicated staff might have forgotten to take the call don't fall sign when he moved to another floor 2 days ago. R164's facesheet printed on 1/29/25, included diagnoses of post-op orthopedic after care for cervical myelopathy (compression of the spinal cord in the neck) and laminectomy (removal of bony arch that protects the spinal cord) repair on 1/14/2025, mild cognitive impairment, and lack of coordination. R164's admission MDS assessment dated 1/27/25, indicated R164 had moderately impaired cognition, clear speech, was usually understood and could usually understand. R164 needed assistance with ADLs (activities of daily living) and did not walk independently. R164 had two or more falls since admission. R164's physician orders dated 1/21/25, included physical therapy (PT) and occupational therapy (OT) evaluate and treat. R164's nursing admission evaluation dated 1/22/25, indicated R164 was at risk for falls. R164's care plan dated 1/22/25, indicated risk of falls due to impaired mobility. The following interventions were entered by registered nurse (RN)-G who was also the nurse manager: --Bed in low position - 1/22/25 --Encourage to transfer and change positions	F 689		

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F 689	Continued From page 37 slowly - 1/22/25 --Have commonly used articles within easy reach - 1/22/25 --Reinforce need to call for assistance -1/22/25 --Reinforce wheelchair safety as needed such as locking brakes -1/22/25 --Report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status post fall - 1/22/25 On 1/23/25, the DON added the following to R164's care plan: have evaluated by therapy. However, this was already an admission order dated 1/21/24. R164's CAA for falls dated 1/27/25, indicated R164 had periods of confusion, several falls, no injuries. May be linked to Roxicodone (narcotic pain medication) use for pain management. Monitoring closely and trying Tylenol for pain when able. Is assisted with cares as needed. Is working with therapy and goal is to return home. Incontinent at times, use of disposable undergarments as needed. Taking Effexor for mood/behavior which put at greater fall risk. During an interview on 1/27/25 at 4:31 p.m., FM-B stated R164 had two falls that she was aware of since his admission on 1/21/25. FM-B stated R164 was at the facility for short-term rehabilitation following neck surgery. FM-B stated R164 has been confused and had been impulsive, trying to stand without assistance. Progress notes in the EMR and/or incident reports indicated R164 had three falls since admission: 1. 1/22/25 - witnessed fall, R164 was using the toilet and once done attempted to get off toilet independently. R164 lowered himself to the floor.	F 689		

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F 689	Continued From page 38	F 689		

No injury sustained.
2. 1/24/25 -- unwitnessed fall. R164 was found on the floor in supine position and told staff he got up from the wheelchair and fell to the floor. R164 was sent to the ED. No injury sustained.
3. 1/26/25 -- unwitnessed fall. R164 was found on the floor next to his bed. R164 was sent to the ED. No injury sustained.

Two of three incident reports requested were received for falls on 1/22/25, and 1/26/25, but not for the fall on 1/24/25. Incident reports did not identify causal factors for falls nor did they identify new interventions to prevent future falls.

During an interview on 1/29/25 at 11:52 a.m., with RN-J who was also corporate vice president of success, and the DON, RN-J stated she was not able to locate an incident report for R164's fall on 1/24/25. The DON stated she was usually notified when a resident sustained a fall but was not notified of the fall on 1/24/25. The DON stated IDT (interdisciplinary team) met every weekday morning and discussed residents who sustained a fall to determine root cause and potential interventions. With RN-J and the DON, reviewed each of R164's three falls:
--1/22/25: IDT note indicated the root cause of the fall appeared to be difficulty with transfers and intervention was evaluation by therapy. Therapy evaluation was completed on 1/23/25.
--1/24/25: No incident report. This fall was not discussed at IDT as the DON was unaware of the fall until R164 returned to the facility. The DON stated that should have prompted her to look for an incident report, but she stated she missed it. Consequently, this fall was not discussed at IDT, no root cause analysis was done and no new interventions were put into place. RN-J stated she

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F 689	Continued From page 39 would have expected an IDT review and new intervention(s) initiated. --1/26/35: Not discussed at IDT; no root cause analysis was done and no new intervention(s) were initiated. The DON described the process that should be following after a resident falls: nurses address the physical needs of the resident, and once addressed, expected staff to initiate an incident report, inform the provider, the DON and resident representative and enter a note in the electronic medical record (EMR). Each weekday, the DON reviewed risk management notes in the EMR and if there was a fall, looked for an incident report. The fall was then discussed at IDT. The IDT discussed the nature of the fall and potential interventions. RN-J stated the nurse would also complete a post-fall assessment which was used to determine last fall, reasons for the fall, patterns of falls and interventions currently in place and what new interventions to consider. RN-J stated a fall risk assessment was to be completed upon admission and following each fall. The DON and RN-J verified R164 had been admitted on 1/21/25, and sustained three falls within seven days. Further verified an incident report was completed for only two of three falls, IDT reviewed only one of three falls. No causal factors were identified and no new interventions were identified for two of the three falls, and a post-fall assessment was completed for only one of the three falls. The DON admitted in regard to R164's falls, the facility did "poorly." The facility Fall Prevention and Management policy dated 7/18/24 included: -Each resident will be assessed for fall risk and	F 689		

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F 689	Continued From page 40 will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. -Suggested standard interventions may include: Implement universal environmental interventions that decrease the risk of falling including a clear pathway to the bathroom and bedroom doors, bed is locked and lowered to a a level that allows the resident's feet to be flat on the floor when resident is sitting on edge of bed, call light and frequently used items within reach, wheelchairs and assistive devices in good repair. Implement routine rounding schedules, monitor changes in resident's cognition, gait, ability to rise/sit and balance, encourage residents to wear shoes or slippers with non-slip roles, complete a fall risk assessment quarterly, post-fall and as with a significant change of condition. -Review of each fall/fall investigation during the next morning meeting/clinical meeting with the IDT team. Actions of the IDT may include: Review of investigation and determination of potential root cause of fall; review of fall risk care plan and any updates to plan of care completed post-fall; additional revisions to the plan of care including any physical adaptation to room, furniture, wheelchair and or assistive devices; education of staff as to any care plan revisions.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		3/11/25

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F 690	Continued From page 41 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 1 of 1 residents (R163) reviewed for urinary catheter, when his leg bag had not been changed to a urinary drainage bag at night. Findings include:	F 690	Based on observation, interview, and documentation review, the facility allegedly failed to ensure appropriate management of an indwelling catheter provided for 1 of 1 resident (R163). Effected resident (R163) was hospitalized on 2/9/2025 and has passed away.	

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F 690	Continued From page 42 R163's facesheet printed on 1/29/25, included a diagnoses of urinary retention. R163's discharge assessment/return anticipated Minimum Data Set (MDS) assessment dated 1/24/25, indicated R163 was dependent upon staff for most activities of daily living (ADL) and had an indwelling urinary catheter. R163's physician orders dated 1/27/25, indicated indwelling Foley catheter (drains urine from bladder). R163's care plan dated 1/27/25, did not include R163's urinary retention, use of an indwelling Foley catheter, leg bag, or urinary drainage bag. During an observation on 1/27/25 at 2:21 p.m., R163 was resting in bed; urinary drainage bag visible. During an observation on 1/28/25 at 10:19 a.m., R163 was sitting on top of his bed with a urinary leg bag in place on his left leg. During an observation on 1/29/25 at 7:17 a.m., R163 was in bed sleeping. No urinary drainage bag was visible. During an interview and observation on 1/29/25 at 7:53 a.m., licensed practical nurse (LPN)-A stated residents who had a urinary catheter with leg bag should have the catheter hooked up to a urinary drainage bag at night so the urine drained properly. Together went into R163's room. LPN-A pulled the sheet back and observed R163's urinary catheter was still hooked up to his leg bag and was about three-quarters full of yellow urine.	F 690	Like residents, who are individuals with urinary catheters, have the potential to be impacted by this alleged practice. Resident care plan and order audits have been completed to ensure that appropriate practices are being followed. Director of Nursing or designee provided re-education to direct nursing staff regarding catheter care policy and procedure. Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 690	Continued From page 43 Observed two urinary drainage bags hanging in R163's bathroom. LPN-C didn't know why the catheter had not been hooked up to the drainage bag last night. During an interview and observation on 1/29/25 at 8:01 a.m., nursing assistant (NA)-B stated residents were not supposed to sleep with their leg bag on -- should be switched to a urinary drainage bag so the urine drained properly. NA-B stated it would be the responsibility of the evening shift to switch from leg bag to urinary drainage bag, then in the morning the day shift switched back to the leg bag. NA-B was informed R163 had his leg bag on. Together with NA-B, went into R163's room. NA-A helped R163 to sit on the side of the bed. NA-A emptied the urine from the leg bag into a urinal. NA-A observed straps from the leg bag had made R163's skin red, so removed the leg bag and attached the urinary drainage bag to relive R163's skin and stated she would inform the nurse. During an interview on 1/29/25 at 11:43 a.m., the DON was informed R163's urinary catheter had not been switched from a leg bag to a urinary drainage bag last night. The DON stated typically a resident who used a leg bag would have a urinary drainage bag hooked up at bedtime in order for gravity to pull urine away from bladder. The DON states it was important to prevent urine backflow into the bladder in order to prevent a urinary tract infection. The facility Catheter Care policy with revised date of 3/15/23, indicated it was the policy of this facility to ensure that residents with indwelling catheters received appropriate catheter care when indwelling catheters are in use. Legs bags	F 690		

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F 690	Continued From page 44 may be worn during the day but need to be removed and a bedside drainage bag replaced on the catheter at night.	F 690		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure meals were served at a warm and palatable temperature to promote quality of life and nutritional intake for 3 of 3 residents (R6, R9, R35) reviewed for dining. This had the potential to affect all 30 residents who resided on second floor. Findings include: R6's facesheet printed on 1/28/25, included diagnoses of congestive heart failure (when the heart doesn't pump as it should) and diabetes. R6's annual Minimum Data Set (MDS) assessment dated 11/22/24, indicated R6 had moderate cognitive impairment and ate independently after set up help. R6 was on a consistent carbohydrate, cardiac diet. R6's care plan dated 11/27/23, indicated her food	F 804	In-house residents could be impacted by the alleged practice. Plate warmer has been repaired to assure meals are served at correct temperatures. Trays will be announced to the nursing team when arriving to the floor so nursing is aware they are there and can start passing meal tray to residents. Nursing staff and Dietary staff have been re-educated on the process. Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and	3/11/25

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	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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F 804	Continued From page 45 preferences would be honored. R9's facesheet printed on 1/29/25, included diagnoses of stroke and diabetes. R9's admission MDS assessment dated 1/19/25, indicated moderate cognitive impairment and ate independently after set-up help. R9 was on a consistent carbohydrate, cardiac diet. R9's care plan dated 1/8/25, indicated her food preferences would be honored. R35's facesheet printed on 1/29/25, included diagnoses of multiple sclerosis and diabetes. R25's quarterly MDS assessment dated 12/16/24, indicated intact cognition and ate independently. R35 was on a regular diet. During an interview on 1/27/25 at 3:28 p.m., R6 who ate meals either in her room or the dining room, stated most of the time her food was cold. R6 stated she poured coffee in her oatmeal to warm it up and her eggs this morning were cold -- food was cold for every meal. During an observation on 1/28/25 at 12:35 p.m., carts with meal trays were observed parked on second floor. One cart was a metal, enclosed thermal cart and one was a tall open sided cart with plastic over it. Residents were seated at tables in the dining room waiting for their meals. No staff were delivering the trays. During an observation on 1/28/25 at 12:41 p.m., the first meal tray was delivered; several staff had begun passing trays. Per a menu posted on a bulletin board, the menu was burgundy beef	F 804	recommendations.	

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	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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F 804	Continued From page 46 tenderloin tips, waxed beans, roasted potatoes, roll, and apple crisp. During an observation on 1/28/25 at 12:55 p.m., staff starting to deliver room trays. During an observation on 1/28/25 at 1:02 p.m., four room trays left to be passed. During an observation and interview on 1/28/25 at 1:07 p.m., room meal trays on the open sided cart had been standing in the hallway for at least 32 minutes. Staff scheduler (SS)-J was asked to remove the last meal tray and take it to the dining off the kitchen to have the temperature of the food checked. SS-J was accompanied to the dining room. During an interview and observation on 1/28/25 at 1:09 p.m., in the dining room with dietary manager (DM)-F, the director of nursing (DON), DM-F temped the food with an instant read dial thermometer. Readings were as follows: Beef tips: 120 degrees Fahrenheit (F) Potatoes - 110 degrees F Waxed beans - 115 degrees F The DON and surveyor tasted the food for purposes of temperature palatability. The DON stated she thought it was fine -- she didn't like her food too hot. Surveyor felt food was lukewarm. DM-F stated the temperature of the food should be closer to 135 degrees F. DM-F stated their plate warmer broke down about two weeks ago and maintenance was looking for someone to service it. The DON stated she would expect resident food to taste good and be hot. The DON stated	F 804		

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F 804	Continued From page 47 nursing assistants (NA) and nurses were expected to deliver meal trays on second floor, and that most days a manager or two assisted with passing trays. The DON stated no managers were assigned to pass trays, nor were they required to help. During an interview on 1/28/25 at 1:18 p.m., registered dietician (RD)-E stated food served to residents should be 130 degrees or higher for hot food. RD-E was informed of meal trays sitting on second floor for over 30 minutes before being delivered to residents, and of the temperatures obtained by DM-F. RD-E stated when hot food temps were below 130-135 degrees, there was a concern for food being in the temperature danger zone, resulting in formation of bacteria causing foodborne illness. RD-E stated and if food wasn't hot, it may be a palatability issue for residents. RD-E stated she would help look into how they could improve the process. During an interview on 1/28/25 at 1:32 p.m., R9 who received a room tray on second floor stated her lunch today was okay but it wasn't very warm. R9 stated her food was usually not warm - especially the dinner meal, and asked if surveyor could do something about that. Resident Council Meeting: During an interview on 1/29/25 at 10:31 a.m., R35 stated she had voiced her concern to management last week (could not recall to whom) about cold food. R35 stated breakfast, lunch and supper were cold on second floor. R35 stated there were not enough staff to pass meal trays, so trays sat for a long time and food got cold. R35 stated the kitchen staff delivered the trays to second floor in carts, and if nursing staff were not	F 804		

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F 804	Continued From page 48 in the immediate vicinity, they don't know trays were there. The facility Food Quality and Palatability policy with revised date of 2/2023, indicated food would be prepared by methods that conserved nutritive value, flavor and appearance. Food would be palatable, attractive and served at a safe and appetizing temperature. The cook(s) prepared food using temperature guidelines as outlined in the Federal Food Code. Food was prepared in a manner, form and texture that meets each residents needs.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 812	No specific residents were identified.	3/11/25

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F 812	Continued From page 49 review the facility failed to ensure dishwashing sanitization at the correct level and was appropriately monitored during dishwashing. Further, staff failed to ensure expired food was identified and removed from a unit refrigerator that stored resident personal food. Findings include: Dishwashing On 1/27/25 at 3:00 p.m., during the kitchen tour dietary aide (DA)-A placed dishes through the dish machine. DA-A stated the wash dial needed to indicate a temperature of 120 degrees Fahrenheit (F) and rinse dial at 140 degrees F. During the observation DA-A placed dishes through the dish machine and the wash dial indicated a temperature of at 130 degrees F and rinse dial at 140 degrees F. A vial of Ecolab chlorine test paper strips was on top of the dish machine. DA-A stated the dish machine sanitized dishes with hot water. DA-A stated the bottle with the test strips were used to test the chemicals of the water after dishwashing was completed. DA-A confirmed she had not checked the chemicals of the water and had already washed dishes. DA-A removed a test strip from the bottle and dipped the test strip in the water reservoir of the dish machine and the paper did not change color, DA-A was observed to check the chemicals six times with six different strips, and the strip did not change color. DA-A stated the strip was expected to change color to know the dishes were sanitized. DA-A stated the strip was to change to a purple or darker color. A box above the machine dish machine had a light flashing red and dietary manager (DM)-A stated, "we have been battling the dish machine". The DM-A confirmed the dish machine used the sanitization	F 812	The dietary storage areas were inspected, and any expired or improperly stored foods were discarded. In house residents can be impacted by the alleged practice. Checklists for safe storage of food items in dry and cold storage have been posted for quick reference by dietary staff when storing, rotating, dating, and discarding food items. Checklists for dish room were posted for quick reference by dietary staff. Director of nursing or designation provided education on food storage, discarding, and cleaning of resident□s refrigerator. Dietary staff reeducated on when to check the dish machine for proper ppm of sanitizing solution in the machine and what to do if not in the proper range. Dietary staff to monitor for proper levels and record of the parts per million. Refrigerators that contain items placed by dietary will be monitored and cleaned by Dietary staff. Dietary staff have been reeducated on proper cleaning of the refrigerators and proper documentation. All undated and expired items will be removed. The nursing team has been reeducated on proper cleaning of resident refrigerators and proper documentation.	

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F 812	Continued From page 50 of chemicals not temperature of water. DM-A viewed the Ecolab chlorine test paper strips on top of the dish machine and DM-A verified the strips were not expired. DM-A stated she would immediately contact Ecolab to troubleshoot the problem. DA-A and DM-A provided a clipboard with a form titled Dish Machine Log dated January 2025. The log had 13 columns for date, wash and rinse temperatures, ppm (parts per million) and staff initials for each meal service of breakfast, lunch and dinner. DM-A stated chemicals was used in the dish machine to sanitize dishes. When asked how the ppm of the chemical sanitizing solution was determined, DM-A stated with strips. The log was reviewed, and documentation indicated all the readings documented were the same (and were within range noted below). DA-A stated she had not documented the readings on the log for the day. DM-A pointed to the bottom of the log which indicated temperature and ppm standards of: Chemical sanitizing (low temp): Wash 120-140 F. Rinse 120-140 F. Manufacturer recommended PPM: 50-200 ppm. On 1/27/25 at 7:10 p.m., DA-A and DM-A stated an Ecolab representative had been to the facility and fixed the sanitization on the dish machine. DM-A stated the sanitization line was clogged. The box above the dish machine was no longer blinking red. DA-A was currently using the dish machine and DA-A stated the test strips were used prior to check the level and the test strip now changed color and was measured at 50ppm. DA-A was observed and removed a test strip from Ecolab vial and checked the water in the	F 812	Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 812	Continued From page 51	F 812		

dish machine reservoir and the strip changed a purplish color and was observed at 50ppm. DA-A and DM-A stated the expectation going forward is to check the level of sanitization prior to all the dishes washed.

On 1/28/25 11:24 a.m., DM-G, known as the district dietary manager, stated the dish machine chemicals were expected checked prior to the first load of dishes washed to ensure the test strip the chemicals were at the proper level to sanitize the dishes.

On 1/28/25 at 11:26 a.m., registered dietician (RD)-E stated she came to the facility weekly. RD-E stated the level of chemicals with the test strips was expected checked during the dish washing process to ensure the dishes were properly sanitized.

Food Storage
On 1/28/25 at 11:00 a.m., a refrigerator on second floor was observed with a sign posted on the door and indicated please note this refrigerator is cleaned every Tuesday night after 10 p.m., all items must be labeled with the resident's name and the date its placed in the refrigerator.

On 1/28/25 at 11:04 a.m., the second-floor refrigerator was observed with registered nurse (RN)-B. RN-B stated the refrigerator was used for residents' personal food items brought in from outside the facility. The refrigerator was observed with a freezer section located without a built-in door. The inside freezer section was not able to be observed due the ice built up and enclosed the freezer section. RN-B confirmed the following items located in the refrigerator were expired and

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F 812	Continued From page 52 were not expected in the refrigerator: clear plastic container dated 12/2/24, with resident name with red sauce and pasta. An ice-cream sandwich with no date or name, miracle whip expired 10/21/24 with resident name, yogurt expired 1/1/25 with resident name , cantaloupe expired 12/31/24, Styrofoam container with ¼ piece of lemon pie dated 12/22/24 with resident name , cardboard pizza box with 3 pieces of pizza dated 1/8/25, cardboard box with cheese breads dated 1/1/2 with resident name 5. RN-B removed the food from the refrigerator and stated the food was expired food removed from the refrigerator and would discard them. On 1/28/25 at 11:15 a.m., the DON stated the second-floor unit refrigerator was for resident's personal food and the overnight night NA's were expected to clean and discard of expired food. The DON observed the fridge and confirmed the fridge was not clean. The DON stated expired food was not expected in the refrigerator, and staff were expected to discard the expired food, and confirmed the fridge and freezer were not clean. On 1/28/25 at 11:33 a.m., DM-F stated nursing was expected to clean and discard of expired food of the resident unit refrigerator on second floor. DM-F stated she had mentioned to the DON during meeting the refrigerator was not cleaned and expired food had not been removed as expected. DM-F stated the food was expected removed after three days or based off the expiration label on the product. On 1/28/25 11:36 a.m. RD-E stated staff were expected to ensure expired food was not located in the unit refrigerators.	F 812		

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F 812	Continued From page 53 The facility Ware Washing policy with revised dated of 2/2023, indicated all dishware would be cleaned and sanitized after each use. The dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. All dish machine water temperatures would be maintained in accordance with the manufacturer recommendations for high or low temperature machines. Temperature and/or sanitization concentration logs would be completed as appropriate, and that all dishware would be air dried and properly stored. The facility Food Brought in from Outside Sources and Personal Food Storage policy dated 4/2020, indicated ... will be handled according to safe food handling guidelines. Designated staff will monitor foods and beverages brought in from outside sources for storage refrigeration units for food or beverage disposal, units the tips in the Resource: food Safety for Your Loved One.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		3/11/25

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F 880	Continued From page 54 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 55 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure personal protective equipment (PPE) was utilized for 2 of 2 residents (R54, R23) reviewed for medication administration and performed cares on these residents that were on enhanced barrier precautions (EBP). Finding include: R54's quarterly Minimum Data Set (MDS) assessment dated 1/13/25, indicated severe cognitive impairment, dependent on staff for activities of daily living (ADL's), feeding tube, diagnoses included Parkinson's disease, gastrostomy (g-tube, surgical procedure used to insert a tube through the abdomen and into the stomach, and dysphagia (condition that makes it difficult to swallow). R54's care plan revised 1/27/25, indicated at risk for infection r/t (related to) indwelling medical device tube-feeding and interventions included enhanced barrier precautions when performing	F 880	R54 and R23 have been free of signs or symptoms of infection related to this practice. Infection Preventionist validated that signage was on resident□s door and that supplies were readily available when alerted of the concern. R54 and R23 care plans were updated to include infection control needs/enhanced barrier precautions.¿¿ Residents who require enhanced barrier precautions can be affected by this practice. Care plans were reviewed and verified infection control/ enhanced barrier care plans were in place for like residents.¿ Validated signage was on doors of those residents for enhanced barrier precautions and carts were readily available with supplies.¿¿ Infection Preventionist or designee provided re-education to direct care nursing staff on the rationale for enhanced	

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F 880	Continued From page 56 high-contact care activities. On 1/27/25 at 3:38 p.m., registered nurse (RN)-A entered R54's room and failed to don PPE, R54 was lying in bed. RN-A used gloved hands lifted up R54's shirt and exposed the g-tube with gloved hands, then removed the covering of the g-tube, connected a syringe to the tube and pulled back the syringe. RN-A stated she was checking for residual prior to administering the medication. RN-A was observed to use a syringe and administered medication in the g-tube, and then flushed the g-tube with water. After the medication administration, RN-A changed gloves, disinfected hands, applied new gloves, pulled R54's shirt down over upper body, and then placed blankets on R54's upper body. RN-A confirmed R54 was expected placed on EBP due to the g-tube, with a sign indicating EBP and PPE cart outside R54's door. RN-A confirmed sign was not posted on R54's door as expected to indicate EBP precautions and a gown was not worn as expected. On 1/27/25 at 3:40 p.m., trained medication aide (TMA)-A stated she was not aware R54 was on EBP precautions and confirmed PPE was not worn during the care of R54 during transfers or cares. TMA-A stated a gown and gloves were expected to be worn during transfers for residents placed on EBP. TMA-A stated a sign on the door was expected for resident on EBP. On 1/27/25 at 4:52 p.m., RN-B, known as the infection preventionist, stated R54 was recently on isolation precautions for COVID and stated the EBP sign had been removed mistakenly and not replaced. RN-B stated residents on EBP had signage posted on the resident doors that	F 880	barrier precautions and provided a CDC pocket guide resource for staff to refer to if a resident is on enhanced barrier precautions.¿¿ Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.¿¿¿	

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F 880	Continued From page 57 indicated the resident was on EBP, PPE cart outside the room, and EBP placed on the resident's care plan. RN-B stated R54 did not have a sign on the door as expected or PPE outside of the room. On 1/28/25 at 11:15 a.m., the director of nursing (DON) stated residents with a g-tube were expected on EBP and a EBP sign was expected on resident doors for staff to know the residents on EBP. The DON stated during g-tube medication administration staff were expected to wear gown and gloves. On 1/29/25 at 8:58 a.m., RN-B, confirmed R54 was on EBP due to a g-tube, and stated staff were expected to wear a gown and gloves during high contact care including medication administration, transfers, brief changes, and dressing changes. RN-B stated a sign on R54's door indicating she was on EBP was expected to ensure staff were aware. RN-B stated the EBP was not on the care plan as expected until 1/27/25. R23's facesheet printed on 1/30/25, included diagnoses of unspecified dementia, anxiety, osteoarthritis, atrial fibrillation (abnormal heartbeat). R23's quarterly MDS assessment dated 12/11/24, indicated R23 had no cognitive impairment, clear speech, could understand and be understood. R23 required substantial to maximum staff assistance with some ADL's including dressing and toileting hygiene, incontinent of bowel and bladder. R23 was dependent upon staff for transferring in and out of bed. R23 did not walk. MDS further identified R23 had stage 2 pressure ulcer (Partial thickness loss of dermis presenting	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 58 as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister). R23's care plan dated 1/13/25, indicated at risk for infection r/t (related to) wound (coccyx wound) and interventions included enhanced barrier precautions when performing high-contact care activities. During an observation on 1/28/25 at 12:17 p.m., R23 was calling for help to go to the bathroom. RN-E entered room, placed gloves on and assisted R23 while in bed, including performing peri cares for R23 with no gown in place. RN-E then repositioned R23 and proceeded to leave room after performing cares and completing hand hygiene. Sign on outside of R23's door directed EBP precautions, and PPE cart outside of room. During an interview on 1/28/25 at 12:26 p.m., RN-E stated she works full time and was familiar with R23. RN-E stated was aware that R23 did have pressure ulcers on bottom. RN-E explained that she forgot to put on a gown when doing cares with R23. When prompted RN-E explained that she remembered after she came out of R23's room that R23 was on EBP precautions. On 1/28/25 at 2:19 p.m., RN-B, known as the infection preventionist, stated R23 was placed on EBP precautions due to her increase in skin alteration (pressure sore). RN-B stated residents on EBP were expected to have signage posted on resident doors with EBP precautions, PPE cart outside the room, and EBP placed on the resident's care plan. On 1/28/25 at 11:15 a.m., DON stated residents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 59 with pressure sores were expected on EBP and a EBP sign was expected on resident doors for staff to know the residents on EBP. The DON stated while performing cares staff were expected to wear gown and gloves. The facility Enhanced Barrier Precautions policy dated 8/8/24, indicated The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. Initiation of Enhanced Barrier Precautions: An order for enhanced barrier precautions (in accordance with physician-approved "standing orders") will be initiated for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices(e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions. infection or colonization with a CDC-targeted or novel MDRO when Contact Precautions do not otherwise apply. Implementation of Enhanced Barrier Precautions: Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care).	F 880		

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	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 60	F 921		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 tub/shower room on second floor was maintained in good repair and in sanitary conditions for the 30 residents on second floor who could potentially use the area. Findings include: During an observation on 1/28/25 at 2:26 p.m., the second floor tub/shower room had a wall partially enclosing the shower area. The wall was covered with yellow tiles, approximately 4 inches x 4 inches in size. On the lower portion of a wall adjacent to the floor, six tiles were missing creating an opening in which wood and plaster were visible. During an interview and observation on 1/28/25 at 3:52 p.m., along with the corporate maintenance director (CMD), looked at the wall in the tub room. CMD was not aware of the missing tiles and stated maintenance relied on staff to inform them of this sort of thing so it could be repaired. CMD acknowledged this was not sanitary nor a homelike environment for residents. During an interview on 1/29/25 at 8:24 a.m., housekeeper (H)-A stated he was aware of the missing tile and stated he had told someone about it but couldn't recall who or when.	F 921	The affected area has been repaired. Like areas within the building are bathrooms, shower rooms, and tub rooms. Afore mentioned areas have been inspected/reviewed, no other areas of concern were noted in these like areas. Maintenance Director or designee provided training to team members on being aware of their working environment and to report like issues as soon as possible via appropriate preventive maintenance program. Maintenance Director or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month.¿ Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	3/11/25

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	245184	A. BUILDING _____ B. WING _____	C 01/29/2025

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F 921	Continued From page 61 During an interview on 1/29/25 at 8:58 a.m., facility maintenance director (MD)-A stated he had only been in this position for two months and had not been aware of the missing tiles and didn't recall if he had a received a maintenance requisition informing him of it. MD-A stated he had been trying to catch up on the backlog of repairs. A policy on building maintenance, upkeep and repairs was requested and not received.	F 921		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245184	A. BUILDING: _____ B. WING _____	**1/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245184	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure written notice of transfer was provided to the resident and/or resident representative for 1 of 2 residents (R20) reviewed for hospitalization.

Findings include:

R20's facesheet printed on 1/29/25, included diagnoses of chronic kidney disease with heart failure, recent femur fracture, morbid obesity and diabetes.

R20's significant change Minimum Data Set (MDS) assessment dated 1/16/25, indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 was independent with some activities of daily living, including eating, toileting, and self-propelling in her wheelchair. R20 was dependent upon staff for dressing, showering and transferring in and out of bed.

During an interview on 1/27/25 at 5:12 p.m., R20 stated on 12/28/24, she was standing in the bathroom when her knees gave out, causing her to fall and fracture her left femur. R20 was subsequently transferred to the hospital and admitted for surgical repair of her fractured femur. R20 returned from the hospital on 1/9/25. R20 stated she didn't receive written notice of transfer or sign anything at the time of her transfer.

A written notice of transfer was not found in R20's electronic medical record (EMR) or paper chart.

During an interview on 1/28/25 at 12:34 p.m., the director of nursing (DON) stated nursing staff provide a written notice of transfer to the resident or resident representative at the time of transfer. The notices are then given to DON, and she in turn gives them to the business office.

During an interview on 1/28/25 at 2:00 p.m., admissions coordinator (AC)-C stated if she had received a transfer notice for R20, she would have scanned it into the EMR right away. AC-C looked in R20's EMR and did not find it. AC-C looked in R20's paper file and did not find it. AC-C asked health unit coordinator (HUC)-H if she had it and she did not.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245184	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/29/2025

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ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 During an interview on 1/29/25 at 11:34 a.m., the DON was informed that written notice of transfer had not been located for R20 for her transfer to the hospital on 12/28/24. The DON stated nursing staff knew to do this and if a resident was not able to sign a form at the time of transfer due to pain, staff could take it to the resident the next day in the hospital. The facility Transfer and Discharge policy dated 7/15/22, indicated staff would provide a transfer notice as soon as practicable to resident and representative.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notice of bed hold was provided after an emergent transfer to the hospital for 1 of 2 residents (R20) reviewed for hospitalization. Findings include: R20's facesheet printed on 1/29/25, included diagnoses of chronic kidney disease with heart failure, recent femur fracture, morbid obesity and diabetes. R20's significant change Minimum Data Set (MDS) assessment dated 1/16/25, indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 was independent with some activities of daily living, including eating, toileting, and self-propelling in her wheelchair. R20 was dependent upon staff for dressing, showering and transferring in and out of bed.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245184	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 3

During an interview on 1/27/25 at 5:12 p.m., R20 stated on 12/28/24, she was standing in the bathroom when her knees gave out, causing her to fall and fracture her left femur. R20 was subsequently transferred to the hospital and admitted for surgical repair of her fractured femur. R20 returned from the hospital on 1/9/25. R20 stated she didn't sign anything about a bed hold at the time of her transfer.

A written notice of bed hold including payment for holding bed, was not found in R20's electronic medical record (EMR) or paper chart.

A progress note dated 12/29/24 at 2:52 p.m., (the day after transfer to the hospital) indicated R20 verbally agreed to a bed hold before transfer to hospital.

During an interview on 1/28/25 at 12:34 p.m., the director of nursing (DON) stated nursing staff provide a written notice of transfer to the resident or resident representative at the time of transfer. The notices are then given to DON, and she in turn gives them to the business office.

During an interview on 1/28/25 at 2:00 p.m., admissions coordinator (AC)-C stated if she had received a bed hold notice for R20, she would have scanned it into the EMR right away. AC-C looked in R20's EMR and did not find it. AC-C looked in R20's paper file and did not find it. AC-C asked health unit coordinator (HUC)-H if she had it and she did not.

During an interview on 1/29/25 at 11:34 a.m., the DON was informed of lack of a bed hold notice for R20 when transferred to the hospital on 12/28/24. The DON stated nursing staff knew to do this and if a resident was not able to sign a form at the time of transfer due to pain, staff could take it to the resident the next day in the hospital.

The facility Transfer and Discharge policy dated 7/15/22, indicated staff would provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST** **ROCHESTER, MN 55904**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/28/2025. At the time of this survey, ROCHESTER EAST HEALTH SERVICES found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/27/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ROCHESTER EAST HEALTH SERVICES is a 3-story building with full basement. ROCHESTER EAST HEALTH SERVICES building was constructed in 1968 and was determined to be Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 000	Continued From page 2 spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 111 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that monthly 30-second and 90-minute annual emergency light testing is being completed. 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that emergency light fixture (C2) did not function upon testing - it did not illuminate.	K 291	The emergency light fixture, C-2, was replaced by the maintenance director and is operational. Other emergency light fixtures throughout the building were reviewed at the same time and found to be operational. Emergency Light fixtures are part of the Preventive Maintenace program. The Maintenance Director will be responsible for further compliance.	3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 3 An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.	K 291		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking	K 324	All cords have been removed from the second floor and third floor ovens, and the ovens are no longer operational. These	3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 324	Continued From page 4 devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). These deficient findings could have a widespread impact on the residents within the facility. Findings Include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that the residential stove-range located on the 3rd Floor - PT / OT Activities Room was outfitted with key lock-out, but not 120 min max timeout hardware. 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that the residential stove-range located on the 3rd Floor - Memory Care Unit - Dining Area was outfitted with key lock-out, but not 120 min max timeout hardware. An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.	K 324	are the only household appliances of its type in the building. The Maintenance Director will be responsible for future compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire	K 345	Maintenance Staff have been re-educated on the proper documentation	3/11/25

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 345	Continued From page 5 alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that documentation present for review did not confirm that signal transmission of a fire alarm system is occurring as part of fire drill(s). An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 345	for fire drills. They have been re-educated so we must ensure that the monitoring company receives the alarm when a fire drill is conducted. Executive Director and Maintenance director will be responsible for future compliance.	
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. These deficient findings could have a widespread impact on the residents within the facility.	K 346	The fire alarm Out-Of-Service policy has been updated by the Maintenance team to reflect MN Department of Public Safey-Fire Marshall Division in the policy. The Emergency Operation Plan will be reviewed and revised annually. Executive Director will be responsible for this annual	3/11/25

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 346	Continued From page 6 Findings include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that the Fire Alarm System - Out-of-Service Policy identifies the Wisconsin Department of Health as a point-of-contact / notification for Fire Alarm - Out of Service event(s). 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that the Fire Alarm System - Out-of-Service Policy did not include in the notification listing, the MN Department of Public Safety - Fire Marshal Division (point of contact and phone #). An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 346	review and the accuracy of the plan.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		3/11/25

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 7 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 5.1.1, 5.2.1, 5.2.1.1.1, 5.2.1.1.2(6) These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation on the 2nd Floor in the resident corridor, adjacent to RM 204, a sprinkler head exhibited paint splatter on the frangible bulb. 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that no documentation was available to confirm annual sprinkler system inspection / test was completed in 2024. 3. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, documentation presented for review confirmed that 2-of-3 sprinkler quarterly inspection / test of the sprinkler system were completed in 2024.	K 353	The documentation has been found for the Annual sprinkler inspection. This inspection took place November 5, 2024. 3 Quarterly sprinkler inspections took place in 2024. These inspections were March 5, 2024, June 19, 2024 and December 10, 2024. All Quarterly inspections were done, and the Annual inspection was two months late. This was due to not having a Maintenance director in place at this time. The Maintenance Director has been educated on the importance of making sure all sprinkler inspections are done on time. The maintenance director and executive director will be responsible for future compliance.	

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 353	Continued From page 8 An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). Theses deficient findings could have a widespread impact on the residents within the facility. Findings include: 1.On 01/28/2025 between 9:00 AM and 2:30 PM,	K 354	The fire alarm Out-Of-Service policy has been updated to reflect MN Department of Public Safey-Fire Marshall Division in the policy. The Emergency Operation Plan will be reviewed and revised annually. Executive Director will be responsible for this annual review and the accuracy of the plan	3/11/25

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 354	Continued From page 9 it was revealed by a review of available documentation, that the Fire Sprinkler System Out-of-Service Policy identifies the Wisconsin Department of Health as a point-of-contact / notification for Fire Alarm - Out of Service event(s). 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that the Fire Sprinkler System Out-of-Service Policy did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (point of contact and phone #). An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 354		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.5, 7.3.2.1, These deficient findings could have a	K 355	The Maintenance team inspected all fire extinguishers within the building. A check list of all fire extinguishers in the building has been developed to prevent missing any extinguishers. Fire extinguisher inspection is part of our monthly preventative maintenance program. The maintenance director will be responsible for future compliance.	3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 355	Continued From page 10 patterned impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that the following fire extinguishers were not up-to-date on monthly inspection as they were last inspected on 11/30/2024: 3rd Floor - adjacent to RM 331; Elevator RM #1; Elevator RM #2. An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.	K 355		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition),	K 374	The smoke barrier door has been adjusted to properly close and seal. All smoke barrier doors within the community	3/11/25

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 374	Continued From page 11 Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that in the Basement that the smoke barrier door assembly, adjacent to the Medical Records Room, did not properly self-close and seal the opening upon testing. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 374	have been reviewed for proper operation and doors were adjusted where needed. Smoke door inspection is part of our monthly Preventative maintenance program. The Maintenance Director will be responsible for future compliance.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section	K 511	The electrical panel in the 2nd floor resident corridor has been secured and locked by the maintenance team. All electrical panels within the building have been inspected and are found to be secure. Electrical panels throughout the	3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 511	Continued From page 12 110.26(F), 110.27(A)(1) This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation on the 2nd Floor there was an unsecured electrical panel in the resident corridor. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 511	building will be monitored weekly via the Preventive maintenance program. The Maintenance Director will be responsible for future compliance.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed	K 541		3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

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K 541	Continued From page 13 by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the chute door assembly(s) per NFPA 101 (2012 edition), section 19.5.4.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation and testing that the laundry chute door located on the 1st Floor did not function properly upon test - to close, latch and seal the vertical shaft. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 541	The laundry room chute has been properly fixed so that it closes and seals when shut. This is the only such chute in the community. Laundry chute monitoring will be added to our weekly preventative maintenance plan. The Maintenance Director will be responsible for future compliance	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

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K 712	Continued From page 14 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that fire drill documentation for January through July 2024 was incomplete in content and data capture. 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that fire drill documentation for August through December 2024 was not available for review and assessment. An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.	K 712	Maintenace team members were re-educated on fire drill routines and the required documentation. All future fire drills will be conducted following NFPA 101 guidelines. Maintenance Director and Executive director will be responsible for scheduling and conducting future fire drills.	
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO	K 741		3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

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K 741	Continued From page 15 SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and have available for review the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that the smoking policy was generic in content, not providing identified and approved locations for staff, residents, visitors to smoke. An interview with the Regional Maintenance	K 741	The smoking policy has been updated to reflect this buildings smoking policy, in regard to providing identification and approved locations for staff, residents, and visitors to smoke. Residents and families are educated at time of admission that we are a no smoking facility/campus. Signs are posted on all doorways entering the building. Staff will be reeducated on the smoking policy. The Executive Director will be responsible for future compliance.	

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 741	Continued From page 16 Director verified this deficient finding at the time of discovery.	K 741		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that annual smoke / fire door inspections had been initiated in Q2 of 2024 but not completed.	K 761	The Maintenance Director was educated on the requirement to complete an annual fire door inspection and the documentation needed. The fire door inspection will be completed by the completion date of 3-11-2025. This is part of our annual preventative maintenance schedule. The maintenance director will be responsible for future compliance.	3/11/25

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K 761	Continued From page 17 An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed maintain and test electrical receptacle(s) in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility.	K 914	Room 221 outlet cover has been replaced by the maintenance department, and all outlets within the facility have been reviewed by maintenance team members for compliance . Outlets were evaluated by Power Plus Electric. Multiple outlets throughout the building were replaced, tightened to wall, and like repairs were	3/11/25

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K 914	Continued From page 18 Findings include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by review of available documentation that electrical outlet testing was last completed in 2023. No documentation was presented to confirm that testing occurred in 2024. 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that in resident RM 221 that an outlet cover plate was damaged, exposing the interior of the electrical box. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 914	completed. The Maintenance Director was educated on the requirement to complete an annual receptacle inspection and the documentation needed. The receptacle inspection will be completed by the completion date of 3-11-2025. This is part of our annual preventative maintenance schedule. The maintenance director will be responsible for future compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		3/11/25

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K 918	Continued From page 19 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect and test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that the most recent weekly visual inspections of the emergency generator last occurred - Sept 2024. 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available	K 918	The Maintenance Director was educated on the importance of testing the generator weekly and documenting the tests. He was also educated on performing a monthly load test and documenting this. He was also educated on the importance of making this documentation readily available for review. Documentation has been found for the periods listed in the findings. We have included these inspections. We performed weekly load tests of the generator and recorded the results in our Preventive Maintenace program. The Maintenance Director is responsible for weekly testing and ongoing monitoring.	

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K 918	Continued From page 20 documentation that the most recent monthly inspection and operational test of the emergency generator occurred - Sept 2024. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices	K 920	The appliance was removed from the Power strip by the executive director.	3/11/25

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K 920	Continued From page 21 in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that in RM 121 an appliance was connected to a relocatable power tap. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 920	Residents have been re-educated on appropriate plug ins and inappropriate plugging in use of appliances in their rooms. The maintenance director inspected all outlets within resident rooms, checking for similar situations issues have been rectified. Monthly auditing is part of our preventive maintenance program. The Maintenance director will be responsible for monitoring.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923		3/11/25

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K 923	Continued From page 22 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that in the 1st Floor - Med Gas (O2) Storage Room, there was no identifiable location for placement / storage of full cylinders. 2. On 01/28/2025 between 9:00 AM and 2:30 PM, it was revealed by observation that in the 1st	K 923	A designated area in the Oxygen storage room has been determined. Signage as appropriate has been posted. Rubbish from the area has been removed. This is the only area in the building where oxygen is stored. The Maintenance Director and Executive Director will be responsible for further compliance.	

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K 923	Continued From page 23 Floor - Med Gas (O2) Storage Room, there was storage of combustibles. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 923		