Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 15, 2026

Administrator
Courage Kenny Rehabilitation Institutes Trp
3915 GOLDEN VALLEY ROAD
GOLDEN VALLEY, MN 55422

RE: CCN: 245519
Cycle Start Date: June 30, 2026

Dear Administrator:

On June 30, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 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

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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

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 September 30, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 30, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING B. WING	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITUTES TRP	3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 55422

(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
E0000	Initial Comments On 6/29/26 through 7/1/26 , a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 6/29/26 through 7/1/26, a standard recertification survey (S#S5519039-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was IN compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H 55192866C H 55192870C H 55192868C H 55928267C NO deficiencies were cited. The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING **01 - BUILDING 1** B. WING	**06/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/24/2026. At the time of this survey, ROCHESTER REHAB AND LIVING CENTER was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		07/20/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 1** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. ROCHESTER REHAB AND LIVING CENTER is a 1 story building with partial basement and parking garage. The building was constructed in 2015 and was determined to be Type V (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. There is a 2-hour fire separation between the Skilled Nursing Facility and the Assisted Living. The facility has a capacity of 56 beds and had a census of 36 at the time of the survey.	K0000		07/20/2026

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K0000 Bldg. 01	Continued from page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K0000		07/20/2026
K0291 SS = F Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on 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. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by a review of available documentation that no documentation was available to confirm emergency light testing is being completed (30 sec monthly / 90 minute annual). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0291	K0291 Emergency Lighting Corrective Action Emergency lighting fixtures have been tested for compliance, including the 30-second monthly test and the 90-minute annual test. All emergency lighting fixtures were inspected and confirmed operational. Documentation of corrective actions has been placed in the Life Safety compliance binder. Measures/Systemic Changes 30-second monthly test and the 90-minute annual test are included in the TELs preventative maintenance schedule to ensure ongoing compliance. Maintenance staff to receive education on proper emergency lighting testing intervals and documentation requirements. Monitoring Director of Plant Operations or designee will audit emergency lighting testing documentation monthly for 3 months to ensure compliance. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 1** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

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K0324 SS = F Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, section(s) 9.2.3, 19.3.2.5.3, NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section(s) 4.1, 4.1.5, 11.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by a review of available documentation that the most current 6-month inspection of the ansul type fire suppression system was completed - 10/09/2025. An interview with the Maintenance Director verified	K0324	K0324 Cooking Facilities Corrective Action The 6-month inspection of the Ansul fire suppression system has been completed. Measures/Systemic Changes 6-month Ansul fire suppression system inspection is included in the TELs preventative maintenance schedule. Director of Plant Operations to receive education on NFPA 96 inspection intervals and documentation requirements pertaining to the Ansul fire suppression system. Monitoring Director of Plant Operations or designee will audit fire suppression system inspection documentation semi-annually for 1 year to ensure compliance. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026

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K0324 SS = F Bldg. 01	Continued from page 4 this deficient finding at the time of discovery.	K0324		08/31/2026
K0353 SS = F Bldg. 01	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 _____ 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 STANDARD is NOT MET as evidenced by: Based on observation 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), 5.1, 5.2, 5.2.1.1.1(5). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 at 1:00 PM, it was revealed by observation that sprinkler heads located in the resident corridors (in close proximity to HVAC diffusers) exhibited debris loading. On 06/24/2026 at 1:15 PM, it was revealed by observation that sprinkler heads located in the	K0353	K0353 Sprinkler System – Maintenance and Testing Corrective Action Identified sprinkler heads in the facility showing debris have been cleaned to ensure compliance. Measures/Systemic Changes Sprinkler head inspection and cleaning requirements are included in the TELs preventative maintenance schedule. Maintenance staff to receive education on proper sprinkler head inspection intervals, debris identification, and documentation requirements. Monitoring Director of Plant Operations or designee will audit sprinkler head condition and documentation monthly for 3 months to ensure compliance. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026

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K0353 SS = F Bldg. 01	Continued from page 5 Kitchen / Dishwashing Area(s) exhibited debris loading. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0353		08/31/2026
K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors serving bariatric resident rooms per NFPA 101 (2012 edition), Life	K0363	K0363 Corridor – Doors Corrective Action Door assemblies serving bariatric resident rooms RM 1122, RM 1123, and RM 1151 have been equipped with proper latching hardware and gasketing to prevent the passage of smoke. Measures/Systemic Changes Corridor door inspection requirements are included in the TELs preventative maintenance schedule. Maintenance staff to receive education on proper corridor door inspection intervals, smoke-resistance requirements, and documentation procedures. Monitoring Director of Plant Operations or designee will audit corridor door condition and documentation monthly for 3 months to ensure compliance. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 1** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

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ROCHESTER REHABILITATION AND LIVING CENTER	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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K0363 SS = F Bldg. 01	Continued from page 6 Safety Code, section(s) 19.3.6.3, 19.3.6.3.1, 19.3.6.3.5, . These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 at 12:15 PM, it was revealed by observation that the following double door assembly serving bariatric resident rooms were not equipped with proper latching hardware and gasketing to prevent the passage of smoke – RM 1122 / RM 1123 / RM 1151. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0363		08/31/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7, 4.7.4*, and 4.7.6* These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by a review of available documentation, that documentation presented for review exhibited missing and incomplete data / patterning of fire drills / no documentation to confirm that 3rd shift – Q4 was conducted.	K0712	K712-Fire Drills Corrective Action A randomized 12-month Fire Drill Schedule was immediately generated. Measures/Systemic Changes Maintenance staff to receive education how to properly conduct and document Fire Drills. Monitoring Director of Plant Operations or designee will audit Fire Drills monthly for 3 months to ensure compliance. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 1** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

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ROCHESTER REHABILITATION AND LIVING CENTER	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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K0712 SS = F Bldg. 01	Continued from page 7 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712		08/31/2026
K0914 SS = F Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to 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. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by review of available documentation that electrical outlet testing was incomplete: missing date(s) of testing / no signature(s) of individual(s) that conducted the testing / discontinuity of data collected and reference numbering of outlets / no confirmation that corrective action(s) have been completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0914	K914-Electrical Systems Testing Corrective Action All outlets tested and verified correct operational status. The results of the testing were documented in testing log. Measures/Systemic Changes Administrator conducted a mandatory re-education with Maintenance Personnel regarding NFPA 99 electrical testing regulations. Audit requirements entered into TELS system to ensure timely documentation of completion. Monitoring Director of Plant Operations or designee will verify completion of required audits monthly for 3 months. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026

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K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.1.1.6.1, 6.4.1.1.15, 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 5.6.4, 8.3.1*, 8.3.8, 8.4.2, 8.4.9. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 at 12:30 PM, it was revealed by	K0918	K918 Generator Testing Corrective Action Generator service vendor contacted to schedule immediate comprehensive testing and annual inspection. This testing includes fuel quality testing and 2 hr/ 4 hr load bank testing. Measures/Systemic Changes Administrator conducted a mandatory re-education session with the Maintenance Department regarding NFPA 110 generator testing requirements Audit requirements entered into TELS system to ensure timely documentation and completion. Monitoring Director of Plant Operations or designee will verify completion of required audits/testing monthly for 3 months. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026

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K0918 SS = F Bldg. 01	Continued from page 9 observation that the oil filter on the emergency generator has a service date of 06/24/2025, but no vendor documentation confirming an annual inspection occurred in 2025. On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by review of available documentation that no documentation was presented to confirm that annual fuel testing is occurring. On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by review of available documentation that the most recent document of record of annual emergency generator service/inspection was dated 05/22/2024. On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by review of available documentation that the most recent, annual 2-hr load-bank testing, document of record was dated 05/22/2024. On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by review of available documentation that the most recent, 36-month – 4-hr load-bank testing, document of record was dated 05/24/2023. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		08/31/2026
K0346 SS = C Bldg. 01	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. These	K0346	K346 Fire Alarm Out of Service Policy Corrective Action Fire Alarm System Out of Service Fire Watch Policy was immediately reviewed and revised by the Administrator and Director of Maintenance to include proper contact information for the state fire marshal, Steven Jurrens. Measures/Systemic Changes The corrected policy and emergency notification contact sheets were immediately printed and placed into the master Life Safety and Emergency Preparedness binders	08/31/2026

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K0346 SS = C Bldg. 01	Continued from page 10 deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by a review of available documentation that the facility fire alarm out-of-service policy did not include the correct listing of the AHJ - Deputy State Fire Marshal Inspector assigned to the area in which the facility is located (point of contact and phone #). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0346	Continued from page 10 Monitoring Administrator will verify updated policy and placement in Emergency Binder. Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026
K0354 SS = C Bldg. 01	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and 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, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K0354	K354 Sprinkler System Out of Service Policy Corrective Action The facility’s Systems Out of Service / Fire Watch Policy was immediately reviewed and revised by the Director of Maintenance. Measures/Systemic Changes The physical copy of the fully updated policy was placed into the master Emergency Preparedness and Life Safety binders located at the Main Maintenance Office and the Administrator’s Office for immediate access. Administrator conducted a mandatory re-education session with the Director of Maintenance, and the facility’s Clinical Leadership/Department Heads regarding the updated policy, focusing on notification steps and vendor verification processes mandated in Section A2. Monitoring Administrator will verify updated policy and placement in Emergency Binder and Life Safety Binder.	08/31/2026

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K0354 SS = C Bldg. 01	Continued from page 11 On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by a review of available documentation that the facility initiation of the fire sprinkler system out-of-service policy was missing content in section A2, and there was no information/section covering - restoration of service and notification(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0354	Continued from page 11 Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026
K0355 SS = C Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to properly 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, 7.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2026 between 9:00 AM to 3:00 PM, it was revealed by a review of available documentation that fire extinguisher monthly documentation log was missing date(s) of inspection(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0355	K355 Fire Extinguishers Corrective Action Director of Maintenance conducted an inspection of all fire extinguishers in the skilled nursing facility and ensured the correct documentation was entered. Measures/Systemic Changes The facility has updated its preventative maintenance schedule in TELS Administrator conducted a re-education session with the Maintenance Department regarding proper documentation of inspections of fire extinguishers Monitoring The Director of Maintenance or designee will audit facility fire extinguishers monthly for 3 months to ensure proper documentation of inspections Audit results will be shared at QAPI for further recommendations. Director of Plant Operations is responsible for compliance. Date of Alleged Compliance 08.31.2026	08/31/2026