Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2026

Administrator
Rochester Rehabilitation And Living Center
1900 BALLINGTON BOULEVARD NW
ROCHESTER, MN 55901

RE: CCN:245626

Cycle Start Date: June 24, 2026

Dear Administrator:

On June 24, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

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

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 24, 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 24, 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.

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,

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: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING 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

(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 6/22/26 to 6/24/26, 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		07/20/2026
F0000	INITIAL COMMENTS On 6/22/26 to 6/24/26, a standard recertification survey (S5626013) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H56262977C (2700679). NO deficiencies were cited. The following complaint was reviewed: H56262978C (2600227). An incidental finding was discovered and cited at (F677). 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.	F0000		07/13/2026

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

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

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F0554 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 record review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 2 of 2 residents (R3, R15) reviewed for self-administration of medications. Findings include: R3 R3's quarterly Minimum Data Set (MDS) assessment, dated 4/27/26, indicated R3 was cognitively intact with no signs of delirium or behaviors. R3 had no upper body impairment and bilateral lower body impairment. R3 required setup for eating and oral hygiene, partial assist for toilet hygiene, bathing, and upper body dressing, and substantial assist for lower body dressing, footwear, and personal hygiene. R3 also required substantial assist with bed mobility and transfers to/from bed/chair. R3's careplan indicated R3 required 1 assist for transfers and activities of daily living. During observation and interview on 6/22/26 at 6:45 p.m., an unlabeled bottle of fluticasone nasal spray was noted on R3 bedside table. R3 stated she administers it on her own in the morning and in the evening. R3's medication administration record (MAR) lacked an order for fluticasone nasal spray. R3's self-administration medication assessment dated 1/26/26 indicated R3 did not wish to self-administer medications or keep medications at bedside. During observation and interview on 6/23/26 at 9:16 a.m., R3 was returning from breakfast and stated she administered the fluticasone nasal spray prior to breakfast. The nasal spray was located on R3's bedside table next to her water glass. R3 stated her family member brought the nasal spray in for her. At 9:21 a.m., registered nurse (RN)-A entered R3's room with morning medications, reached across	F0554	Corrective Action for Affected Resident(s) Medications left at the bedside of Resident 3 and Resident 15 were immediately removed by licensed nursing staff. The residents were assessed for any adverse effects; none were noted, and the physician/representative was notified. Nurse Manager on 6.24.26 educated resident 3 on self-administration policy and resident did not want to obtain a specific order for self-administration. Resident followed up with on 7.15.26 and a self-administration assessment completed. Resident now wants to have medication scheduled and administered by facility. Provider notified of resident preference on 7.15.26 and provider order obtained. Care Plan is reflective of resident wishes. Nurse Manager on 6.24.26 educated resident 15 and resident family on self-administration policy and resident did not want to obtain a specific order for self-administration. Resident followed up with on 7.15.26 and a self-administration assessment completed. Resident now wants to have medication scheduled and administered by facility. PRN order obtained for Imodium. Care Plan is reflective of resident wishes. The attending practitioner and resident representative, as applicable, were notified of the findings and interventions. Identification of Other Residents at Risk. A facility-wide audit of all residents with medications maintained at bedside and all residents approved to self-administer medications (including inhalers, eye drops, topical medications, PRN medications, and over-the-counter medications) was conducted by the DON. Audit verified that each resident self-administering has: A current, signed physician's order. A completed, up-to-date self-administration assessment confirming clinical safety.	07/29/2026

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F0554 SS = D	Continued from page 2 R3's bed and picked up the water glass. After administering R3's medications, RN-A placed the water glass back on the bedside table, picked up the nasal spray, looked at both sides of the spray, and placed it back on the bedside table. R15 R15's quarterly MDS assessment, dated 4/14/26, indicated R15 was cognitively intact with no delirium and no behaviors. R15 had no upper or lower body impairment, was independent with oral and personal hygiene as well as bed mobility. R15 required set-up for meals, partial assist for upper and lower body activities of daily living, and was dependent on staff for transfers. R15 was also receiving dialysis. R15's careplan indicated R15 required 1 staff assist with activities of daily living and transfers and received dialysis treatments. During an observation and interview on 6/22/26 at 1:10 p.m., a bottle of Pepto Bismol (over the counter medication used to treat diarrhea and stomach upset) was on the nightstand between R15's recliner and bed. The bottle was ¾ full. R15 stated she used it when she had diarrheal episodes "about a month ago" and likes to keep the bottle on hand incase another episode "creeps up" on her. R15's MAR record lacked an order for Pepto Bismol. R15's most recent self-administration assessment dated 6/12/25 indicated R15 "does not wish to keep medications at bedside". R15's facility progress notes indicated R15 had 2 diarrheal episodes on 5/1/26 however no mention to having Pepto Bismol in her room. During observation on 6/23/26 at 8:48 a.m., the Pepto Bismol bottle remained on the nightstand. The bottle measures 473 milliliters and does not have a pharmacy label. During an interview on 6/23/26 at 11:39 a.m., registered nurse (RN)-B stated if a medication was found in a resident's room, the medication is removed and the nurse manager or director of nursing (DON) is notified. If a resident wishes to administer a medication independently, a self-administration assessment is performed to make sure the resident is safe to administer the medication independently. If there is no order for the medication, the medication is removed, and an order is obtained by the provider.	F0554	Continued from page 2 Proper documentation in their care plan. Secure, locked storage for their medications in their room. No additional residents were identified as self-administering medications or maintaining bedside medications without the required physician order, self-administration assessment, care plan documentation, and secure storage. Systemic Changes Facility policy on Resident Self-Administration of Medications was reviewed thoroughly and left unchanged by the interdisciplinary team. Residents requesting to self-administer medications upon admission or during their stay will not be approved until a physician order, self-administration assessment, care plan documentation, and secure medication storage requirements have been completed. Mandatory education will be provided to all licensed nursing staff RNs and LPNs. Education will focus on: The requirement for a physician's order prior to allowing self-administration for all medications including bedside inhalers and creams. How to properly conduct and document the Self-Administration of Medication Assessment. Ensuring bedside medications are stored securely in a locked compartment and out of reach of cognitively impaired residents. Reporting and documenting any unauthorized self-administration. The Interdisciplinary Team will be educated on	07/29/2026

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F0554 SS = D	Continued from page 3 During an interview on 6/23/26 at 12:59 a.m., RN-A stated it was her first time working down that hall. RN-A stated if a medication is found in a resident's room, the medication is removed and verified against existing orders. The provider and pharmacy would also be notified. If there was no order for the medication, RN-A stated she would "investigate" where it came from and not leave the medication in the room. RN-A stated a provider order is required if a resident requests to administer a medication independently. RN-A confirmed R3 did not have an order for fluticasone and said "did I leave it in her room? I don't recall giving it to her this morning." RN-A also confirmed R3 did not have a self-administration order from the provider. RN-A stated R15 was already at dialysis at the start of her shift, so she had not been in R15's room yet. RN-A entered room and confirmed bottle of Pepto Bismol on the nightstand and confirmed it was ¾ full with no pharmacy label. RN-A confirmed R15 did not have an order for Pepto Bismol. During an interview on 6/23/26 at 1:14 p.m., RN-C stated if a resident brings in medications from home, the family is asked to take it with them. The facility is only permitted to dispense medications from the pharmacy. If a resident requests to administer a medication independently, a self-administration assessment is performed. An order is then obtained from the provider authorizing the resident to administer the medication independently. RN-C stated medications should not be left in a resident's room without a self-administration assessment and providers' order. RN-C reviewed R3's medical record and confirmed R3 did not have an order for fluticasone. RN-C confirmed R3's last self-administration assessment was dated 1/26/26 and indicated R3 did not wish to self-administer or keep medications at bedside. RN-C then reviewed R15's medical record and confirmed R15 did not have an order for Pepto Bismol. RN-C also confirmed R15's most recent self-administration assessment dated 6/12/25 indicated R15 did not want to self-administer medications or have medications left in her room. During interview on 6/23/26 at 1:57 p.m., the director of nursing (DON) stated if family brought in medication from home, the facility would verify the medication is correct, make sure it is labeled, and	F0554	Continued from page 3 identifying, reporting, and promptly notifying licensed nursing staff of residents maintaining medications at bedside outside of an approved self-administration program. Quality Assurance & Monitoring The DON or designated RN will conduct audits of residents self-administering medications to verify compliance with assessments, orders, and secure storage. Frequency of audits will be Weekly for 4 weeks, monthly for 3 months, and quarterly thereafter. The results of these audits will be reported by the DON to the facility Quality Assurance and Performance Improvement QAPI Committee monthly. The QAPI committee will review the audit trends to determine the need for further education or systemic modifications. If 100% compliance is maintained at the end of 4 months, the committee may decide to reduce the frequency of audits or transition to spot-checks.	07/29/2026

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F0554 SS = D	Continued from page 4 make sure there is a provider order. Medications should remain locked up in the medication cart. If a resident requested to self-administer a medication, a self-administration assessment is performed and an order would be obtained from the provider. The director of nursing confirmed R3 did not have an order for fluticasone and R15 did not have an order for Pepto-bismol. A policy titled “Self-Administration of Medications” dated 5/22/18 indicated “It is the right of the resident to self-administer their medications if the interdisciplinary team has assessed and evaluated that the resident is able to physically and cognitively, safely administer the prescribed medication.” The policy continues “If the resident wishes to self-administer their medications, at the time of admission and during stay at the facility, the interdisciplinary team will initiate a Self-Administration of medication Assessment to determine if the resident is capable and clinically appropriate, based on the resident’s cognition, physical ability, functionality and status of health conditions. A physician order will be obtained by the nurse prior to proceeding with self-administration. To ensure safe and accurate self-administration, education will be provided to the resident to ensure that a resident is able to: state the name, dose, strength, route, frequency, and purpose for use of his/her medications. The policy also states the resident should understand the possible side effects of his/her medications and that he/she should notify facility staff if he/she experiences any side effects. The resident should demonstrate correct and timely administration of the medication and demonstrate and consistently maintain, safe storage of his/her medications in a locked storage. Each resident self-administering their medications will have their individualized self0administration plan defined on their careplan. This will include the specific plan for the self-administration including the specific medications the resident is responsible for, the monitoring plan, the reassessment plan, the storage plan-including self-storage, reordering plan. The facility staff should document the self-administration of medications on the resident’s MAR/TAR according to the medication administration schedule. The policy also indicates the facility should document in the resident’s careplan whether the resident or facility staff is responsible for the storage of the resident’s medications. If the resident is responsible for the storage, the facility should provide a secure compartment for storage of such medications in accordance with facility policy, applicable law, the State Operations Manual.	F0554		07/29/2026

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F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to provide activities of daily living (ADL) for 2 of 2 residents (R41, R20) who were dependent on staff for timely assistance for personal hygiene. Findings Include: R41 R41's quarterly Minimum Data Set (MDS) was not completed at time of survey; R41 admitted to the facility on 6/9/26. R41's care plan dated 6/9/26 indicated R41 required extensive assistance to total assistance with personal hygiene and grooming. R41's care plan lacked resident-specific directions about facial hair/removal. R41's provider orders dated 6/9/26 indicated R41 was to have weekly skin checks and vital signs every evening shift every Saturday for bath day, if resident refuses, document reason and attempts. The treatment administration record (TAR) indicated the skin checks and vital signs had been completed; the TAR lacked documentation a bath had been performed. R41's 30 day look back for point of care task history for bathing/showering indicated R41 had not had a shower or bath since her admission. During observation and interview on 6/22/26 at 12:45 p.m., R41 had multiple long hairs on her upper left and upper right lip, additionally, R41 had a patch of long grey hairs on her bottom right chin and several long hairs on her bottom left chin. R41 stated she does not like facial hair, it was embarrassing for her to have facial hair; stating this	F0677	Affected Residents Residents cited in the survey, Resident 20 and Resident 41, were immediately provided with comprehensive personal hygiene and grooming care. This included facial hair grooming/removal according to resident preference. The Director of Nursing reviewed the cited resident's care plan and CNA care sheets to ensure they detail the resident's individualized hygiene routines and preferences. The nursing staff assigned to the residents at the time of the omission received immediate 1-on-1 education on their duty to provide and document daily grooming and personal hygiene care as outlined in the resident's care plan. Licensed nursing staff assessed each resident for any additional unmet personal hygiene or grooming needs and documented completion. Care plans, CNA care guides, and task sheets were reviewed and revised as needed to accurately reflect each resident's individualized hygiene preferences and required level of assistance. Potentially Affected Residents All Residents have the potential to be affected Director of Nursing and Nursing Staff conducted a Facility-wide visual audit of all residents, with particular attention to residents requiring assistance with personal hygiene and grooming. This audit checked for: Cleanliness of hair and scalp. Facial hair (shaved according to preference). Fingernail length and cleanliness. Oral hygiene teeth/gums brushed, dentures clean	07/29/2026

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F0677 SS = D	Continued from page 6 is a reason she doesn't like to leave her room. During an interview with R41 on 6/22/26 at 1:57 p.m., R41 looked upset with a frown on her face and stated this chin hair "really, really bothers her and she is really really upset about it". During an interview on 6/23/26 at 1:56 p.m., registered nurse (RN)-B, stated residents should have facial hair removed, per their preference, on bath days. Additionally, nursing assistant (NA)-C stated R41 did get a bath today and would expect the resident to have gotten her facial hair removed if that was her preference. NA-A stated she did not notice any facial hair on R41 when she gave her a bath today. During an interview on 6/23/26 at 2:24 p.m., R41 stated she was given a bath today, but stated she continued to have facial hair. R41 stated as someone who likes fashion, facial hair is very embarrassing for her. She wishes it was all gone. R41 stated she tried to remove her facial hair on her own but was unable to remove all the hairs, she "wished they would help her with this". R20 R20's MDS dated 6/19/26 indicated R20 had no cognitive impairment and required partial to moderate assistance with personal hygiene, including shaving. R20's care plan dated 6/1/26 indicated R20 required extensive assistance to total assistance with personal hygiene and grooming. R41's care plan lacked resident-specific directions about facial hair/removal. R20's provider orders dated 6/9/26 indicated R20 was to have nursing weekly bath/skin checks and vital signs, if resident refuses, document reasoning and attempts. The treatment administration record (TAR) indicated the skin checks and vital signs had been completed; the TAR lacked documentation a bath had been performed. R20's 30 day look back for point of care task	F0677	Continued from page 6 and in place. Cleanliness of clothing (free of food stains, bodily fluids, or odors). Any identified grooming or hygiene deficits were corrected on the spot by the auditing team, and care sheets were updated to reflect any newly identified resident needs. Residents refusing hygiene or grooming services were assessed to ensure refusals were documented and addressed in accordance with facility policy. Systemic Changes Mandatory education conducted for all nursing staff. Training focused on: Maintaining dignity through regular grooming and personal hygiene for dependent residents. Following and accurately documenting care interventions on CNA flow sheets/EHR tasks. Reporting changes in resident hygiene preferences or a decline in self-care abilities to the charge nurse. Education reinforced providing care based on individualized resident preferences and care plans. Daily Resident Appearance Audit to be completed daily for 3 weeks by CNAs and submitted to the DON, or until substantial compliance is achieved on every resident. CNAs must verify and sign off that their assigned residents are clean-shaven, have clean nails, received oral care and wearing presentable clothing each day. Monitoring & Quality Assurance. The DON, or Nursing Staff will conduct random visual checks of dependent residents using a	07/29/2026

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F0677 SS = D	Continued from page 7 history for bathing/showering indicated R20 completed baths on 6/6/26, 6/9/26, 6/13/26, 6/16/26, 6/20/26, and 6/23/26. R20 had not refused a bath or personal hygiene cares. During an observation and interview on 6/22/26 at 2:18 p.m., R20 had a patch of chin hair on her upper right lip and a patch of hair on her bottom right and left chin. R20 stated she does not like the chin hair, but the facility had not helped her remove it. During observation and interview on 6/23/26 at 11:12 a.m., R20 was sitting outside her room, she stated she was waiting for someone to come take her to a bath. R20 stated she hoped they would assist her with removal of her facial hair; thinks bath time is the perfect time to remove facial hair. During observation and interview on 6/24/26 at 9:49 a.m., R20 stated she had gotten her bath yesterday. However, R20 stated she was disappointed they did not remove her facial hair. R20 stated the bath would have been the best time to remove her facial hair. During an interview on 6/23/26 at 2:06 p.m., nursing assistant (NA)-A, stated she gave R20 a bath today. NA-A stated she did not notice if R20 had any facial hair; acknowledging facial hair on female residents could be distressing to them. Again stating, she did not notice facial hair on R20. During an interview on 6/24/26 at 10:35 a.m., the director of nursing (DON) stated it is an expectation to address facial hair during bath days and complete removal per the resident's preferences. Female residents should specifically be addressed for facial hair because it is not normal for them to have facial hair. The DON stated she would expect both R41 and R20 to have had their facial hair removed during their bath time yesterday. A facility policy titled Activities of Daily Living (ADL)'s dated 5/1/25, the purpose of the policy is to establish consistent expectations for providing ADL care and services that preserve resident dignity, promote independence, and prevent avoidable decline in function across all long-term and skilled nursing facilities. Additionally, a resident who is unable to carry out ADL's will be provided the necessary care and services to maintain good	F0677	Continued from page 7 Hygiene and Grooming Compliance Tool. Audit Frequencies: Weeks 1–4: Five (5) dependent residents audited daily across alternating shifts, 5 days per week. Weeks 5–12: Five (5) dependent residents audited three times per week. Months 4–6: Five (5) dependent residents audited weekly. Auditors will physically verify that audited residents have clean, brushed hair; have no unwanted facial hair; have clean, trimmed fingernails; have clean teeth/dentures; and are wearing clean, appropriate clothing. Any identified deficiency will be corrected immediately by nursing staff. Residents' hygiene and grooming preferences will be reviewed during care plan reviews, significant changes in condition, and upon resident or representative request to ensure care remains individualized and person-centered The QAPI Committee will review audit results monthly to evaluate trends and the effectiveness of corrective actions. Additional education, increased monitoring, or process changes will be implemented as indicated to maintain compliance.	07/29/2026

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F0677 SS = D	Continued from page 8 nutrition, grooming, and personal and oral hygiene.	F0677		07/29/2026

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	245626	A. BUILDING **01 - BUILDING 1** B. WING	**06/24/2026**

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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

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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

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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

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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

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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

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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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