DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3RTP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245306**

2.STATE VENDOR OR MEDICAID NO.
(L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER HEALTH SERVICES WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **04/05/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Danette Bakken, HFE II 04/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/16/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
___ 1. Facility is Eligible to Participate
X 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Documentation supporting the request for a waiver of the following life safety code (LSC) deficiency.

K521 – HVAC 42 CFR 483.70(a) NFPA Life Safety Code Standard, Approval of the waiver request has been recommended.

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CMS Certification Number (CCN): 245306

April 16, 2018

Mr. Jim Laine, Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

Dear Mr. Laine:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 29, 2018 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K918.

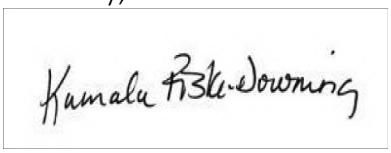
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
April 16, 2018

Mr. Jim Laine, Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: Project Number S5306028

Dear Mr. Laine:

On March 23, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective March 28, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 19, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on January 19, 2018, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 15, 2018. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 5, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 5, 2018, as of March 29, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 29, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 23, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 19, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 19, 2018, is to be rescinded. They will also notify the State

Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 19, 2018, is to be rescinded.

In our letter of March 23, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 19, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 29, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency cited under K918 at the time of the January 19, 2018 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3RTP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245306**

2.STATE VENDOR OR MEDICAID NO.
(L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER HEALTH SERVICES WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **03/15/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kyla Einertson, HFE NE II — 03/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 04/14/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
___ 1. Facility is Eligible to Participate
X 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency.

K521 – HVAC 42 CFR 483.70(a) NFPA Life Safety Code Standard

Approval of the waiver request has been recommended.

Refer to the CMS 2567 forms for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Electronically delivered

March 23, 2018

Mr. Jim Laine, Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: Project Number S5306028

Dear Mr. Laine:

On February 7, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 19, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 15, 2018, the Minnesota Department of Health and on March 5, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 19, 2018. The deficiencies not corrected are as follows:

F585 -- S/S: D -- 483.10(j)(1)-(4) -- Grievances
F656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan

K918 -- S/S: F -- 483.90(f) -- Electical Systems - Essential Electric Systems

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective March 28, 2018. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b)

require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 19, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 19, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 19, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Rochester Health Services West is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective April 19, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be

affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of

correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor

Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	R 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 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
F 000	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 3/15/18, and found to have NOT corrected all the citations issued on the survey exited 1/19/18. 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.	F 000		
F 585	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		3/29/18

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

Electronically Signed | 03/29/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	R 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 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
F 585	Continued From page 1	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	R 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 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
F 585	Continued From page 2 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to make prompt efforts to resolve cold food grievances for 1 of 1 resident (R8) reviewed for grievances. Findings include: R8's current Admission form dated 10/11/16, indicated diagnoses of Type 2 diabetes mellitus, major depressive disorder, chronic kidney	F 585	Concerns about food temperatures voiced by R8 have been documented on the facility Grievance form. R8 was offered options including reheating his meal if food temperature is not to his liking or eating meals in the dining room. R8 declined either option. R8 stated that food temperatures have been warmer. Residents expressing grievances have	

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F 585	Continued From page 3 disease, and obstructive sleep apnea. R8's annual Minimum Data Set (MDS) and assessment dated 11/17/17, identified R8 with intact cognition and independent with eating after set up. Facility complaint/grievance form dated 8/14/17, identified R8 stating his meal is cold when received. R8 stated this has happened for 3 weeks. The facility plan of correction for survey exited 1/19/18, included, "Concerns expressed by R8 have been addressed and resolution has been completed. R8 is receiving meals at appropriate temperatures." However, the grievance resolution documentation was requested for review during the post recertification revisit, none was provided and R8 had ongoing concerns related to the food being too cold. During an interview on 3/15/18, at 10:17 a.m. R8 stated the temperature of the food when delivered a room tray had improved a little but not significantly. R8 stated the food was cold two out of every three times he was served. R8 stated the facility staff had been checking with him to see how the food had been, not often, but on occasion. R8 stated, "I have not complained lately. I guess I have acclimated to the situation (with the food being cold when served)." R8 stated this morning, the eggs were warm, the pancakes were cold and the oatmeal was borderline cold. During an interview on 3/15/18, at 2:55 p.m. the interim director of nursing (IDON) stated there was no documentation found related to follow-up	F 585	the potential to be affected if their grievances are not addressed and resolved timely. Residents receiving meals via room trays have the potential to be affected if food temperatures are not adequate. Residents receiving meals via room trays were interviewed regarding food temperatures and were informed that they could have their meal reheated should the temperature not be to their preference. Dietary staff have received education on proper serving temperature of room trays. Temperature logs are completed each meal. Temperatures outside of recommended serving temperatures are adjusted as they are noted. IDT has received education on the grievance process resolution. Grievances will be reviewed daily. Follow up on grievance resolution will continue x 4 weeks to insure the grievance has been resolved satisfactorily with no further occurrences. Dietary Manager will conduct 3 interviews weekly of residents receiving room trays x 4 weeks then monthly x 2 months on appropriate food temperatures. Negative results will be addressed immediately. Interview results will be reviewed at QAPI for recommendations and need to continue interviews. Executive Director or designee will be responsible party. Completion date: 3/29/18	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 4 with R8's concerns related to the food being too cold when served. The IDON verified the facility had no documentation to show R8's concern related to the food being cold had been addressed per the facility plan of correction. The IDON stated she would have expected the grievance form to be completed and for there to be documentation/follow-up on R8's ongoing concerns related to cold food. An undated facility document titled, "Combined Federal and Minnesota State Bill of Rights," indicated under, "Grievances," 2. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances that resident may have, in accordance with this paragraph. Severity/Scope = 2/1	F 585		
F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		3/29/18

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F 656	Continued From page 5 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (R4) reviewed for use of a urinary catheter. Findings Include: R4 had been admitted on 7/20/17, according to the face sheet. In addition, it included the diagnosis of obstructive and Reflux Uropathy, and Retention of Urine. R4's care area assessment (CAA) dated 8/1/17, identified R4 had an indwelling urinary catheter	F 656	Comprehensive care plan for R4 catheter use was updated 3/15/18. All residents have the potential to be affected if care plan is not developed to address care areas identified in CAA□s. All other residents with catheters in use were reviewed to ensure care planning had been completed. Staff responsible for care plan development has received education on addressing areas of concern identified in	

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F 656	Continued From page 6 and was at risk for adverse side effects related to catheter usage. The CAA also indicated that R4 needed assist of staff to provide perineal care and catheter management. During a review of the plan of care in R4's electronic health record during the post recertification visit, no care plan related to the indwelling urinary catheter had been developed for R4, despite R4 being cited for this problem during the recertification survey. During an interview on 3/15/18, at 2:29 p.m. the nurse consultant (NC) stated she could not find a care plan for R4 regarding catheter use and care. NC stated she would have expected the facility follow the plan of correction and to have developed a care plan for R4's catheter. An undated Care Planning policy was provided by the facility, indicating that a care plan will be developed based on the results of a resident's assessment. The person-centered care plan will include measurable objectives and timelines specific to the resident. Severity/Scope = 2/1	F 656	CAA□s. Audits will be completed on 3 care plans weekly x 4 weeks then monthly x 2 months to insure all areas of concern are addressed. Negative findings will be care planned immediately. Audit results will be reviewed at QAPI for recommendations and need to continue audits. Director of Nursing or designee will be responsible party. Completion date: 3/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3RTP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245306**

2.STATE VENDOR OR MEDICAID NO.
(L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER HEALTH SERVICES WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **01/19/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Stephanie Powers, HFE NE II 02/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 03/16/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
X 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency.

K521 – HVAC 42 CFR 483.70(a) NFPA Life Safety Code Standard

Approval of the waiver request has been recommended.

Refer to the CMS 2567 forms for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2018

Ms. Tianna Bagley, Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: Project Number S5306028

Dear Ms. Bagley:

On January 26, 2018, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 28, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 28, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by April 19, 2018 (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). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted January 16, 17, 18, & 19, 2018, during a recertification survey. The facility was found to be in full compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On January 16, 17, 18, & 19, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		2/28/18

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

Electronically Signed | 02/15/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to communicate and provide personal care assistance when requested to promote dignity for 1 of 1 resident (R3) who expressed feelings of not being treated with dignity.	F 550	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director	

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F 550	Continued From page 2 Findings include: R3's Quarterly, Minimum Data Set (MDS) and assessment dated 10/16/17, identified R3 with intact cognition and required 2 person extensive assist with all activities of daily living (ADL). R3's, Admission Record identifies R3 with an admittance date of 4/20/17, and a diagnosis of amyotrophic lateral sclerosis (ALS, a progressive disease that affects nerves in your brain and spinal cord that control your muscles) and muscle weakness. R3's Care Plan dated 5/12/17, revealed a goal was to maintain involvement with ADL performance and social activities. Interventions: offer choices to enhance sense of control, reassure when expressing (specify), and to validate feelings. During observation on 1/16/18, at 7:37 a.m., R3 was lying in bed on her back, dressed in a blue facility gown, with the head of her bed raised, looking at the television. Has red alert call light (call light that easily activates with contact from any body part), placed to the left of R3's head and attached to her pillow. On 1/16/18, at 2:32 p.m., R3 continues to be in her bed dressed in a blue facility gown with her eyes closed and the television is on. On 1/17/18, at 12:53 p.m., R3 lays in bed wearing a blue gown, with the head of the bed inclined to a sitting position and is assisted with eating by one staff member.	F 550	or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facilities credible allegation of compliance F550 R3 is receiving assistance with personal cares in a dignified manner. All residents have the potential to be affected if assistance is not provided in a dignified manner. Nursing staff have received education on resident rights and providing cares with dignity. Resident interviews on receiving care in a dignified manner will be conducted on 3 residents weekly x 4 weeks then monthly x 2 months. Negative findings will be addressed immediately with involved staff. Interview results will be reviewed at QAPI for recommendations and to determine need to continue interviews.	

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F 550	Continued From page 3 On 1/18/18, at 7:50 a.m., R3 is sitting in her bed and the director of nursing (DON) is assisting R3 with a drink of water by holding the glass, while R3 drinks out of the straw. On 1/18/18, at 8:58 a.m., R3 is laying in her bed being assisted with eating breakfast from an unidentified facility staff. During interview on 1/17/18, at 1:29 p.m., R3 stated she always requests her medication before she receives her nasal spray, because she feels like she is choking. R3 stated about 3 weeks ago, licensed practical nurse (LPN)-B was mad at R3, because R3 requested her medications before using the nasal spray. R3 stated she could tell LPN-B was mad because LPN-B was staring at R3 with a "mean" look on her face and was slamming things on R3's bedside table. R3 stated, (with tears in her eyes) "She [LPN-B] tried to give me all my pills in yogurt at once, and she made me take it, I told her no, and she shoved them in my mouth anyways, then I asked for a drink, she gives me a drink of water and shoves the straw way in the back, then I asked her to set it down." R3 then explains to this surveyor that if people hang onto the straw while they give her a drink she can't control it with her tongue to drink, and feels like she is choking. R3 further stated, "I tried to put my tongue on the straw to push it away, but I couldn't even drink." R3 stated LPN-B finally put the cup of water down. R3 then asked LPN-B to go get registered nurse (RN)-B. R3 stated RN-B came into her room and R3 tried to explain what happened and RN-B stated that they could keep LPN-B away from R3 because that is her right. R3 verified she agreed to not have LPN-B provide her care anymore.	F 550	Social Services Director will be responsible party. Completion date 2/28/18	

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F 550	Continued From page 4	F 550		

R3 stated another incident happened with a trained medication aide (TMA)-A was giving her nasal spray and R3 asked TMA-A not to lay her flat after that, and TMA-A proceeded to lay R3 flat. R3 explained to this surveyor that it causes her to choke from the nasal spray dripping down the back of her throat. R3 stated TMA-A was frustrated because she was getting me ready for bed and has to do my medications too. R3 started to cry and stated she said to TMA-A, "Get me up, I can't breathe." R3 stated nursing assistant (NA)-A was in the room helping and asked R3 what was wrong, and TMA-A stated, "Oh she is gagging on her snot." R3 stated they finally put her on her side and then she could breathe. R3 stated that TMA-A is usually really good, but stated she heard TMA-A tell another staff that she had to get everybody ready for bed by herself that night, R3 stated, "So I am sure she was frustrated." R3 then stated she never told anyone this occurred. R3 then stated, "I do not feel like any of these situations were abuse, but I definitely was not treated with respect and dignity! I need to advocate for myself and I will keep telling people until I get it done. I like this place and I like everyone here."

During interview on 1/17/18, at 6:54 p.m., DON stated if a resident has a complaint the staff will get RN-B or myself and we will handle it and get it resolved. DON further stated, "I can't say that I do document when we fix things such as resident issues."

During interview on 1/17/18, at 7:25 p.m., RN-B verified that LPN-B does not work with R3 anymore and further verified there is no documentation regarding the reason LPN-B is not working with R3. RN-B stated, "I was told you

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F 550	Continued From page 5 don't put something like that in the chart." RN-B further stated LPN-B has been known to be real abrupt, wears a hearing aid and that R3 talks real soft and that it could all be a communication error. During interview on 1/18/18, at 5:46 p.m., administrator stated, "If it was reported to me, I would investigate it and report it. We are going to investigate it." Facility policy, "Quality of Life-Dignity," revised, 8/09, revealed that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Resident shall be treated with dignity and respect at all times. 2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 8. Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		2/28/18

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F 561	Continued From page 6 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate personal preferences for food choices for 1 of 1 resident (R3) reviewed for choices. Findings include: R3 had been interviewed on 1/17/18, at 1:12 p.m., R3 stated, "Sometimes the food is real bad, like real dry. A lot of the time the food is burnt or cold. I have requested lemonade punch, or iced tea from the kitchen several times, I tell the aides and they go to the kitchen and the kitchen tells them they don't have any, and no one has come to talk to me about it." R3 further stated about two months ago she asked for some extra mayonnaise, because the food was so dry. The kitchen said they didn't have any and, "I told the nursing assistant (NA) to tell them I am calling the department of health." The NA came back with some mayonnaise. "I talked to the dietary manager (DM)-A about how I would like some	F 561	F561 Food preferences for R3 have been added to preference list. R3 is receiving desired preferences as available. Food preference lists have been completed for all residents. Dietary Manager has received education on completing resident food preference lists. Nursing staff has received education on honoring preferences and completing preference change requests when needed. Resident interviews will be completed on 5 residents weekly x 4 weeks then monthly x 2 months to determine if preferences are being honored. Negative results will be addressed immediately. Interview results will be reviewed at QAPI for recommendations and to determine need to continue interviews. Dietary Manager will be responsible party.	

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F 561	Continued From page 7	F 561		

lemonade punch, iced tea, and that I get sick of the scrambled eggs every day. He never addressed the drinks, but told me I would start getting over easy eggs on Mondays, Wednesdays and Fridays. Usually the over easy eggs were burnt, so the NA's would have to scrape off the burnt parts and all I really got was the yolk. This week I didn't get any over-easy eggs." R3 stated that she has requested biscuits and gravy several times because they have not had them for a long time. R3 then said, "Sometimes if something is good, I will request more and the kitchen says there is nothing left. My roommate eats in the private dining room and she tells me they always get seconds if they ask."

R3's Quarterly, Minimum Data Set (MDS) and assessment dated 10/16/17, identified R3 with intact cognition and requires two person extensive assist with all activities of daily living (ADL).

R3's, "Admission Record," identifies R3 with an admit date of 4/20/17, and a diagnosis of amyotrophic lateral sclerosis (ALS-a progressive disease that affects nerves in your brain and spinal cord that control your muscles) and muscle weakness.

R3's Care Plan, dated 5/12/17, revealed the goal was to maintain involvement with ADL performance and social activities. Interventions: offer choices to enhance sense of control, a subsequent goal revealed resident will remain adequately hydrated as evidenced by good skin turgor and moist oral mucosa. Intervention is to follow the tray card preferences and meal types. Double check at all tray passes.

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F 561	Continued From page 8	F 561		

Review of facility grievances did not identify any food preference concerns with R3.

Facility document dated 11/15/17, "Care Conference Summary," revealed under comments: over-easy eggs. Would like soup change, chili bun, and more yogurt with medications.

R3's medical doctor visit dated 12/18/17, revealed R3 was diagnosed with ALS in 2014 and now has quadriplegia, (paralysis of all four limbs) and spastic flaccid dysarthria (speech deterioration). R3 speaks softly, but clearly, is alert and oriented, follows directions, is bedfast, and she is fed by staff. Further revealed R3 has chronic dry mouth likely secondary from her medications. I have prescribed biotene mouthwash 3 times a day.

During interview on 1/18/18, at 2:26 p.m., DM-A verified he was familiar with R3 and her food preferences. DM-A stated there is scrambled eggs served 3-4 times a week, and that R3 has requested to have over-easy eggs on Mondays, Wednesdays and Fridays. Further verified the facility refrigerator in the kitchen that held the eggs has broken down and it may be a couple weeks before it is fixed. DM-A stated R3 really likes biscuits and gravy but they just transitioned to the fall/winter menu and won't have any till the spring menu, "These orders come from our corporate dietician." "Our menu is set and the only legitimate reason I can change it is during an emergency or if we run out of something." "For the lemonade punch and the iced tea, that is an alternative so she knows we do have it. There has been times she has requested it." If a resident has a request for something the nursing assistants can fill out a preference change sheet

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F 561	Continued From page 9 in the kitchen. Requested documentation of food preference interview for R3's food choices and none was provided. During interview on 1/19/18, at 11:31 a.m., registered nurse (RN)-B stated, "My expectation would be for any resident to have their food preferences identified and met, and if they are not being met we need to go to corporate for that. With R3 we should have no problems getting her that lemonade punch and iced tea." Facility policy, dated 2005, "Food Preferences," revealed it is the center policy that individual food preferences are identified for all residents/patients. 2. The Food Services Director or designee will complete a food preference interview within 72 hours of admission for the purpose of identifying individual food and beverage preferences.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		2/28/18

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F 578	Continued From page 10 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have the correct advanced directive available for staff reference in case of and emergency for 1 of 17 residents (R8) reviewed for advance directives. Findings include: R8's current Admission Record dated 10/11/16, indicated diagnoses of Type 2 diabetes mellitus, major depressive disorder, chronic kidney disease, and obstructive sleep apnea.	F 578	F578 Advance Directives and EHR for R8 was immediately reviewed and updated to reflect R8's wishes. Advance Directives for all residents were reviewed for all residents to insure resident wishes were current and accurately reflected in the EHR. Education was provided to licensed staff on Advance Directives and procedure for validating code status. Education also provided to staff responsible for entering Advance Directives into the EHR for	

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F 578	Continued From page 11 R8's provider orders for life sustaining treatment (POLST) document dated, 1/5/18, was marked to indicate cardiopulmonary resuscitation (CPR). The document was signed by the resident, physician and the registered nurse (RN)-B. However, when compared to the electronic record, R8's code status was documented as: do not resuscitate/do not intubate DNR/DNI on 1/16/18, at 11:37 a.m. R8's care plan dated 12/23/15, indicated "DNR/DNI." Untitled and undated facility document identified R8's code status DNR/DNI. R8's annual Minimum Data Set (MDS) and assessment dated 11/17/17, indicated R8's cognition was intact. During an interview on, 1/17/18, at 12:31 p.m., R8 stated regarding the status of the advance directive, "I changed it when I was in the hospital to, I am going to fight like hell!" R8 verifies he wants CPR if he looses respirations/heart beat. R8 stated he wants the CPR because he will miss his wife. During an interview on 1/18/18, at 10:03 a.m., when registered nurse (RN)-A was asked where he would look for a code status on R8 if he was found not breathing. RN-A stated, "I haven't quite been trained on where to look for that, I guess I would look in the electronic health record (EHR)." RN-A pulls a document out of his pocket and stated he has an assignment sheet and it has resident code statuses on it. RN-A verifies in the EHR and written on his assignment sheet that R8's code status is a DNR/DNI. RN-A then	F 578	accuracy. Advance Directives will be reviewed during care conferences to insure resident wishes in case of emergency are current and reflected in the EHR. Audits of 5 resident records will be completed weekly x 4 weeks then monthly x 2 months to validate Advance Directives are accurately reflected in the EHR. Negative findings will be immediately updated to reflect resident wishes. Audit results will be reviewed at QAPI for recommendations and need for continued audits. Director of Nursing will be responsible party.	

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F 578	Continued From page 12 stated, "I guess I would not do CPR then." When RN-A reviewed the current POLST order in R8's hard chart, he said it had CPR checked and the information on the assignment sheet and in the EHR is not correct. During an interview on 1/18/18, 10:07 a.m., director of nursing (DON) verifies that R8's POLST orders state R8's code status as a full code dated 1/5/18. DON further verifies R8's EHR and assignment sheet was not correct. DON stated, "We will do some training," and my expectation is that all nursing staff grab the residents hard chart to check for a code status, "they should always look there for the POLST order, it is bright orange, you can't miss it." The facility's policy, "Advance Directives," revised April 2013, included: 7. the plan of care for each resident will be consistent with his/her documented treatment preferences and/or advance directive. 19. The staff development coordinator will be responsible for scheduling advanced directive training classes for newly hired staff members as well as scheduling annual advanced directive training programs to ensure that our staff remains informed of our resident rights to formulate advance directives and facility policy governing such rights.	F 578		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		2/28/18

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respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 15 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to make prompt efforts to resolve grievances for 1 of 1 resident (R8) reviewed for grievances. Findings include: R8's current Admission form dated 10/11/16, indicated diagnoses of Type 2 diabetes mellitus, major depressive disorder, chronic kidney disease, and obstructive sleep apnea. R8's annual Minimum Data Set (MDS) and assessment dated 11/17/17, identified R8 with intact cognition and independent with eating after set up. Facility complaint/grievance form dated 8/14/17, identified R8 stating his meal is cold when received. R8 stated this has happened for 3 weeks. During observation on 1/16/18, at 7:28 a.m., R8 is lying in bed on his left side sleeping wearing a white t-shirt and covered with blankets. At 1:25 p.m., R8 stated 4 out of 5 times the food is too cool according to his preference. R8 said, "If I say something they will heat it in the microwave, you can't reheat toast though it becomes a brick." At 1:54 p.m., R8 stated to the surveyor, "You	F 585	F585 Concerns expressed by R8 have been addressed and resolution has been completed. R8 is receiving meals at appropriate temperatures. All residents have the potential to be affected if expressed grievances are not addressed and resolved timely. Staff has received education on the Grievance Process. Nursing and Dietary staff have received education on timeliness of passing trays to insure residents receive meals at appropriate temperatures. Grievances will be reviewed daily. Follow up on grievance resolution will continue x 4 weeks to insure the grievance has been resolved satisfactorily with no further occurrences. Dietary Manager will conduct 3 resident interviews weekly x 4 weeks then monthly x 2 months on appropriate food temperatures. Negative results will be addressed immediately. Interview results will be reviewed at QAPI for recommendations and need to continue interviews. Social Service Director will be responsible party.	

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should have a meal before you leave here, you will see, the food is cold. The lasagna today was cool. It's cool all the time, I am just used to it, plus I am hungry."

During interview on 1/17/18, at 12:27 p.m., R8 stated, my food this morning was scrambled eggs and they were ice cold. Someone from the kitchen came and talked to me and they said they would get me another tray. That was the last that I saw of her, until she came back to collect the trays, and then she brought me a tray. The eggs were warm, but it was a half-serving and they looked like they were scraped off the bottom. "You get the feeling that no one in the kitchen gives a damn." When R8 was asked about how his lunch is now he stated, my meal is lukewarm, not hot, the sweet potatoes are good, the chicken and the corn are lukewarm. R8 then said, "It tastes good, just not a good temperature."

During interview on 1/18/18, at 4:23 p.m., R8 verified he filled out a grievance form for the food being too cold on 8/14/17, and further stated, "I do not feel my grievance was resolved. Out of the 21 meals I receive here a week, I would say 3 of the meals served to me are at a decent temperature." R8 verifies he eats all meals in his room unless he has guests. R8 goes on to state, "It isn't the kitchens fault you know, that cart sits out in the hallway a long time, probably because they are short of staff. Today it was good, but it's because you people are here, it's not every day I have the director delivering my meal." R8 further stated, "After being here for two years, it is a lack of coordination between the people that set up the food and send the food out. I have learned to accept that my food is not at a decent temperature, I don't always send it back. I have

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F 585	Continued From page 17 to laugh because the last couple of meals have been served warm and I think you people [surveyors] have a lot to do with it." During interview on 1/18/18, at 4:31 p.m., registered nurse (RN)-B verified R8 had a grievance about cold foods on 8/14/17. RN-B said, "A couple weeks before R8 was in the hospital, he complained of cold pancakes." RN-B stated, my expectation is for the residents to have their food to be delivered resident's preferred temperature and not cold. RN-B then said, "It has to be a direct hand off, not a drop off, for the food to start getting better with the food temps." An undated facility document titled, "Combined Federal and Minnesota State Bill of Rights," indicated under, "Grievances," 2. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances that resident may have, in accordance with this paragraph.	F 585		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 637		2/28/18

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F 637	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on, interview and document review, the facility failed to complete a significant change Minimum Data Set (MDS) an assessment for a change in functional ability for toileting, bed mobility, transfers, and status of urinary continence for 1 of 1 resident (R27) reviewed for activities of daily living (ADL) decline. Findings include: R27 admitted to the facility on 10/2/17, with diagnosis of malignant neoplasm of prostate, and was admit to hospice on admission according to the admission form. R27's Admission MDS dated 10/9/17, identified R27 required for toilet use supervision (oversight, encouragement or cueing) for bed mobility and transfer, and limited assist with personal hygiene and toilet use. In addition, for urinary continence R27 was occasional incontinent, had diagnosis of cancer and dementia. R27's quarterly MDS dated 1/2/18, identified R27 declined from 10/9/17 MDS the following areas, required, for bed mobility, transfers, personal hygiene, and toilet use extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist and for urinary continence R27 was frequently incontinent, had diagnosis of cancer, dementia. During interview on 1/18/18, at 5:42 p.m., with trained medication aide (TMA)-A, stated that R27 has good days and bad days, is more depressed on some days. R27 is assist of 1 with transfer,	F 637	F637 R27's care plan has been updated to reflect changes in status. All residents have the potential to be affected if changes in status are not identified and properly care planned to reflect the changes. MDS Coordinator has received education on significant change criteria. Audits will be completed weekly x 4 weeks then monthly x 2 months on completed MDS' to determine if a significant change has occurred. If a significant change has occurred, RAI guidelines will be followed. Audit results will be reviewed at QAPI for recommendations and need to continue audits. MDS Coordinator will be responsible party.	

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and extensive to limited assist with personal hygiene and toilet, depending on how his day is going.

During interview on 1/19/18, at 8:38 a.m., with TMA-B, R27 is mostly extensive assistance of one staff; it depends on R27. R27 has good day and bad day. The last couple of morning R27 has wanted to walk down to the dining room, so I will walk with him.

During interview on 1/19/18, at 9:13 a.m., with registered nurse (RN)-C. Stated that after looking into decline in ADL's for quarterly MDS dated 1/2/18, they should have completed a significant change MDS due to the decline in ADL's, increased incontinence, and pain, these declines were due to disease process dx malignant neoplasm of prostate.

Requested policy for regarding significant change and was told they follow the RAI (Resident Assessment Instrument) manual guidelines.

The CMS's (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual pages 2-21 through 2-28 indicated 03. Significant Change in Status Assessment (SCSA). Assessment Management Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline

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F 637	Continued From page 20 within two weeks. Guidelines for Determining a Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Decline in two or more of the following: Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur; Resident incontinence pattern changes or there was placement of an indwelling catheter.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		2/28/18

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F 656	Continued From page 21 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for 2 of 2 residents (R14, R4) reviewed for falls and use of a urinary catheter. Findings include: R14 had been admitted to the facility according to the face sheet on 3/14/17. Also included diagnosis of a fistula (abnormal connection between two body parts) of the intestine, anemia,	F 656	F656 Care plan has been developed to address falls for R14 and catheter use for R4. All residents have the potential to be affected if care plan is not developed to address areas of concern identified in CAA's.. Staff responsible for care plan development has received education on addressing areas of concern identified in CAA's.	

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F 656	Continued From page 22 ileus (obstruction or lack of movement in the intestine), muscle weakness, heart failure, abnormalities of gait and mobility, major depressive disorder, and post traumatic stress disorder (PTSD). R14's care area assessment (CAA) dated 3/24/17, identified R14 as a fall risk due to balance deficits and use of antidepressant. According to the facilities incident report 11/1/17, R14 was found on the floor by staff. The intervention put into place was to remind R14 to wait for assistance. During a review of the plan of care in R14's electronic health record, no care plan related to falls was located. On 1/18/18, at 2:34 p.m., during an interview with the interim director of nursing (IDON), she verified no care plan interventions was in place related to falls. The IDON stated it would be her expectation that a fall care plan would be in place and that it would be person-centered. R4 had been admitted on 7/20/17 according to the face sheet. Also it included the diagnosis included Obstructive and Reflux Uropathy, and Retention of Urine. R4's care area assessment (CAA) dated 8/1/17, identified R4 had an indwelling urinary catheter and was at risk for adverse side effects related to catheter usage. The CAA also indicated that R4 needed assist of staff to provide perineal care and catheter management. During a review of the plan of care in R4's	F 656	Audits will be completed on 4 care plans weekly x 4 weeks then monthly x 2 months to insure all areas of concern are addressed. Negative findings will be care planned immediately. Audit results will be reviewed at QAPI for recommendations and need to continue audits. Director of Nursing will be responsible party.	

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F 656	Continued From page 23 electronic health record, no care plan interventions related to the indwelling urinary catheter was located. On 1/19/18, at 9:40 a.m., during an interview with the interim director of nursing (IDON), she verified no care plan for catheter use was present. Her expectation would be that a care plan would be in place and person-centered. An undated Care Planning policy was provided by the facility, indicating that a care plan will be developed based on the results of a resident's assessment. The person-centered care plan will include measurable objectives and timelines specific to the resident.	F 656		
F 677 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 ensure oral care was provided to 1 of 1 residents (R3) reviewed for activities of daily living (ADL) and whom was dependent on staff for care. Findings include: R3's, Admission Record, identifies R3 with an admit date of 4/20/17, and a diagnosis of amyotrophic lateral sclerosis (ALS-a progressive disease that affects nerves in your brain and spinal cord that control your muscles) and muscle	F 677	F677 R3 is receiving oral care twice daily. Residents dependent on staff for oral care have the potential to be affected if oral cares are not provided. CNA education was completed on oral care. Audits will be completed on 4 residents dependent on staff for oral care weekly x 4 weeks then monthly x 2 months. Negative findings will be addressed immediately with involved staff. Audit results will be reviewed at QAPI for	2/28/18

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F 677	Continued From page 24 weakness. R3's Quarterly, Minimum Data Set (MDS) and assessment dated 10/16/17, identified R3 with intact cognition and requires 2 person extensive assist with all activities of daily living (ADL)'s. Facility document dated 7/3/17, titled, "Care Conference Summary," revealed under the comment section that R3 wants to start flossing her teeth. During interview on 1/17/18, at 2:45 p.m. R3 stated, "I did not get my teeth brushed today, it makes me feel terrible, I have always brushed twice a day and now I am lucky if I get them brushed once a week." R3 further stated her gums bleed now and a couple times the staff have used a washcloth to wipe her teeth. During interview following bath on 1/18/18, at 11:54 a.m., R3 verified no one had offered to brush her teeth. R3 stated, "I always want to get my teeth brushed, usually when they are done with me they will tell me they have to keep moving, so then I feel bad and don't want to ask them to brush my teeth." During interview on 1/18/18, at 11:57 a.m. nursing assistant (NA)-B verified she did not offer to brush R3's teeth during morning cares. During interview on 1/18/18, at 11:57 a.m. director of nursing (DON) stated, "My expectation is to have staff offering and assisting all residents to brush their teeth with the same diligence as they brush their own, morning and night." Facility policy dated, 2001, revised October 2010,	F 677	recommendations and need to continue audits. Director of Nursing will be responsible party.	

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	245306	A. BUILDING _____ B. WING _____	01/19/2018

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F 677	Continued From page 25 Teeth, Brushing, revealed the purpose of this procedure is to clean and freshen the resident's mouth, to prevent infections of the mouth, to maintain the teeth and gums in a healthy condition, to stimulate the gums, and to remove food particles from between the teeth. General Guidelines #6. Floss as necessary and desired by the resident, between the teeth before bedtime. Daily flossing helps to stimulate the gums and remove trapped food particles between the teeth.	F 677		
F 918 SS=D	Bedrooms Equipped/Near Lavatory/Toilet CFR(s): 483.90(f) §483.90(f) Bathroom Facilities Each resident room must be equipped with or located near toilet and bathing facilities. For facilities that receive approval of construction plans from State and local authorities or are newly certified after November 28, 2016, each residential room must have its own bathroom equipped with at least a commode and sink. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide unobstructed access to the bathroom toilet for 1 of 3 residents (R8) reviewed for toilet facility access. Findings include: R8's current Admission Record dated 10/11/16, indicated diagnoses of Type 2 diabetes mellitus, major depressive disorder, chronic kidney disease, and obstructive sleep apnea. R8's annual Minimum Data Set (MDS) an assessment dated 11/17/17, identified R8 with	F 918	F918 R8 is able to have unobstructed access to toilet facility. EZ stand lift has been removed from the area. Residents needing access to toilet facilities have the potential to be affected if access is blocked. Nursing staff has received education on providing clear access to toilet area. Education was also provided on proper storage of EZ stand lift. Audits will be completed twice daily x 4 weeks to insure there is clear access to the toilet facility. Negative findings will be	2/28/18

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F 918	Continued From page 26 intact cognition and 1 person extensive assist with transfers and help toileting. During observation and interview on 1/16/18, 1:34 p.m. R8 stated he had a bowel movement in his pants about 1 week ago, because he could not get into the bathroom located down the hall from his room. R8 said they store the big electric lift in this bathroom and there isn't enough room for an electric lift and a wheelchair in there. R8 said this has happened before. At 1:48 p.m., R8 stated he is unable to use his bathroom because his wheelchair does not fit through the door. R8 further stated he uses the lavatory located down the hall from his room. During observation on 1/18/18, at 8:56 a.m., R8's designated resident bathroom located on the north hallway next to the beauty shop has an EZ-stand parked in front of the resident toilet. This is also used by two other residents in the facility. During interview on 1/18/18, at 8:58 a.m., director of nursing (DON) verifies the EZ stand is in front of the resident toilet on the north hallway and should never be in front of the toilet in this bathroom because residents use it. DON further stated the EZ stand should be stored in the hallway. DON verified that 3 residents down this wing use this bathroom because their wheelchairs do not fit in their personal bathrooms and that no resident should have to soil themselves trying to get to the bathroom because of the EZ lift being in the way of their toilet. DON stated her "expectation would be for any resident requiring the use of this bathroom, it should have a clear path to get to the toilet and the easy stand should not be in the way."	F 918	immediately addressed. Audit results will be reviewed at QAPI for recommendations and need to continue audits. Director of Nursing will be responsible party.	

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	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2018**

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Rochester Health Services West) 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

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

Electronically Signed | 02/15/2018

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. (Golden Living Center) is a 1-story building with a partial basement. The original building was constructed in 1961 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101	K 521		2/28/18

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K 521	Continued From page 2 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Findings Include: On facility tour between 01:00 PM and 05:00 PM on 1/26/2018, based on documentation review and interview that the following include: That the Facility needs a waiver for ventilation. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 521	K521 The facility will be requesting a waiver. Facility administrator or designee is responsible.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		2/28/18

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K 712	Continued From page 3 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to conduct fire drills for months of April, May, June, November and December per LSC 19.7.1.4-19.7.1.7 This requirements is not met as evidenced by failing to provide documentation to fire drills were completed. This deficient practice could affect the safety of all 54 the residents, staff and visitors within the Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 1/26/2018, observations and staff interview revealed the following: The Facility is missing fire drills for April, May, June, Nov, Dec. 2017 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	K712 Fire drills will be conducted and properly documented monthly. Facility administrator or designee is responsible.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		2/28/18

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K 914	Continued From page 4 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to, complete annual outlet testing in resident rooms per NFPA 99 6.3.4. The results could caused failure of the electrical outlets This deficient practice could affect the safety of all(54) of the residents, staff and visitors within the Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 1/26/2018, observations and staff interview revealed the following: The facility has not completed the annual testing of the resident outlets. This deficient practice was confirmed by the	K 914	K914 Outlet testing for resident rooms will be completed annually and properly documented. Facility administrator or designee is responsible.	

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K 914	Continued From page 5 Facility Maintenance Director at the time of discovery.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual 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	K 918		6/30/18

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K 918	Continued From page 6 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to conduct a monthly run test on generator per NFPA 99 6.4.4, 6.5.4 6.6.4 and NFPA 110. Based on observation and staff interview, the facility does not have an emergency shut down button for the generator per NFPA 110. This could cause the generator not a operate and be able to be shut down in an emergency. This deficient practice could affect the safety of all (54) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 1/26/2018, observations and staff interview revealed the following: 1. Documentation review indicated that the Facility need monthly generator testing completed. 2. Observation during the inspection the Generator has no emergency shut down switch. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918	K918 The generator will be tested monthly and properly documented. Completion 2/28/18 An emergency shutdown switch will be installed on the generator. Completion date 6/30/18 Facility administrator or designee is responsible.	

Name of Facility Rochester Health Care Center West

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 K521 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K067. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 3/17/18 for a complying ducted HVAC system is $ 126,200. 2. Efforts to obtain an estimate for a ducted system have been unsuccessful. 3. A ducted system would decrease the corridor headroom to less than that required by the LSC. 4. The building electrical system would need to be upgraded to support a new ducted system. 5. The ducted system would need to penetrate load bearing walls, decreasing building structural integrity. 6. Installation of a ducted system would require asbestos abatement which would increase the cost. 7. Existing non-complying HVAC systems can be allowed to continue in use. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 Edition. 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. Resident sleeping rooms do have smoke detectors in lieu of fire sprinklers. 4. The corridors are equipped with a complying smoke detection system. 5. The facility is in compliance with all other fire safety requirements, or 6. The facility has obtained an approved plan of correction for any other fire safety deficiencies that were cited. 7. This annual/continuing waiver has been approved in the past.

Surveyor *(Signature)*	Title	Office	Date

Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	03-07-2018