Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 27, 2023

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

RE: CCN: 245184
Cycle Start Date: January 12, 2023

Dear Administrator:

On February 23, 2023, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2023

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

RE: CCN: 245184
Cycle Start Date: January 12, 2023

Dear Administrator:

On January 12, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 12, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 12, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245184	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 1/12/2023
NAME OF PROVIDER OR SUPPLIER **ROCHESTER EAST HEALTH SERVICES**	STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge

Notice Requirements Before Transfer/Discharge
CFR(s): 483.15(c)(3)-(6)(8)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245184	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 1/12/2023
NAME OF PROVIDER OR SUPPLIER **ROCHESTER EAST HEALTH SERVICES**	STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN**		

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

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

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman (SO) of hospital transfer for 1 of 1 residents (R16) reviewed for hospitalizations.

Findings include:

R16's Admission Record printed 1/12/23, indicated R16 had diagnoses of Type 2 Diabetes Mellitus, paranoid personality disorder, nonalcoholic steatohepatitis (toxic buildup of fat in the liver), vascular dementia and carcinoma of right breast.

A progress note dated 1/7/23, at 3:11 p.m. indicated R16 had a change of condition and was difficult to arouse. R16 was laying in bed with eyes closed and stares when her eyes are open. Blood sugar was 171 and blood pressure 76/50. R16 was sent to the emergency department for evaluation and prompt treatment.

A progress note dated 1/10/23, at 5:57 p.m. indicated R16 returned to the facility back at her baseline physically, vitally and mentally.

During interview on 1/12/23, 11:20 a.m., the director of nursing (DON) indicated the previous social services director notified the SO but unsure who is completing task now but thinks it may be registered nurse (RN)-B or RN-A. The DON indicated RN-B is not at the facility today but maybe RN-A may have further information.

During interview on 1/12/23, at 11:30 a.m., RN-A indicated she had no idea who notified the SO regarding hospitalization and was not aware it needed to be completed.

During interview on 1/12/23, at 11:49 a.m., the vice president of success (VPS) indicated she was not aware of who was notifying the ombudsman and checked with the business office staff who indicated they were not notifying the SO regarding hospitalizations.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 During interview on 1/12/23, at 11:52 a.m. social services (SS) indicated she was not aware of the need to notify the State Ombudsman regarding hospitalizations and confirmed she has not been completing this task. An electronic mail (E-mail) was sent 1/12/23, at 12:01 p.m., to current SO for the facility to inquire about notifications regarding hospitalizations. The SO responded at 1:23 p.m., and indicated no notifications were received since January 2022. Facility policy and procedure titled Transfer and Discharge dated 7/15/22, included: Emergency Transfers/Discharges initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident...and social services director or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/9/23 to 1/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/9/23, to 1/12/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H51847248C (MN88526) H51847249C (MN87152) H51847266C (MN87092) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Electronically Signed — 02/09/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 01/12/2023

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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an interdisciplinary team assessment for safety was completed prior to self administration of medication for 1 of 1 resident (R32) reviewed for medication administration. Findings include: R32's Face Sheet printed 1/12/23, indicated diagnosis including asthma, type 2 diabetes mellitus, heart failure, kidney failure, high blood pressure and chronic pain. R32's significant change Minimum Data Set (MDS) assessment dated 10/15/22, indicated R32 was cognitively intact, had adequate hearing and vision and required supervision with eating, locomotion and toileting, and one person assist with dressing and personal hygiene. R32 received 4 days of insulin, and 7 days of diuretic, antidepressant and antibiotic. R32's Self-Administration of Medication Assessment dated 8/9/22, indicated R32 was considered safe for self-administration of Novolin N suspension twice a day and Victoza Solution	F 554	R32 was reassessed for self-administration of medication on 02/07/2023 and self-administration care plan and orders reviewed. Residents who self-administer medications have the potential to be impacted by the alleged practice. Residents who self-administer medications were reassessed and care plans and orders reviewed with updates if indicated. Self-administration assessments will be reviewed on a quarterly basis to determine if they need to be updated or revised. Education was provided by the Director of Nursing or designee to licensed nurses beginning February 2, 2023. Education included review of self-administration assessment, identifying which medications are approved for self-administration, and remaining with the resident while taking medications that are not approved for self-administration. Audits for compliance with	2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 554	Continued From page 2	F 554		

Pen injector 18 milligrams (mg)/3 milliliters (ml) daily, both medications to be kept with staff.

R32's physician orders included:
-Advair HFA 230-21 MCG/ACT 2 puffs inhaled orally two times a day
-Claritin 10 mg tablet by mouth one time a day
-Coreg 25 mg by mouth two times a day
-Cozaar 100 mg tablet by mouth one time a day
-torsemide 40 mg tablet by mouth one time a day
-Novolin N suspension inject 22 units subcutaneously one time a day
-Novolog FlexPen Solution 100 units/ml, inject 4 units subcutaneously one time a day
-Novolog Flex pen 100 units/ml, inject 6 units subcutaneously two times a day
-Plaquenil tablet 400 mg tablet by mouth one time a day
-Senokot-S tablet 8.6-50 mg tablet, 2 tablets by mouth two times a day
-vitamin D3 tablet 25 mcg by mouth one time a day
-Victoza pen-injector 18 mg/3ml, inject 1.8 mg subcutaneously one time a day
-artificial tears solution 1-0.3% instill 1 drop in both eyes as needed three times a day

R32's plan of care dated 8/9/22, indicated R32 may self-administer insulin, nebulizer and inhaler medications following set up by nursing staff.

During interview on 1/9/23, at 5:22 p.m., R32 indicated she can self-administer her insulin and check her own blood sugars. R32 indicated she requested to keep her glucose monitor and insulin in her room as she sometimes doesn't get her insulin pen until long after she eats her meal but has been told no32. R32 indicated she has a locked bedside storage container in her room and

self-administration policies will be completed by the Director of Nursing or designee with review of three residents weekly for four weeks, then two residents weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement for review and recommendations.

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	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 554	Continued From page 3	F 554		

is capable of doing things herself. R32 added she is independent in making her meals and doing all her own activities of daily living activities such as dressing, toileting and transferring herself and feels she is capable of self-administering all her own medications.

During observation and interview on 1/9/23, at 6:10 p.m., licensed practical nurse (LPN)-B entered R32's room with a tray that included insulin pen, glucometer and pill cup with 1 tablet present. LPN-B set the tray on the bedside table and left the room. R32 checked her blood sugar and took her oral medication and said she will wait until her meal is prepared to complete her insulin. LPN-B indicated the oral medication was Coreg 25 mg for blood pressure and heart failure. LPN-B indicated R32 is able to safely administer all her medication and will go back later and retrieve the insulin pen and glucometer.

During interview on 1/11/23, at 11:26 a.m., registered nurse (RN)-A indicated R32 is allowed to self administer her insulin's and check her blood sugar but both are kept in the carts and are brought into her to complete. RN-A indicated it has been a struggle as RN-A has found insulin pens in R32's room on multiple occasions long after self- administration and R32 gets upset if staff observe her self-administering her medications. RN-A added she is not allowed to self-administer her oral medications as R32 has a history of leaving her medications sitting on her bedside table and forgetting to take them.

During interview on 1/11/23, at 12:34 p.m., LPN-B indicated she had just brought R32's insulin pen and her oral medications and left them in R32's room.

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F 554	Continued From page 4	F 554		

During observation and interview on 1/11/23, at 12:36 p.m., R32 indicated she is allowed to take her oral medications and insulin without a nurse in the room. R32 had an empty pill cup sitting on the bedside table along with her insulin pen and said she had just taken her oral medications and her insulin.

During observation and interview on 1/12/23, at 7:46 a.m., LPN-D indicated she had just placed R32's insulin pens, glucometer, and oral medications including Cozaar, Claritin, Plaquenal torsemide, Vitamin D3 and 2 senna tablets in cup and sat on R32's bed side table on a tray. LPN-D indicated R32 can self-administer all her medications and gets upset if staff watch her. LPN-D indicated R32 generally gets up at 8:00 a.m. so she tries to set up her medications and insulin and put on a tray for her so they are all ready for her when she gets up.

During observation on 1/12/23, at 7:53 a.m., R32 was sleeping in her bed. 1 pill cup container with multiple pills, 1 inhaler, 1 eye drop bottle and 3 insulin pens was present on her bedside table.

During interview on 1/12/23, at 8:04 a.m., LPN-E indicated R32 may self-administer her insulin and inhalers/nebulizers, but not her oral medications.

During observation and interview on 1/12/23, at 8:28 a.m., R32 was sting in her wheelchair in her room. Insulin pens were sitting on the bed and the pill cup container was empty. R32 was checking her blood sugar and indicated she just took her oral medications, eye drops and inhaler and will give her insulin after she checks her blood sugar.

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F 554	Continued From page 5	F 554		

During interview on 1/12/23, at 9:02 a.m., the director of nursing (DON) indicated R32 can self-administer her own insulin but staff should be observing her. The DON indicated staff are to observe R32 take her oral medications and should not be left for her to take on her own. The DON indicated they previously tried allowing R32 to self-administer her oral medications and R32 would say she would take them later and then would forget. The DON indicated R32 should be reassessed for self-administration of her oral medications as she is independent with many of her own activities of daily living.

Facility policy and procedure titled Self-Administration by Resident dated 11/17, included:
-Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration.
-If a resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical and visual ability to carry out this responsibility during the care planning process.
-Results of the interdisciplinary team assessment are recorded on the "Medication Self-Administration Assessment" which is placed in the residents medical record.
-If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted.
-At least once during each shift, the nursing staff checks for usage of the medications by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ____ B. WING ____	C 01/12/2023

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

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F 554	Continued From page 6 resident. -If the interdisciplinary team determines that bedside or in-room storage of medications would be a potential safety risk to other residents, the medications of residents permitted to self-administer are stored in the central medication cart. -The decision that a resident has the ability to self-administer medications is subject to periodic assessment by the interdisciplinary team (IDT), based on changes in the resident's medical and decision-making status. If self-administration is determined not to be safe, the IDT should consider, based on the assessment of the residents abilities, options that allow the resident to actively participate in the administration of their medications to the extent that is safe.	F 554		
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. §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.	F 561		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 561	Continued From page 7 §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 observation, interview, and document review, the facility failed to ensure preference for location of dining were honored and implemented for 1 of 4 residents (R205) reviewed for food. Findings include: R205's face sheet printed on 1/12/23, included diagnoses of stroke, kidney disease and diabetes. R205's quarterly Minimum Data Set (MDS) assessment dated 11/18/22, indicated R205 was cognitively intact and was independent with eating. During an interview on 1/12/23, at 11:02 a.m., R205 stated no one had asked her where she preferred to eat -- her room, or the dining room, adding before Covid she always ate in the dining room. R205 stated as far as she knew, they couldn't eat in the dining room, adding she would like to as she missed socializing with other residents. During an interview and observation on 1/11/23, a 12:51 p.m., observed all but three residents on	F 561	R205 was informed she can choose where to eat her meals each day and that she can eat in the dining room if desired on January 16, 2023, and interviewed about her preference on February 7, 2023. She indicated during interview she will let staff know if she wants to eat in her room or the dining room as she likes to eat in both locations. Residents were informed that they can choose to eat in the dining room beginning January 16, 2023. A formal invitation was posted on January 31, 2023. A resident council meeting was held on February 1, 2023 and the ability to choose dining location was reviewed with residents during the meeting. An audit of resident's preference for dining location will be completed the week of February 6, 2023. Newly admitted residents are asked about their preference during the admission process. Care plans were updated with preference as needed. The Director of Nursing or designee provided education beginning February 2,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 561	Continued From page 8 second floor eating lunch in their rooms. Nursing assistant (NA)-B stated she heard residents were still eating in their rooms because there wasn't enough kitchen help to to serve food directly from the steam table in the second floor dining room. During an interview on 1/12/23, at 9:56 a.m., the director of nursing (DON) stated residents could eat in the dining room if they wanted, that dining rooms were back open, however could not answer how a resident would know that. The DON stated a resident just had to ask. The DON stated that pre-Covid 19 pandemic, residents ate in the dining room on second floor from food served directly from the steam table located in the dining room. The DON stated there wasn't a lot of room on second floor for social distancing, and there had been an issue with whether or not the kitchen had enough help to man the steam table. The DON stated leadership had discussed, but had not made a decision about residents resuming communal dining on second floor. During an interview on 1/12/23, at 10:33 a.m., (RN)-A stated residents could eat in the dining room if they wanted, but could not answer how a resident would know that. RN-A stated it was a question asked of new residents upon admission -- if they preferred to eat in their room or in the dining room however admitted she didn't communicate that preference to the nursing staff. RN-A stated they would need to reassess all residents for preferred location to eat. RN-A stated it would be time-saving for the nursing staff if residents could eat in the dining room and it would probably address cold food complaints. RN-A stated leadership had talked about cold food complaints in the past, but recalled something about dietary not having enough staff	F 561	2023, to licensed nurses and certified nursing assistants on serving residents meals in the dining room if that is their preference. The Infection Preventionist provided education to nursing and certified nursing assistants on current infection prevention and control practices beginning February 8, 2023. The Director of Nursing or designee will interview five residents weekly for four weeks, then two residents weekly for four weeks regarding their dining location preference and if this preference is being met. Results of audits will be forwarded to the quality assurance and performance improvement committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ____ B. WING ____	C 01/12/2023

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

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F 561	Continued From page 9 to serve food from the steam table on second floor. RN-A stated she wasn't aware of current guidelines regarding communal dining during Covid 19, but the IDT (interdisciplinary team) would meet and discuss it.	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman	F 583		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 583	Continued From page 10 to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to protect a resident's right to personal privacy and space for 1 of 1 resident (R24), who voiced concern regarding resident (R51) coming into room on multiple occasions without permission. Findings include: R24's quarterly Minimum Data Set (MDS) assessment dated 11/19/22, indicated R24 had moderately impaired cognition and required set-up from staff for activities of daily living (ADL). The MDS also indicated R24 had diagnosis including dementia (memory loss), epilepsy (seizure disorder), major depression, and homonymous bilateral field defects of right eye (vision loss). R51's quarterly MDS assessment dated 12/14/22, indicated R51 had severely impaired cognition, required supervision and limited staff assistance for ADLs. R51's care plan, printed on 1/11/23, indicated a history for wandering, interventions for staff consisted of; accompanying to meals and scheduled activities, calmly redirect to an appropriate area, engage in activities/tasks to keep occupied, observe for changes in mood/behavior/psychological needs/cognition, and to redirect when R51 around others that disturb R51 or that R51 disturbs. R51's face sheet, printed on 1/11/23, included diagnosis of; Alzheimer's disease (disorder of the brain causing memory loss and mental dysfunction)	F 583	R24 has not experienced further interruptions in her room by wandering residents since R51's planned discharge to home. A "PRIVACY" sign has been posted on R24's door. Residents who have difficulty with wandering have the potential to inadvertently enter another residents room. Review of current residents for this type of behavior will be completed and care plans updated if indicated. The Director of Nursing or designee provided education on methods to manage wandering behaviors to licensed nurses and certified nursing assistants beginning February 2, 2023. Audits and observations of residents will be completed by the Director of Nursing or designee three times weekly for four weeks then weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 583	Continued From page 11	F 583		

and cataract (cloudy vision).

R51's behavior monitoring form, reviewed from 12/13/22-1/11/23, indicated R51 displayed behaviors of frequent wandering, occasional repetitive movements and verbal threatening towards others.

During an observation and interview, on 1/9/23 starting at 3:50 p.m., ending at approximately 4:30 p.m., R24 indicated she was bothered by R51 always coming into room. R24 stated staff were aware of multiple incidents of R51 coming into room without permission, staff would come into room and escort R51 back to her room. Surveyor observed R51 come into R24's room 3 times during interview, R24 noted to be upset when R51 would open door, walk into room. R24 was witnessed saying to R51 in an irritated, angry manner "Get out of my room, this is not your room, go back to your own room". Staff were not present during time of interview with R24.

When interviewed, on 1/11/23 at 9:48 a.m., nursing assistant (NA)-A indicated awareness of R51 going into R24's room daily. NA-A stated when R51 went into R24's room, R24 would tell R51 to leave room; if staff present and visualized R51 going into R24's room, staff would escort R51 back to own room. NA-A stated R51 was provided constant re-direction when going into R24's room, which was effective only 25% of time, and not aware of any further interventions put in place to prevent R51 from going into R24's room. NA-A indicated awareness of R51 going into another resident's room a couple of months ago and had taken resident's cell phone, exact resident unknown. NA-A stated staff looked for missing cell phone for 2 days, found in R51's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 583	Continued From page 12 room after R51 called 911, 911 called facility to update about a report received by R51. During an interview, on 1/11/23 at 10:40 a.m., licensed practical nurse (LPN)-A indicated R24 reported to her a couple of times R51 had gone into her room. LPN-A stated she had placed a "do not enter" sign on R24's bathroom door, no longer there. LPN-A indicated staff had been providing re-education/re-direction when R51 wandered into R24's room. LPN-A stated she had brought concerns of R51 going into R24's room to the director of nursing (DON), approximately 1 month ago, the DON stated she would investigate situation further, no resolution to issue yet. While interviewed, on 1/11/23 at 2:18 p.m., the DON indicated awareness of R51 wandering into R24's room, issue brought to her attention per staff. The DON stated staff tried to involve R51 in various activities, tried to redirect R51 when going into R24's room. The DON indicated R24 had been informed to keep her door shut to keep R51 from wandering into room, and staff are looking into a room change for R51. Facility policy and procedure titled Resident Rights revised 7/22, indicated the resident has the right to personal privacy, the resident has the right to voice grievances to this facility or other agency concerning treatment/care/behavior of staff and/or other residents, deny visitors as chooses.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 585	Continued From page 13 §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 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	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 585	Continued From page 14 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, 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;	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 585	Continued From page 15 (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 observation, interview and document review, the facility failed to follow their grievance process for missing personal property for 1 of 1 resident (R9) who reported missing property in the facility. Findings include: R9's admission record printed,1/11/23, indicated R9 had diagnosis including dementia and type 2 diabetes mellitus. R9's quarterly Minimum Data Set (MDS) assessment dated 12/23/22, identified R9 had severely impaired cognition with cognitive decision making highly impaired. R9 required extensive assistance of two with all activities of daily living except eating which required supervision of one person. R9 had no partial dentures, missing or broken teeth and no difficulty with chewing or swallowing. R9's care care assessment (CAA) dated 6/22/22, indicated R9 was edentulous with no natural teeth and is on a mechanical soft diet.	F 585	R9 was referred to Apple Tree Dental for assessment of dental needs. Dental consult was completed on February 6, 2023. R9 was accompanied by her significant other for this appointment. Residents who misplace or lose an item have the potential to be impacted by this practice. Residents were educated on the grievance process during a resident council meeting completed on February 1, 2023. Grievance forms were placed where residents can easily access them on January 12, 2023. The Director of Nursing or designee provided education on the grievance process and responding to reports of lost or misplaced items to the interdisciplinary management team on February 2, 2023 and to the licensed nurses and nursing assistants beginning February 2, 2023. Audits will be completed by the Executive Director of designee on grievance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 16	F 585	reporting, response, and resolution three times weekly for four weeks then weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.	

R9's plan of care dated 8/5/22, indicated a self-care deficit with interventions including oral care for upper and lower dentures.

During interview on 1/9/23, at 2:20 p.m., R9's family member (FM)-D indicated R9's bottom denture plate disappeared about 6 months ago. FM-D added staff indicated R9 likely wrapped them up and threw them in the garbage. FM-D indicated administrative staff but was unable to identify who stated they would replace the lower denture plate and R9 could see the dentist here at the facility, but FM-D included so far no dentist has seen R9 and doesn't understand what the delay is. FM-D added he would also replace her top plate which is 25 years old. FM-D indicated R9 has been able to eat without difficulty but indicated R9 should have a bottom denture plate regardless.

During interview on 1/10/23, at 1:36 p.m., licensed practical nurse (LPN)-A indicated R9 has both upper and lower dentures and was not aware her bottom plate was missing. LPN-A observed R9 eating but indicated she was not able to determine if her bottom denture plate was missing or not.

During interview on 1/10/23, at 1:30 p.m., FM-D indicated dentures were lost about 4 months ago prior to her moving from 2nd floor to 3rd floor. FM-D again stated "she should have her bottom denture plate replaced".

During observation and interview on 1/11/23, at 8:53 a.m., R9 was in the dining room eating breakfast. R9 had her upper denture plate in her mouth, but bottom plate was not present in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 17	F 585		

mouth. R9 did not remember what happened to them.

During interview on 1/11/23, at 8:55 a.m., NA-D indicated R9's dentures have been missing for about two years.

During interview on 1/11/23, at 11:17 a.m., registered nurse (RN)-A indicated R9 was residing on the 2nd floor until October 2022. RN-A remembers R9's denture plate went missing and R9 would wrap the dentures in napkins and leave them sitting all over the place. RN-A indicated she remembers NA-E notifying her of the bottom denture plate missing but does not remember when or what happened to them. RN-A indicated R9 moved up to 3rd floor in October and at that time a care conference was held and the missing dentures were talked about at that time. RN-A indicated she can not make a promise about replacing dentures because she does not have the authority to do so. RN-A indicated FM-D still brings up the missing denture plate whenever he see's her. RN-A added they probably should have filled out a grievance form.

During interview on 1/12/23, at 7:48 a.m., NA-E indicated he was working on 2nd floor during late September 2022 or early October 2022, unable to recall specific date, and noticed R9 no longer had her bottom denture plate. NA-E contacted FM-D thinking he maybe took them home, but FM-D reported he had not. NA-E indicated he searched everywhere for them but was not able to locate the bottom denture plate. NA-E indicated he reported the denture plate missing to the nurse working that day (was not able to identify who was working) and the nurse manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585		F 585		

Continued From page 18

During interview on 1/11/23 at 11:59 a.m., the administrator indicated there were no grievance reports completed for R9 since admission.

During interview on 1/12/23, at 8:53 a.m., with vice president of success (VPS) and the director of nursing (DON), the DON indicated she was aware of the missing denture plate and the plan is to replace it. The VPS indicated they are in the process of switching companies for the dental contract and the last dental services offered at the facility was in September. The DON indicted R9 is on the list to see the dentist as soon as services at the facility resume. The DON indicated she did not complete a grievance form.

During interview on 1/12/23, at 9:00 a.m., the administrator indicated a grievance form should have been completed for R9's lost bottom denture plate for proper follow-up.

A facility policy and procedure titled Grievance Policy dated 2/2018, included:
-Residents will be in-serviced through Resident Council Meetings and on admission that they can access and initiate a concern form and that staff members, the residents family members/friends can assist them in completing the form upon request.
-A copy of the initiated concern form will be placed in the Grievance Notebook as a reminder that the grievance is still being investigated and resolved. The original form will be forwarded to the department head for which the grievance pertains.
-The department head that is assigned the concern form is responsible for investigating he issue and follow-up to provide a resolution to the issue within 72 hours of being assigned the

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	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 585	Continued From page 19 grievance.	F 585		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information	F 660		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 660	Continued From page 20 regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 660	Continued From page 21	F 660		

Based on interview, and document review, the facility failed to develop and implement an effective discharge planning process that included the resident and/or responsible party for 1 of 1 resident (R53) closed record reviewed for discharge planning.

Findings include:

R53's Admission Record printed 1/12/23, indicated R53 was admitted to the facility on 10/5/22, and discharged to home on 10/15/22, diagnoses included compression fracture of vertebra, muscle weakness, repeated falls, abnormalities of gait and mobility, lack of coordination, need for assistance with personal care, severe protein-calorie malnutrition, dementia, and Alzheimer's disease

R53's admission Minimum Data Set (MDS) assessment dated 10/12/2, indicated R53 was rarely or never understood, short term and long term memory problem, severely impaired cognition, required two-person assist for bed mobility, transfers, dressing, toilet use, personal hygiene; one-person assist with eating, and utilized a wheelchair. MDS indicated discharge plan in place for resident to return to the community.

R53's care plan dated 10/10/22, indicated R53 does not show potential for discharge to the community due to physical care needs and interventions included provider referrals to area centers upon request, reassess care needs and potential for discharge as needed, support resident, family, and or representative as needed.

Progress note dated 10/5/22, indicated R53 was

R 53 no longer resides at facility.

Residents who discharge from the facility to home or another care facility have the potential to be impacted by the alleged practice. The Director of Nursing implemented a discharge audit tool to ensure that discharge documentation is provided to the resident and recapitulation of stay is completed upon discharge.

Education was provided to the interdisciplinary team by the Director of Nursing or designee on February 2, 2023. Review of the discharge process was completed by the Director of Nursing or designee with licensed nurses beginning February 2, 2023.

Audits for compliance with discharge practices will be completed by the Director of Nursing or designee for each discharge for eight weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 660	Continued From page 22	F 660		

admitted from the hospital, in a wheelchair, with a T12, L1, and L2 fracture from a recent fall. The note further indicated R53 was at the facility for short term rehab, before hospitalization was living at home with the son and the son reported that over the last few months, R53 has been declining, and he doesn't think that he and his brother are able to give her the care she needs anymore. Looking into options for more long term care. Resident is very pleasant, she has advanced dementia. She does not have any complaints of pain, and is on scheduled Tylenol for pain management.

R53's record review failed to indicate the facility provided documents, or information regarding facility discharge planning to R53 or R53's representative.

On 1/12/23, at 10:47 a.m. vice president of success (VPS) indicated the facility process for resident discharge included recapitulation of stay, and a brief discharge summary. The VPS confirmed a discharge summary was not completed for R53. The VPS indicated the discharge was initiated by R53's representative after 10 days and insurance no longer paying for the stay. VPS confirmed the facility did not provide discharge planning for R53 through interdisciplinary team involvement, discharge notes, or a discharge summary. The VPS indicated would expect discharge planning starting on admission and during care plans.

On 1/12/23 at 10:54 a.m. the director of nursing indicated R53's family abruptly discharged R53 home, and stated discharge planning was difficult due to R53's short stay at the facility. The DON confirmed a recapitulation or discharge summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 660	Continued From page 23 of R53's stay at the facility was not done. Facility policy titled Transfer and Discharge dated 7/15/22, indicated Anticipated Transfers or Discharges -initiated by the resident a. Obtain physician orders for transfer or discharge and instructions or precautions for ongoing care. b. A member of the interdisciplinary team completes relevant sections of the discharge summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge summary is complete and included but not limited to the following: i. A recap of the residents stay that included diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. ii. A final summary of the resident's status iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications iv. A post discharge plan of care that is developed with the participation of the resident, and the resident representative which will assist to adjust to his or her new living environment. c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team. d. Assist with transportation arrangements to the new facility and any other arrangements as needed. e. The comprehensive, person-centered plan shall contain the resident's goals for admission	F 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 660	Continued From page 24 and desired outcomes and shall be in alignment with the discharge. f. Supporting documentation shall include evidence of the residents or residents representative verbal or written notice of intent to leave the facility, a discharge plan and documented discussion with the resident or resident representative.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and	F 661		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 661	Continued From page 25 non-medical services. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete summaries of the resident stay (recapitulation) and medication reconciliation for 1 of 1 resident (R53) reviewed for closed record discharge. Findings include: R53's Admission Record printed 1/12/23, indicated R53 was admitted to the facility on 10/5/22, and discharged to home on 10/15/22, diagnoses included compression fracture of vertebra, muscle weakness, repeated falls, abnormalities of gait and mobility, lack of coordination, need for assistance with personal care, severe protein-calorie malnutrition, dementia, and Alzheimer's disease R53's admission Minimum Data Set (MDS) assessment dated 10/12/22, indicated R53 was rarely or never understood, short term and long term memory problem, severely impaired cognition, required two-person assist for bed mobility, transfers, dressing, toilet use, personal hygiene, one-person assist with eating, and utilized a wheelchair. MDS indicated discharge plan in place for resident to return to the community. R53's care plan dated 10/10/22, indicated R53 does not show potential for discharge to the community due to physical care needs and interventions included provider referrals to area centers upon request, reassess care needs and potential for discharge as needed, support resident, family, and or representative as needed.	F 661	R 53 no longer resides at facility. Review of documentation completed and validated resident received list of reconciled medications at discharge. Residents who discharge from the facility to home or another care facility have the potential to be impacted by the alleged practice. The Director of Nursing implemented a discharge audit tool to ensure that discharge documentation is provided to the resident, including reconciliation of medications, and recapitulation of stay is completed upon discharge. Education was provided to the interdisciplinary team by the Director of Nursing or designee on February 2, 2023. Review of the discharge process was completed by the Director of Nursing or designee with licensed nurses beginning February 2, 2023. Audits for compliance with discharge practices will be completed by the Director of Nursing or designee for each discharge for eight weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 661	Continued From page 26	F 661		

Progress note dated 10/5/22, indicated R53 was admitted from the hospital, in a wheelchair, with a T12, L1, and L2 fracture from a recent fall. The note further indicated R53 was at the facility for short term rehab, before hospitalization was living at home with her son and the son reports that over the last few months, R53 has been declining, and he doesn't think that he and his brother are able to give her the care she needs anymore. Looking into options for more long term care. Resident is very pleasant, she has advanced dementia. She does not have any complaints of pain, and is on scheduled Tylenol for pain management.

R53's record review failed to indicate the a recapitulation of the stay, lacked medication reconciliation or a discharge summary.

On 1/12/23, at 10:47 a.m. vice president of success (VPS) indicated facility process for resident discharge included recapitulation, and a brief discharge summary, the VPS confirmed a discharge summary was not completed for R53. The VPS indicated the discharge was initiated by R53's representative after 10 days and insurance no longer paying for the stay. VPS confirmed the facility did not provide discharge planning for R53 through interdisciplinary team involvement, discharge notes, or a discharge summary. The VPS indicated would expect discharge planning starting on admission and during care planning.

On 1/12/23 at 10:54 a.m. the director of nursing (DON) indicated R53's family abruptly discharged R53 home, and stated discharge planning was difficult due to R53's short stay at the facility. The DON confirmed a recapitulation or discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 661	Continued From page 27	F 661		

summary of R53's stay at the facility was not done.

Facility policy titled Transfer and Discharge dated 7/15/22, indicated:
Anticipated Transfers or Discharges -initiated by the resident
a. Obtain physician orders for transfer or discharge and instructions or precautions for ongoing care.
b. A member of the interdisciplinary team completes relevant sections of the discharge summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge summary is complete and included but not limited to the following:
i. A recap of the residents stay that included diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
ii. A final summary of the resident's status
iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications
iv. A post discharge plan of care that is developed with the participation of the resident, and the resident representative which will assist to adjust to his or her new living environment.
c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team.
d. Assist with transportation arrangements to the new facility and any other arrangements as needed.
e. The comprehensive, person-centered plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 661	Continued From page 28 shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge. f. Supporting documentation shall include evidence of the residents or residents representative verbal or written notice of intent to leave the facility, a discharge plan and documented discussion with the resident or resident representative.	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 676	Continued From page 29	F 676		

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided, including shaving for 1 of 2 residents (R48) reviewed, who needed staff assistance to maintain good personal hygiene.

Findings include:

R48's annual Minimum Data Set (MDS) assessment, dated 11/25/22, indicated R12 had severe cognitive impairment and required 1 staff to assist for personal hygiene.

R48's care plan, printed on 1/11/22; indicated R48 prefers to shower every Saturday on pm shift; required assist of 1 staff member for showering and personal hygiene needs.

R48's task report titled, trim or remove unwanted facial hair, reviewed from 12/30/22-1/11/23; indicated R48 was provided shaving of facial hair daily.

During observation, on 1/09/23 at 4:05 p.m., R48 was observed to have long, white facial hair present to chin and above right side of lip, which

Provider's Plan of Correction:

R48 was assisted with removal of facial hair on 01/11/2023. Care plan and task list were reviewed and updated if indicated.

Residents who need assistance with removal of facial hair have the potential to be impacted by the alleged practice. Care plan and task lists were reviewed for like residents and updated if indicated.

The Director of Nursing or designee provided education beginning February 2, 2023 to licensed nurses and certified nursing assistants on providing assistance with grooming and shaving with routine cares.

The Director of Nursing or designee will complete audits of grooming for five residents weekly for four weeks, then two residents weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 30	F 676		

continued to be noted upon visualization on 1/10/23 at 12:26 p.m. and again on 1/11/23 at 9:27 a.m.

While interviewed, on 1/11/23 at 10:06 a.m., nursing assistant (NA)-A indicated awareness R48 preferred facial hair to be removed and clean shaven daily. NA-A stated R48's facial hair grew very fast and required staff assistance with shaving cares to maintain good hygiene.

During interview and observation, on 1/11/23 at 10:57 a.m., licensed practical nurse (LPN)-A indicated awareness R48 preferred face to be clean shaven, and needed staff assistance to maintain good hygiene. LPN-A indicated R48 was shaved on her scheduled bath days, every p.m. on Saturdays, as well as when noticed and needed during routine cares. LPN-A visualized R48's facial hair above right lip and to chin, and verified long facial hair present to areas, should've been removed per staff during routine cares.

While interviewed and during observation, on 1/11/23 at 2:47 p.m., the director of nursing (DON) indicated R48 needed staff assistance for personal hygiene needs, including shaving. DON stated residents were provided shaving cares on scheduled bath days and anytime when needed. The DON visualized R48's facial hair above right lip and to chin, and verified long facial hair present to chin and above right lip, should've been removed per staff during routine cares.

Facility policy titled Activities of Daily Living (ADLs) revised on 7/26/22, indicated the facility will, based on the resident's comprehensive assessment and consistent with the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 676	Continued From page 31 needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable, Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming, and oral care.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow physician orders for leg wraps for 1 of 1 resident (R205) reviewed for edema, and failed to ensure proper wheelchair positioning for 1 of 1 resident (R25) reviewed for positioning. Findings include: R205's face sheet printed on 1/12/23, included diagnoses of stroke, kidney disease, morbid obesity, and diabetes. R205's quarterly Minimum Data Set (MDS) assessment dated 11/18/22, indicated R205 was cognitively intact, had adequate vision and hearing, required extensive assistance of one or two staff for bed mobility, transfers and toileting, and was independent in moving about the unit in	F 684	Leg wraps were obtained for R205 and provided to caregivers on January 12, 2023. Leg wraps were applied as ordered and staff were advised where additional wraps are stored should they need them in the future. R25 was referred to OT for seating assessment on January 12, 2023 and a new wheelchair has been procured for R25. Care plan and task list were updated if indicated. Residents who require specialized seating or those who elect to refuse certain cares have the potential to be impacted by the alleged practice. Residents using specialized chairs such as BRODA, INVACARE, or Rock and Go will be reviewed for appropriate positioning and referred to OT if indicated. Residents who	2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 684 Continued From page 32
a wheelchair. R205 did not walk.

R205's care plan with date range of 6/13/18, to 2/12/23, did not address wraps for lower leg edema.

R205's physician orders dated 9/20/22, indicated bilateral low stretch wraps, on in the morning and off at bedtime, and staff were to document refusal.

R205's TAR (treatment administration record) indicated bilateral low stretch wraps were applied 30/30 days in November 2022; 24/30 days in December 2022; and 2/12 days in January 2023. In the TAR when wraps were not applied, nursing staff entered a number that corresponded to a reason they were not applied. The reasons ranged from refusals, to absent without medications, sleeping, or other. There was to be a corresponding progress note if the resident refused. There was no documentation of leg wrap refusals in R205's EMR (electronic medical record) in December or January.

During an interview and observation on 1/9/23, at 3:35 p.m., R205 was in her room, in her wheelchair. Observed both lower legs to be edematous. R205 stated staff used to wrap her legs...but not anymore, adding they had not been wrapped for about three weeks.

During an interview and observation on 1/10/23, at 1:08 p.m. in R205's room, along with licensed practical nurse (LPN)-E, observed R205's edematous lower legs. LPN-E stated she needed her legs wrapped, adding there were no wraps available..."I've told about 10 people," but couldn't recall who or when.

F 684

use leg wraps to manage edema were identified and orders, care plans, and TARs reviewed and updated if indicated.

The Director of Nursing or designee provided education beginning February 2, 2023 to licensed nurses and certified nursing assistants on wheelchair positioning and following physician orders, completing prescribed treatments and managing and documenting refusals of prescribed treatments.

The Director of Nursing or designee will audit compliance with resident treatments, documentation and follow up on refusals on five residents weekly for four weeks then two residents weekly for four weeks. The Director of Nursing or designee will audit wheelchair positioning for five residents weekly for four weeks then two residents weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.

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F 684	Continued From page 33	F 684		

During an interview and observation on 1/12/23, 8:28 a.m., after observing lower leg wraps on R205, LPN-E stated he informed registered nurse (RN)-A about the lack of wraps the day before and was informed there were extra wraps in the laundry department that could be used.

During an interview on 1/12/23, at 10:44 a.m., RN-A stated R205 had had lower legs wraps for a long time and they might have gone to the laundry and been lost. RN-A stated nurses didn't tell her R205 no longer had leg wraps until 1/11/23, when LPN-E told her. RN-A stated when staff were not able to find something, they didn't always pursue it by telling someone who could address it. During review of R205's TAR, RN-A confirmed when refusals of leg wraps had been documented on the TAR, there were no corresponding progress notes. RN-A confirmed the physician order indicated to document refusal of leg wraps. RN-A verified the last time R205 consistently had leg wraps applied was in November 2022.

During an interview on 1/12/23, at 12:29 p.m., the director of nursing (DON) and vice president of success (VPS) were informed of findings. The VPS stated they had not been aware of this, and couldn't assist staff if not informed. The DON stated there had been extra leg wraps in the laundry department that could have been used. Both acknowledged nurses were expected to follow physician orders, and also expected to inform someone when resident supplies were not available.

Facility policies were requested for leg edema and/or leg wraps, and following physician orders.

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	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 684	Continued From page 34	F 684		

None were received.

R25
R25's quarterly MDS assessment, dated 12/8/22, indicated R25 had severely impaired cognition and diagnoses which included Alzheimer's dementia (memory loss), osteoarthritis (degenerative joint disease), low back pain, chronic pain syndrome. The MDS further indicated R25 required extensive assistance with bed mobility and transfers, required staff assistance with locomotion on and off unit, had no impairment of all extremities, and used a wheelchair for mobility.

R25's care plan, printed on 1/11/23, instructed staff to provide assist of 1 staff with locomotion, monitor and report changes in physical functioning ability, rehab therapy services as ordered, position in an upright position for meals to enhance focus on eating task, explore non-pharmacological pain alleviating interventions such as repositioning if R25 became restless/exhibited facial grimacing, provide pressure reducing wheelchair cushion.

Review of R25's occupational therapy (OT) recert, progress report, and updated therapy plan; last certification period dated 7/10/20-8/8/20, indicated R25 was provided a high back wheelchair with left lateral support, elevating leg rests, calf, and foot support.

During an observation, on 1/09/23 at 5:53 p.m., while R25 was sitting in dining room at table being assisted with feeding per staff; R25 noted to be leaning to left side of rock-n-go recliner (Tilt-N-Space recliner, rocking) wheelchair armrest, head and chin tilted forward towards

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	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 684	Continued From page 35	F 684		

chest, legs wrapped in Rooke boots (boot designed for protection and insulation of lower extremities), legs dangling towards flooring.

While visualized, on 1/11/23 at 9:29 a.m., R25 was observed asleep in rock-n-go recliner wheelchair, back was leaning to left side of chair armrest, head was propped on corner edge of a pillow that was buckled/secured to top of chair, legs dangling towards flooring.

During an interview, on 1/11/23 at 9:43 a.m., nursing assistant (NA)-A indicated R25 had a rock-n-go recliner wheelchair, had had for a couple of years. NA-A stated she often sees R25 leaning to one side of chair throughout the day, and needed to be repositioned in wheelchair frequently per staff. NA-A indicated R25 had foot pedals for feet, but too short, and did not really need foot pedals with Rookie boots in place. NA-A indicated awareness of pressure reducing device for R25's wheelchair, had not used for a couple months, as R25 would scoot more in seat with use of pressure reducing device. NA-A stated staff to ensure R25 sitting upright at 90-degree angle when eating to reduce choking, and was not aware of any other interventions or devices used while R25 up in rock-n-go recliner wheelchair.

While interviewed, on 1/11/23 at 10:35 a.m., licensed practical nurse (LPN)-A indicated R25 had a rock-n-go recliner wheelchair, often noted R25 leaning to one side of chair. LPN-A indicated R25's care plan included to ensure R25 was sitting upright in rock-n-go recliner wheelchair while eating, stated unawareness of any supportive devices to be used in wheelchair. LPN-A indicated R25 had not been evaluated for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 684	Continued From page 36	F 684		

wheelchair positioning within past year to her knowledge, stated staff could request physical therapy (PT) or occupational therapy (OT) evaluations if positioning concerns including; noticing residents sliding out of wheelchair, leaning to sides or forward in wheelchair, or wheelchair appearing to be of inappropriate size.

During an interview, on 1/11/23 at 2:25 p.m., the director of nursing (DON) indicated awareness of R25 having a rock-n-go recliner wheelchair, had had for many years. The DON stated she was not aware of R25 having any positioning concerns when sitting in her wheelchair, and stated if staff notice residents sliding out of wheelchair or leaning to one side of wheelchair, the standard protocol was for staff to notify PT/OT and request an evaluation for positioning needs. The DON stated she was unaware if PT/OT had ever evaluated R25 for wheelchair positioning, and would need to confer with therapy department.

During observation on 1/12/23 at 7:22 a.m., R25 was visualized sitting in rock-n-go recliner wheelchair at dining room table, leaning towards left side of chair armrest, foot pedals attached to front of wheelchair and stationed high, bilateral legs/feet dangling down towards flooring. R25 was observed to have facial grimacing at time, was moving to arch back while sitting in rock-n-go recliner wheelchair.

During an observation and interview, on 1/12/23 at 8:44 a.m., certified occupational therapy assistant (COTA)-E observed R25 sitting in rock-n-go-recliner wheelchair, indicated R25 was arching back while sitting in recliner wheelchair, stated R25 appeared uncomfortable. COTA-E stated leg/footrest positioned on recliner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 684	Continued From page 37	F 684		

wheelchair were placed inappropriately, too high up for R25 to reach; confirmed appropriateness for re-evaluation of R25's positioning and wheelchair needs. COTA-E indicated upon review of therapy department progress notes, R25 was last evaluated for wheelchair positioning on 7/15/20, unsure how often residents positioning needs are re-evaluated, needed to check with physical therapy assistant (PTA)-F.

During an interview and observation, on 1/12/23 at 9:00 a.m., PTA-F indicated residents were routinely screened for positioning/mobility needs as part of the quarterly MDS assessments. PTA-F stated R25's positioning/mobility screen appeared appropriate during last MDS review on 12/8/22. PTA-F observed R25 sitting in rock-n-go-recliner wheelchair, indicated footrest in place at time were not the footrests originally placed per therapy department. PTA-F stated per R25's last therapy note, R25 was to be placed in a high back wheelchair with left lateral support, have elevating leg rests, calf, and foot support. PTA-F indicated upon observation of R25 and wheelchair at time, the wheelchair R25 was in was not the wheelchair provided per therapy department in 7/2020, stated she had remembered previous nursing case manager of unit replaced R25's wheelchair provided per therapy department approximately 1 year ago, reason unknown. PTA-F indicated when nursing staff notice changes/decline in resident mobility, licensed nursing would complete a mobility assessment, then refer resident to PT/OT for further evaluation/re-evaluation. PTA-F stated she had met with DON yesterday to discuss R25's positioning/wheelchair needs, and planned to have orders for re-evaluation today.

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	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 684	Continued From page 38 Facility policy for positioning was requested, and not received.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure services were provided to maintain and prevent loss of range of motion (ROM) for 1 of 2 residents (R21) reviewed for contractures and limited ROM. Findings include: R21's significant change in status Minimum Data Set (MDS) assessment, dated 12/7/22, indicated R21 had severely impaired cognition and no rejection of cares. R21 had functional limitations in activities of daily living (ADL), impairment of left	F 688	R21's splint was located and applied to left hand as ordered. Care plan and task list were reviewed and revised to ensure use of splint and completion of passive range of motion exercises is documented in daily task charting. Residents who require the use of splints or similar devices and those that have passive or active range of motion exercises recommended by therapy have the potential to be impacted by this practice. Physician orders, care plan and	2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 39	F 688		

upper and lower extremity; required extensive assistance from 2 staff members with bed mobility, transfers, dressing, toileting, personally hygiene, and 1 staff assist to support with eating. R21 did not ambulate. The MDS further indicated diagnosis including hemiplegia (paralysis) affecting left side, dysphagia (swallowing difficulty), brain disorder, epilepsy (seizure), and neuralgia and neuritis (inflammation and pain of nerves), and hospice care.

R21's care plan, printed on 1/11/23, indicated for rehab as ordered, don left soft hand splint with/AM care and remove after lunch, monitor, and report changes in physical function ability, monitor and report changes in ROM ability, passive range of motion (PROM) to left upper extremity (LUE) to patient tolerance. PROM exercises instructed staff to complete twice daily- once in AM and once in PM, PROM exercises included lift left arm up towards ceiling x10, bend and straighten elbow x10, bend and straighten wrist x10, open/close hand (bend and straighten fingers) x10.

Review of Occupational Therapy Treatment Encounter Note (s), dated 8/14/20, indicated due to increased risk of skin breakdown/contractures; R21 to wear left resting hand splint, discussed wear schedule, application/removal process for certified nursing assistants (CNAs).

Review of Therapy Communication to Nursing form, orders originally dated 4/13/18, renewed orders dated 6/29/22; informed staff to complete PROM to left and right upper extremities twice daily, once in a.m. shift and once in p.m. to patient tolerance. Directions included lift left and right arm up towards ceiling x10, bend and

task lists were reviewed and updated if indicated.

The Director of Nursing or designee provided education to licensed nurses and certified nursing assistants beginning February 2, 2023 on compliance with use of splints or similar devices and benefits to the resident and staff with completion of range of motion exercises.

The Director of Nursing or designee will complete audits including direct observation of the use of splints or other devices, documentation of passive or active range of motion exercises and follow-up on refusals for five residents weekly for four weeks, then two residents weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 688	Continued From page 40	F 688		

straighten elbow x10, bend and straighten wrist x10, open/close hand (bend and straighten fingers) x10.

On 1/9/23 at 5:18 p.m., R21 was observed sitting in broda recliner chair, left upper extremity lying on a pillow across her chest, fingers of left hand appeared rigid and curled in towards palm of hand. When R21 tried to open her hand to extend fingers, all fingers of left hand observed to be slightly rigid with extension. R21 was asked if she wore a hand splint for left hand, she replied no, but would like to. R21 was asked if she received any restorative nursing exercises for upper extremities, she replied no, but would like to.

During an observation, on 1/10/23 at 11:47 a.m., R21 was observed sitting in broda recliner chair in dining room, left upper extremity noted resting on pillow across her chest, left hand splint not in place.

During interview and observation on 1/10/23 at 1:30 p.m., nursing assistant (NA)-C indicated awareness of R21's left hand contracture, unaware if R21 was to wear a left-hand splint, and stated R21 did not receive any restorative nursing exercises for bilateral upper extremities to her knowledge. NA-C stated resident therapy orders could be found in point click care (PCC) under NA task list and in a black binder labeled, FMP functional maintenance program, book kept at nursing station. NA-C was observed to look at NA task list in PCC regarding cares needing to be completed for R21, and was unable to verify NA task included application/removal of left-hand splint or bilateral upper extremity restorative nursing exercises for R21. NA-C was visualized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 688	Continued From page 41 to have found active orders for R21's restorative nursing exercises for staff to complete in a black binder labeled, FMP functional maintenance program, at nursing station. R21's orders noted per therapy communication, originally dated 4/13/18, revised date 6/29/22, indicated for staff to complete PROM to bilateral upper extremities 2x/day in AM and PM- lift left and right arm up towards ceiling x10; bend and straighten elbow x10, bend and straighten wrist x10, open/close hand (bend and straighten fingers) x10. During an interview and observation, on 1/11/23 at 10:53 a.m., licensed practical nurse (LPN)-A indicated unawareness of left-hand contracture for R21, unaware if R21 had orders for left hand splint or restorative nursing exercises. LPN-A stated if R21 had orders for left hand splint or restorative nursing exercises, could find in physician orders or care plan. LPN-A was observed to look at R21's care plan in PCC, and verified R21 had orders for left soft hand splint and PROM exercises for bilateral upper extremity to be completed per staff per care plan. While interviewed, on 1/11/23 at 1:50 p.m., physical therapy aide (PTA)-F indicated R21's last note addressing left hand splint was 8/14/20, splint continued to be appropriate for use with known left-hand contracture. PTA-F stated R21's PROM was readdressed on 6/24/22, and was deemed appropriate to continue. PTA-F indicated awareness R21 had transitioned to hospice, unsure if hospice would have discontinued therapy recommendations, if hospice did not discontinue therapy orders, staff should still be continuing per therapy recommendations, unless R21 refused care.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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

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F 688	Continued From page 42	F 688		

During an interview, on 1/11/23 at 2:38 p.m., the director of nursing (DON) indicated awareness of R21's left-hand contracture. DON verified R21's care plan orders for soft hand splint to be applied by NA in AM and removed at lunch time. DON stated NAs to complete R21's PROM exercises needed, stated no restorative nurse at time. The DON indicated if NA unaware of resident needed cares, can pull up NA task list (Kardex) in PCC, stated orders on care plan flow over to NA task list (Kardex) for documentation. The DON reviewed R21's cares on NA task list (Kardex) and verified R21's care plan orders for left soft hand splint and PROM restorative exercises had not flowed over to NA task list (Kardex), therefore R21 had not been receiving left soft hand splint for contracture or PROM restorative exercises for limited ROM. The DON indicated R21 had been in the hospital a couple of months ago, orders must have dropped off during hospitalization, and R21 now on hospice care.

While interviewed, on 1/12/23 at 10:41 a.m., hospice nurse (HN)-G indicated R21's orders for left soft hand splint and PROM to upper extremities were not discontinued per hospice team. HN-G stated it would be good for R21 to continue to use left soft hand splint, if R21 wants to use it and remains comfortable, as use of splints typically keep skin from breakdown with contractures. HN-G indicated R21 should continue PROM exercises to bilateral upper extremities as tolerable to prevent further limitation in ROM.

Facility policy for ROM was requested, received a policy titled Activities of Daily Living (ADLs), dated 7/26/22; indicated the facility will, based on the resident's comprehensive assessment and

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F 688	Continued From page 43 consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable, the facility will provide a maintenance and restorative program as applicable to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. Tips for improving or maintaining ADL skills: training of nursing staff in restorative care concepts, involvement of the therapy or restorative nursing personnel to retrain resident, responding to decline in ADL skills as a change in medical condition.	F 688		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		2/21/23

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F 755	Continued From page 44 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for routine reconciliation of controlled substance medications in 2 of 2 medication carts and destroyed controlled substance medications for 1 of 2 medication rooms. Findings include: During initial tour of medication room on floor 3 on 1/10/23, at 1:44 p.m., with licensed practical nurse (LPN)-A indicated destruction of narcotics required 2 nursing staff, demonstrated by signing off on the "Medication Destruction Form". Review of "Medication Destruction Forms" was completed and LPN-A confirmed there were 4 entries that included only one signature. The Medication Destruction Forms included: -12/28/22 hydromorphone 1 mg/ml, quantity 60 ml's and signed by licensed practical nurse (LPN)-C. -12/14/22 oxycodone 5 mg tablets quantity of 27, signed by LPN-C -12/6/22 oxycodone 5 mg tablets quantity of 27 signed by LPN-C -11-16-22 oxycodone 5 mg tablets quantify of 24 half tablets, signed by LPN-C.	F 755	No identified resident was recorded. Residents have the potential to be impacted by the alleged practice. VPS reviewed process for medication destruction with LPN who had one signature on destruction logs. LPN demonstrated there were two signatures on narcotic page recording the four destructions on separate narcotic sign out pages. Educated on the need to have two signatures on the destruction log form and verbalized understanding. Narcotic shift to shift books were moved to the medication carts from the nurses desks to increase compliance with signing out shift to shift narcotic counts. The Director of Nursing or designee provided education beginning February 2, 2023 to licensed nurses on narcotic accountability and medication destruction process. The Director of Nursing or designee will audit the shift to shift narcotic logs five times weekly for four weeks for compliance with shift to shift counting.	

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F 755	Continued From page 45 During interview regarding narcotic counts on 1/10/23, at 2:10 p.m., LPN-A indicated the narcotic reconciliation are completed at the end of each shift using the "Narcotic Book" and they sign on a separate sheet at the nurses station in a binder. Upon review of signatures, it was noted multiple counts lacked signatures. LPN-A indicated they are required and should be signed off by both staff at the end of each shift. During interview and review of narcotic count book on 2nd floor on 1/11/23, at 9:45 a.m., LPN-B indicated narcotic reconciliation is required at the end of each shift using the "Narcotic book" on each cart and signed off by the two staff who complete it. Review of Controlled Substance Count Sheets from 2nd floor included: 1/2023: 13 of 33 possibilities completed with 2 signatures present 12/2022: 26 of 93 possibilities completed with 2 signatures present 11/2022: 54 out of 90 possibilities with 2 signatures present 10/2022: 31 out of 93 possibilities with 2 signatures present Review of Controlled Substance Count Sheets from 3rd floor included: 1/2023: 21 out of 27 possibilities with 2 signatures present 12/2022: 54 out of 93 possibilities with 2 signatures present 11/2022: 83 out of 90 possibilities with 2 signatures present 10/2022: 33 out of 93 possibilities with 2 signatures present	F 755	The Director of Nursing or designee will audit destruction logs twice weekly for four weeks for compliance with two staff signatures for medication destruction. Results of audits will be forwarded to the quality assurance and performance improvement committee for review and recommendations.	

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F 755	Continued From page 46 During interview on 1/11/23, at 7:19 a.m., the vice president of success (VPS) confirmed 2 nurses are required for destruction of all narcotic medications. During interview on 1/12/23, at 9:10 a.m., the VPS confirmed narcotic counts require two staff and two signatures of completion and confirmed that has not been completed upon review. Facility policy and procedure titled Controlled Medication Storage dated 11/17, included at each shift change or when keys are surrendered, a physical inventory of all schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. Facility policy and procedure titled Disposal of Medications, Syringes and Needles dated 12/12, included: - For the State of Minnesota, controlled substances shall be disposed of by the nursing care center in the presence of appropriately titled professionals which includes two licensed nurses employed by the nursing care center. -A controlled medication disposition log or equivalent form, shall be used for documentation and shall be retained as per federal privacy and state regulations. This log shall contain the resident's name, medication name and strength, prescription number, quantity/amount disposed, date of disposition and signatures of the required witnesses.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals	F 761		2/21/23

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F 761	Continued From page 47 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 2 of 2 refrigerators observed in use for medication storage. This had potential to affect 2 of 2 residents (R21, R38) residing in the facility who receive this medication and 2 of 2 residents (R155 and R156) who were discharged.	F 761	R21 Ativan has been secured in container in medication refrigerator. R38 no longer resides at facility and ativan was destroyed as per policy. Residents who have Ativan stored in the medication refrigerator have the potential to be impacted by this practice. Review of medications stored in the refrigerators was completed. Secured containers have	

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F 761	Continued From page 48 Findings include: During observation and interview on 1/10/23, at 1:44 p.m., in the medication room on floor 3 with licensed practical nurse (LPN)-A, a refrigerator was present and secured with a padlock. LPN-A opened the refrigerator, and 2 boxes of lorazepam concentrate (Benzedrine used to treat seizures and anxiety and a schedule IV controlled substance) 2mg/ml were present in the door. One was labeled for R21 and one for R38. LPN-A indicated inside the door is where they normally store residents lorazepam. Multiple insulin pens were also present in the refrigerator. During observation and interview on 1/11/23, at 9:45 a.m., LPN-B opened the locked refrigerator in the medication room on floor 2. Lorazepam 2 mg/ml 2 boxes were present in the door along with Firvanq (vancomycin used to treat infections) 50mg/ml. The lorazepam boxes were labeled for R155 and R156. Firvanq was labeled for R17. Written in marker on the refrigerator door was ATIVAN above where the lorazepam was stored. The refrigerator also included multiple syringes of labeled and unlabeled insulin pens. LPN-B indicated both residents receiving lorazepam were no longer at the facility. During interview on 1/12/23, at 9:02 a.m., vice present of success (VPS) confirmed lorazepam is a scheduled IV controlled substance and should be stored in a separately affixed box within the refrigerator. Facility policy and procedure titled "Controlled Medication Storage" dated 11/17 included: -Medications included in the Drug Enforcement Administration (DEA) classification as controlled	F 761	been ordered. Ativan, if noted for discharged residents was destroyed following facility policy. The Director of Nursing or designee provided education beginning February 2, 2023 on the storage of Ativan in medication refrigerators. The Director of Nursing or designee will audit compliance with the storage of Ativan three times weekly for four weeks then weekly for four weeks. Results of audits will be forwarded to the quality assurance and performance improvement committee for review and recommendations.	

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F 761	Continued From page 49 substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations. -Controlled medications requiring refrigeration are stored within a locked, permanently affixed box within the refrigerator.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 4 of 4 residents (R3, R205, R49, R27) whom resided on the second floor, and were reviewed for food. Findings include: R3 R3's face sheet printed on 1/12/23, included diagnoses of diabetes and chronic kidney disease. R3's quarterly Minimum Data Set (MDS) assessment dated 10/17/22, indicated R3 was cognitively intact and was independent with	F 804	R3, R205, R49, and R27 have been informed that they may eat in dining area if desired and that steps are being taken to improve temperature of food trays when delivered. Residents have the potential to be impacted by this practice. Heated place and heated wax bases were added to the tray line to improve temperature at delivery. The Registered Dietitian or designee provided training to dietary staff on February 8, 2023 on food temperature, use of heated plates and heated wax bases. The Director of Nursing or	2/21/23

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F 804	Continued From page 50 eating. During an interview on 1/9/23, at 5:18 p.m., R3 stated she ate in her room, and her food was usually cold, "stone cold," but had not told anyone. During an interview and observation on 1/11/23, at 9:04 a.m., observed R3 eating breakfast in her room, and she stated it was cold. Observed biscuits and gravy on her plate. The gravy over the biscuit appeared congealed. R3 stated she would just eat it rather than ask staff to reheat it. During an interview and observation on 1/11/23, at 1:30 p.m., R3 stated her noon meal of meatloaf, scalloped potatoes and peas were, "Just barely warm" and would eat it that way rather than ask staff to warm it. R205 R205's face sheet printed on 1/12/23, included diagnoses of stroke, kidney disease and diabetes. R205's quarterly Minimum Data Set (MDS) assessment dated 11/18/22, indicated R205 was cognitively intact and was independent with eating. During an interview on 1/9/23, at 3:25 p.m., R205 stated her food often came cold, adding her food was a lot warmer when they used to eat in the dining room. R205 stated she ate in her room all the time now - ever since Covid. During an interview and observation on 1/11/23, 9:02 a.m., R205 stated her breakfast was cold, and, "Who wants to eat a cold biscuit and	F 804	designee provided education to licensed nurses and nursing assistants on timely tray delivery to improve customer satisfaction with meal service. The Registered Dietitian or designee will complete audits of tray temperatures weekly for eight weeks, then monthly on an ongoing basis. The Executive Director of designee will complete audits of meal delivery and resident satisfaction with meals through interview of five residents weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.	

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F 804	Continued From page 51	F 804		

sausage." In addition, R205 stated, "Staff said they can't warm it up in the microwave for me unless they have a cover from the kitchen" [to carry the plate to the microwave in the dining room].

R49
R49's facesheet printed on 1/12/23, included diagnoses of diabetes and high blood pressure.

R49's admission Minimum Data Set (MDS) assessment dated 11/22/22, indicated R49 was cognitively intact and was independent with eating.

During an interview and observation on 1/12/23, at 8:54 a.m., R49 received a plate of one fried egg, bacon strips and a small cinnamon roll. R49 stated, the temperature of the egg was, "So so -- not cold, but not hot," adding she would be able to eat it. R49 stated the bacon was not warm, but would eat it.

R27
R27's facesheet printed on 1/12/23, included diagnoses of chronic kidney disease and COPD (chronic obstructive pulmonary disease - a lung disease that blocks airflow from the lungs).

R27's quarterly Minimum Data Set (MDS) assessment dated 10/24/22, indicated R27 was cognitively intact and was independent with eating.

During an interview and observation on 1/12/23, at 8:56 a.m., R27, stated in general, his food was always cold or room temp, adding "I'm used to it, but it's not like home." R27 stated he was last in the line [to receive his meal trays] and attributed

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F 804	Continued From page 52 that to his food being cold. During resident council meeting on 1/10/23, at 2:08 p.m., R14, who was cognitively intact and independent with eating, stated most food was served cold or just luke warm. R32 who was cognitively intact and required supervision when eating stated cold food had been going on for several years, adding staff would reheat the food when able. Both R14 and R32 resided on second floor. During an observation on 1/11/23, noon meal trays for second floor were delivered to the East wing from the first floor kitchen at 12:55 p.m. Some meal trays were delivered in a thermal cart and some were delivered on bakers racks enclosed in thin, clear plastic. Meals were delivered first to the approximately 17 residents on the East wing and to a few residents in the dining room. A bakers rack was then moved to the West wing, 25 to 30 minutes after the meal carts were delivered to second floor (between 1:25 p.m. and 1:30 p.m.), and the approximately 16 residents on the West wing received their meal trays. The meal trays did not have a mechanism for keeping food warm such as an enclosed thermal cart, or a plate warmer. They did have a lightweight plastic thermal cover over the plate. During an observation on 1/12/23, breakfast trays were delivered to the West wing at 8:43 a.m. on a bakers cart and R2's tray was delivered to her room 21 minutes later at 9:04 a.m. During an interview and observation on 1/11/23, a 12:51 p.m., observed all but three residents on second floor eating lunch in their rooms. Nursing	F 804		

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F 804	Continued From page 53	F 804		

assistant (NA)-B stated she heard residents were still eating in their rooms because there wasn't enough kitchen help to serve food directly from the steam table in the second floor dining room.

During an interview on 1/12/23, at 9:56 a.m., the director of nursing (DON) was informed of resident complaints of cold food on second floor and it taking about 30 minutes from the time trays arrived on second floor for residents on the West wing to receive their meal trays. The DON stated residents could eat in the dining room if they wanted, that dining rooms were back open, however could not answer how a resident would know that. The DON stated a resident just had to ask.

During an interview on 1/12/23, at 10:33 a.m., (RN)-A stated residents could eat in the dining room if they wanted, but could not answer how a resident would know that. RN-A stated it would be time-saving for the nursing staff if residents could eat the dining room and it would probably address cold food complaints. RN-A stated leadership had talked about cold food complaints in the past, but recalled something about dietary not having enough staff to serve food from the steam table on second floor.

Facility policy titled Food: Quality and Palatability with revised date of 9/2017, indicated food would be palatable, attractive and served at an appetizing temperature.

Facility Food policy titled Meal Distribution: Infection Control Considerations, revised date 9/17, indicated all food items will be transported promptly for appropriate temperature maintenance.

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review; the facility failed to date opened containers of food and failed to ensure expired food were identified and removed from walk-in cooler. This had the potential to affect all 57 residents who were served food and beverages from the facility kitchen. Findings include: During observation and interview of kitchen on 1/9/23 at 2:16 p.m., with registered dietician (RD)-H, observed food items in walk-in cooler that were not dated or marked and/or were expired. RD-H indicated all kitchen staff were responsible and were aware of checking all food	F 812	No residents were identified as being impacted by this practice. The food items identified as lacking dates opened were discarded following tour of kitchen Residents have the potential to be impacted by this practice. Food storage was reviewed to ensure there were no other open items lacking dates. The Registered Dietitian or designee provided training to dietary staff on storage, labeling, and dating food items on February 8, 2023. The Director of Nursing or designee provided training to licensed nurses and certified nursing	2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 812	Continued From page 55 for opened dates and expiration dates daily, and removing all expired or damaged food. RD-H stated any food or drink not marked/dated when opened, should be removed immediately. RD-H indicated all left-over prepared food and beverage when marked/dated were good for 3-7 days from date opened per facility policy. The following items were observed during tour: Walk-in cooler: 1.. Lactulose free dairy star fat free milk-1.89L -approx. ½ full; not marked/dated; exp date 2/21/23 2. Grape juice-1.36L- approx. ½ full, not marked/dated, exp. date 6/10/23 3. Grape juice-1.36L- approx. ¼ full, not marked/dated, exp date 6/10/23 4. Grape juice-1.36L-approx. ½ full, not marked/dated, exp date 6/10/23 5. 2% reduced fat milk- 3.78 L -approx. ¼ full, not marked/dated, exp date 1/17/23 6. Facility prepared liquid in facility container- 1 gallon- full, orange in color, not marked/dated, no expiration date 7. Facility prepared liquid in facility container- 1 gallon- approx. ½ full, yellow in color, not marked/dated, no expiration date 8. Facility prepared liquid in facility container- 1 gallon- approx. 3/4 full, purple in color, not marked/dated, no expiration date 9. Facility prepared liquid in facility container- 1 gallon- full, red in color, not marked/dated, no expiration date 10. Sliced Swiss cheese in facility container- approx. 1/2 package left, unlabeled, date on container 12/28 When interviewed on 1/9/23 at 2:26 p.m., RD-H	F 812	assistants on storage, labeling, and dating food items that are stored on the nursing unit. The Account Manager or designee will audit kitchen food storage areas for compliance five times weekly for eight weeks. The Director of Nursing or designee will audit food storage on the nursing unit five times weekly for four weeks then twice weekly for four weeks. Results of audits will be submitted to the quality assurance and performance improvement committee for review and recommendations.	

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	245184	A. BUILDING ______ B. WING ______	C 01/12/2023

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F 812	Continued From page 56	F 812		

indicated she was filling in for dietary manager who was out ill, not sure what dietary manager's routine was for ensuring proper food storage, stated typically when food and beverage items are delivered to facility, food items should be rotated, newer food items placed towards the back and older food items brought towards the front to ensure older food items were used up first. RD-H indicated when food items were opened, staff should be placing date opened to indicate when staff needed to discard items, items should be discarded within 3-7 days per facility policy.

Facility policy titled Food Storage: Cold Foods revised date 4/18, indicated all foods will be stored wrapped or in a covered container, labeled and dated, and arranged in a manner to prevent cross contamination.

Facility policy titled Food: Safe Handling for Foods from Visitors, revised date 7/19, consisted of, daily monitoring for refrigerated storage duration and discard of any food items that may have been stored for >7 days. (Storage of frozen foods and shelf stable items may be retained for 30 days).

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/10/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/10/2023. At the time of this survey, ROCHESTER EAST HEALTH SERVICES was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/09/2023

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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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING __________	01/10/2023

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

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K 000	Continued From page 2 automatic fire department notification. The facility has a capacity of 111 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), National Fire Alarm and Signal Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that a semi-annual inspection of the fire alarm system had occurred.	K 345	Fire Alarm System will be inspected semiannually. Documentation of inspections will be maintained by the maintenance director, and available for review to confirm inspections occurred. Executive Director completed Inservice Education with the Maintenance Director regarding NFPA code requirements for semi-annual testing and record keeping 2.8.2023. Annual Fire Alarm Inspection was completed by Custom Alarm 11.11.2022. Custom Alarm's semi-annual fire alarm inspection is tentatively scheduled for May 2, 2023. The Maintenance Director is responsible	2/8/23

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K 345	Continued From page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	to ensure the semi-annual fire alarm system inspections occur as scheduled. Completed Inservice Education will be reviewed by the QAPI Committee for trends as well as necessity of further education.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 8.5.6.2, 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5, 4.1.5.2, and5.2.1.1.2. These deficient	K 353	1. Dining Room sprinkler heads with exhibited signs of oxidation and foreign substance debris were replaced by J.F. Ahern 1.30.2023 2. The 4 - 4 foot X 2 foot ceiling tiles missing from the grid work in the Basement Room LL 1022 were replaced by the Maintenance Director 2.6.2023	2/8/23

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/10/2023**

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K 353	Continued From page 4 findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by observation during the tour of the facility that in the Dining Room Area, sprinkler head(s) exhibited signs of oxidation and foreign substance debris 2. On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by observation during the tour of the facility that in the Basement - RM LL1022, there were 4 - 4 foot x 2 foot ceiling tiles missing from the ceiling grid work. The absence of the ceiling tiles could affect the proper activation and overall efficiency of the sprinkler system 3. On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by observation during the tour of the facility that in the Basement - Physical Therapy Room - East Corridor, there were 2 - 4 foot x 2 foot ceiling tiles missing from the ceiling grid work. The absence of the ceiling tiles could affect the proper activation and overall efficiency of the sprinkler system 4. On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by observation during the tour of the facility that in the Basement - Boiler Room Storage, there were 4 - 4 foot x 2 foot ceiling tiles missing from the ceiling grid work. The absence of the ceiling tiles could affect the proper activation and overall efficiency of the sprinkler system An interview with the Maintenance Director	K 353	3. The 2 - 4 foot X 2 foot ceiling tiles missing from the ceiling grid work in the Basement Physical Therapy Room East Corridor were replaced by the Maintenance Director 2.6.2023 4. The 4 - 4 foot X 2 foot ceiling tiles missing in Basement Boiler Room Storage were replaced by the Maintenance Director 2.6.2023 Inservice Education was completed with Maintenance Director by the Executive Director 2.8.2023 1. Checking sprinkler heads for signs of oxidation foreign debris and scheduling replacement of sprinkler heads with J.F. Aherns as soon as found. 2. Responsible for replacing missing, broken or water damaged ceiling tiles when they are found or reported to maintenance.	

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K 353	Continued From page 5 verified these deficient findings at the time of discovery.	K 353		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the laundry chute system per NFPA 101 (2012 edition), Life Safety Code, section 19.5.4.1, 9.5.2, and NFPA 82 (2009 edition), Standard on Incinerators and Waste and Linen Handling Systems and Equipment, section 5.2.3.3.1.1. This deficient finding could have a	K 541	To ensure the laundry chute doors self-close and positively latch to seal the vertical laundry chute, damaged laundry chute door assembly hardware on 1st, 2nd and 3rd floors was replaced by the Bowman’s Door Solutions 1.25.2023 Audit to validate laundry chute door	1/25/23

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/10/2023**

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K 541	Continued From page 6 widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by observation during the tour of the facility that on the 3rd, 2nd, 1st FL Laundry Chute Rooms, all chute door assemblies exhibited damage hardware, such that the doors did not self-close and positively latch to seal the vertical shaft An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	assembly hardware was in place for doors to self-close and positively latch to seal the vertical laundry chute on the 1st, 2nd and 3rd floor was completed by the Executive Director 2.7.2023. Audits to ensure the self-closure and positively latch to seal the laundry chute doors on the 1st, 2nd and 3rd floor are working will be done 1x weekly for 4 weeks. Review of the audits will be reviewed by the QAPI Committee for trends.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7. This deficient condition could have a widespread	K 712	Fire drills will be conducted once per month every quarter with shift rotation. Fire drills will include the transmission of a fire alarm signal and simulation of an emergency fire condition.	2/8/23

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**01/10/2023**

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K 712	Continued From page 7 impact on the residents within the facility. Findings include: On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed during documentation review that documentation present for review identified that only 1 of 3 drills were conducted in Q1, no drills were conducted in Q2, and 2 of 3 drills were conducted in Q3. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	The Maintenance Director or designee will be responsible to ensure fire drills are done as required. January night shift fire drill was completed 1.20.2023. February pm shift fire drill was completed 2.8.2023. Inservice Education with the Maintenance Director regarding NFPA code fire drill requirement was completed 2.8.2023. Audits will be done 1 X monthly for 2 months and reviewed by the QAPI Committee for trends as well as necessity of further education.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain, inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15, and NFPA 80 (2010 edition),	K 761	Annual inspection and testing of doors (fire and non-rated doors, corridor doors to resident rooms and smoke barrier doors) will be completed as required.	2/8/23

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K 761	Continued From page 8 Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that annual inspection and testing of doors is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	Maintenance Director is responsible for completion of the annual maintenance, inspection and testing of the doors, and maintaining documentation of the inspection and testing. Inservice Education with the Maintenance Director regarding NFPA code 101 door maintenance, inspection, and testing requirements was completed 2.8.2023. The annual door inspection and testing by the Maintenance Director was completed 2.8.2023. Executive Director to validate the annual inspection-testing was done and will review results at the QAPI Committee for trends as well as necessity of further education.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per	K 914		2/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/10/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 9 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 a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023 between 09:15 AM to 01:15 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that annual inspection and testing of electrical outlets was occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Maintenance Director is responsible for ensuring the electrical receptacles in resident rooms are tested at intervals not exceeding 12 months. Inservice Education with the Maintenance Director regarding NFPA 99 code requirements for inspection and testing of electrical receptacles in resident rooms and record keeping was completed 2.8.2023. Electrical inspection and testing of the electrical receptacles in resident rooms by the Maintenance Director was completed 2.8.2023. E D to validate the annual inspection and results of the validation will be review at QAPI Committee for trends as well as necessity of further education.	