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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 7U55
Facility ID: 29822

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245626**

2. STATE VENDOR OR MEDICAID NO. (L2) **859497200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER REHABILITATION AND LIVING CENTER**
(L4) **1900 BALLINGTON BOULEVARD NW**
(L5) **ROCHESTER, MN** (L6) **55901**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/6/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 6/16/2016
Gary Nederhoff, Unit Supervisor (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 6/16/2016
Kamala Fiske-Downing, Health Program Representative (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/07/2015** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00160** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245626

June 14, 2016

Ms. Dena Otto, Administrator
Rochester Rehabilitation And Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

Dear Ms. Otto:

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

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

Effective May 30, 2016 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

An equal opportunity employer

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2016

Ms. Dena Otto, Administrator
Rochester Rehabilitation And Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: Project Number S5626001

Dear Ms. Otto:

On May 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 20, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 20, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 20, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 20, 2016, effective May 30, 2016 and therefore remedies outlined in our letter to you dated May 3, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245626		6/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	Correction Completed 05/30/2016	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 05/30/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 05/30/2016
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 05/30/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 6/14/2016	SIGNATURE OF SURVEYOR 10160	DATE 6/6/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245626	A. Building 01 - BUILDING 1 B. Wing	5/20/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 04/26/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/29/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	6/14/2016	37008	5/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/19/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 7U55
Facility ID: 29822

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2. STATE VENDOR OR MEDICAID NO. (L2) **859497200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER REHABILITATION AND LIVING CENTER**
(L4) **1900 BALLINGTON BOULEVARD NW**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/20/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 6/1/2016
Kyla Einertson, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 6/1/2016
Kamala Fiske-Downing, Health Program Representative (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/07/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00160
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 3, 2016

Ms. Dena Otto, Administrator
Rochester Rehabilitation And Living Center
1900 Ballington Boulevard Northwest
Rochester, Minnesota 55901

RE: Project Number S5626001

Dear Ms. Otto:

On April 20, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 30, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 30, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 20, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING ______ B. WING ______	04/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278		5/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/13/2016

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
	245626	A. BUILDING ______ B. WING ______	04/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the admission Minimum Data Set (MDS) for 1 of 2 residents (R48) reviewed for dental status and services. Findings include: R48's admission MDS dated 3/31/16, identified R48 had no natural teeth or tooth fragments. R48 was observed on 4/18/2016, at 5:42 p.m. R48 was observed to have a broken, chipped front tooth. R48's oral assessment dated 3/25/16, identified R48 had her own teeth. The oral assessment did not identify R48 had an obvious or likely cavity, broken natural teeth or any dental concerns. R48's care plan, did not identify R48 to have a broken, chipped front tooth or any dental concerns. On 4/20/2016, at 7:22 a.m. registered nurse (RN)-B a clinical nurse consultant (CNC) confirmed the admission MDS was inaccurately coded to reflect R48 did not have any natural teeth.	F 278	1. Resident # 48 identified in this statement of deficiency has been clinically reassessed for accurate oral status. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results. All staff responsible for assessing each resident has been educated on assessment and documentation accuracy. 2. The Director of Nursing and/or designee have reviewed oral status of all residents via assessment and/or recent dental examination and compared these results to MDS documentation to ensure accurate information has been recorded. 3. The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: MDS staff were trained as it relates to their respective roles and responsibilities for oral assessment and MDS documentation accuracy as of 5/13/16. Nursing staff trained as it relates to oral assessment as of 5/13/16.	

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F 278	Continued From page 2	F 278	4. The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: MDS nurse will complete an oral assessment of each new admission within the assessment reference period; DON will audit all new admissions for 2 weeks followed by random weekly audits for accuracy of MDS documentation. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QAPI Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Nursing will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 5/30/16.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		5/30/16

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F 281	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to develop an initial care plan to include severely impaired cognition and potential for leaving the building unsupervised for 1 of 1 resident (R99) reviewed for behavior of wandering and elopement/s prior to admission to home. Findings Include: R99's initial care plan (developed on admission and to contain enough information to protect and provide basic cares until the comprehensive assessment and development of the comprehensive care plan is developed is in affect) developed by the facility, did not include resident's severe dementia that was identified on the hospital dismissal summary dated 12/31/15, did not include R99 had resided in a locked memory care unit prior to R99's hospitalization and may be at increased risk for wandering and elopement. R99 was admitted to the facility on 12/31/15, with diagnoses dementia, repeated falls and major depressive disorder according to the facility admission record. R99's admission MDS dated 1/7/16, indicated R99 wandered and was at risk of getting to a dangerous place, had long and short term memory difficulties, and severely impaired decision making skills for daily living. R99's Nurse Progress note dated 1/4/16, included, "Resident is on 15 minute checks due to his wandering behaviors. He was last seen at	F 281	1. Resident # 99 identified in this statement of deficiency was discharged from the facility on 2/4/16. 2. The Director of Social Services and/or designee will implement measures for other residents potentially affected by this practice including: a review of resident records for those residents identified at risk for elopement to ensure elopement assessments have been completed, care plans updated with pertinent information including interventions or checks in place to promote resident safety, and staff communication via elopement books are updated. 3. The Director of Social Services and/or designee will implement measures to ensure that this practice does not recur, including: all new admits will have an elopement assessment done upon admission. Residents will be reviewed based on their quarterly or change of condition MDS assessment reference dates for new diagnosis of dementia, delirium, cognitive impairment, history of wandering, or other reasons to believe there is an elopement risk and will have an elopement assessment done at the time such things come into play. A review of the revised policies by the Medical Director was conducted to determine if policies meet current standards of practice on 5/10/16. All staff were educated on this plan of correction by 5/13/16. Social service and	

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F 281	Continued From page 4 1630 [4:30 p.m.] in the lounge area and the next check at 1645 [4:45 p.m.] he was missing. Staff immediately began searching to locate him and at 1650 [4:50 p.m.] the concierge from Homestead returned him to the Rehab 1 unit unharmed. She [concierge] found him wandering the lounge/entrance area near her desk. He had somehow gotten out of the door between the 2 buildings and walked to her desk. He did have his Versus badge on and staff were unable to locate him using the surveillance system listing the location of the versus badge the resident is wearing. Since the resident was still inside the building and was found unharmed, he was placed at the dining table for the supper meal. Reported to Executive Director and the Director of Clinical Administration. Will continue 15 minute checks. At this time he was asked what he was doing and where he was going and [he] did not remember leaving. He stated that he is looking for his wife now and wants to know how to get home. Due to his dementia he was unable to remember leaving out the door at all." R99's record review revealed an elopement assessment had not been completed by social services until 1/7/16, three days after R99 had eloped from the facility and eight days after his admission to the home. The elopement assessment indicated R99 was a new admission, had eloped from the facility since admission, and had made it to the Homestead. Indicated resident had long and short term memory loss and was disorientated times three. The elopement assessment was not fully completed by social services as the following sections were left blank: contributing conditions, behaviors, does resident verbalize any of the following and does resident have life experience which could contribute to	F 281	nursing staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by 5/30/16. An elopement drill will be completed by 5/30/16. 4. The Director of Social Services and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: IDT will review all new admits and MDSs due via morning stand up report to determine elopement risk assessment was completed. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Social Services will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 5/30/16.	

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F 281	Continued From page 5 elopement. Based on risk factors above, describe overall risk was answered, "Resident is a confused man and has lived at memory care at the Homestead. He made it inside of the building over to the Homestead." R99's elopement incident, post incident review dated 1/4/16 included, "Elopement, Continues on 15 minute checks and will ask about re-evaluating his placement here." R99's progress note dated 1/10/16, included, "Behavior: crying, repetitively asking to leave/call [family member (FM)-A]. Intervention: attempted to call [FM-A] to talk to patient. Left message for [FM-A] to call when able. Repeatedly reminded patient of time of day and that [FM-A] was called." Also included, "Time and Frequency of Intervention: continuous redirection. Unsuccessful. Continued 15 minute checks for patient safety r/t suicidal threats. Evaluation: D/t [due to] patient's severe dementia he is unable to grasp concept of time. Resident Response: Crying, insistent he can go home. States that if he had the means he would 'jump off the building'." R99's nursing note dated 1/15/16, included, "Behavior: attempting to elope unit, Intervention: redirection, offer food, toileting, Time and Frequency of Intervention: every time patient attempted to elope another intervention tried. Evaluation: Patient is unable to be redirected. Continues to search out exits to 'go home'. Resident Response: Continuous attempts to leave unit." On 4/20/2016, at 12:34 p.m. the executive director (ED) stated it was the facility procedure to complete an elopement assessment within the	F 281		

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F 281	Continued From page 6 first assessment period of the ARD (assessment reference date) unless there was reason a resident was identified at risk for wandering or if we admitted a resident that had a known wandering history. The ED stated in hindsight the facility should have completed an admission elopement assessment the day of admission to the facility as R99 had severe dementia and fit the criteria to be at risk for wandering as R99 was coming into a new environment. The ED confirmed the initial care plan did not address R99's severe dementia and did not address R99 was at risk for elopement form being in a new environment. The ED confirmed the facility failed to follow the elopement policy to complete an elopement assessment and initial care plan for elopement risk upon admission for R99. The wandering and Elopement Policy and Procedure with a revised date of February, 2010, included, "...6. Elopement assessment is completed for all who are placed on a secured unit, and whose situation and/or care needs warrant concern and/or potential for wandering. 7. A care plan identifying wandering and elopement risk will be implemented on admission and PRN [as needed]..."	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		5/30/16

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to complete an elopement assessment upon admission for 1 of 1 resident (R99) reviewed for behaviors of wandering into a dangerous place from previous living arrangements. Findings Include: R99 was admitted to the facility on 12/31/15, with diagnoses dementia, repeated falls and major depressive disorder according to the facility admission record. R99's admission MDS dated 1/7/16, indicated R99 wandered at was at risk of getting to a dangerous place, had long and short term memory difficulties, and severely impaired decision making skills for daily living. R99's initial care plan (developed on admission and to contain enough information to protect and provide basic cares until the comprehensive assessment and development of the comprehensive care plan is developed is in affect) developed by the facility, did not include resident's severe dementia that was identified on the hospital dismissal summary dated 12/31/15, did not include R99 had resided in a locked memory care unit prior to R99's hospitalization and may be at increased risk for wandering and elopement. R99's Nurse Progress note dated 1/4/16, included, "Resident is on 15 minute checks due to his wandering behaviors. He was last seen at	F 323	1. Resident # 99 identified in this statement of deficiency was discharged from the facility on 2/4/16. 2. The Director of Social Services and/or designee will implement measures for other residents potentially affected by this practice including: a review of resident records for those residents identified at risk for elopement to ensure elopement assessments have been completed, care plans updated with pertinent information including interventions or checks in place to promote resident safety, and staff communication via elopement books are updated. 3. The Director of Social Services and/or designee will implement measures to ensure that this practice does not recur, including: all new admits will have an elopement assessment done upon admission. Residents will be reviewed based on their quarterly or change of condition MDS assessment reference dates for new diagnosis of dementia, delirium, cognitive impairment, history of wandering, or other reasons to believe there is an elopement risk and will have an elopement assessment done at the time such things come into play. A review of the revised policies by the Medical Director was conducted to determine if policies meet current standards of practice on 5/10/16. All staff were educated on this plan of	

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F 323	Continued From page 8 1630 [4:30 p.m.] in the lounge area and the next check at 1645 [4:45 p.m.] he was missing. Staff immediately began searching to locate him and at 1650 [4:50 p.m.] the concierge from Homestead returned him to the Rehab 1 unit unharmed. She [concierge] found him wandering the lounge/entrance area near her desk. He had somehow gotten out of the door between the 2 buildings and walked to her desk. He did have his Versus badge on and staff were unable to locate him using the surveillance system listing the location of the versus badge the resident is wearing. Since the resident was still inside the building and was found unharmed, he was placed at the dining table for the supper meal. Reported to Executive Director and the Director of Clinical Administration. Will continue 15 minute checks. At this time he was asked what he was doing and where he was going and [he] did not remember leaving. He stated that he is looking for his wife now and wants to know how to get home. Due to his dementia he was unable to remember leaving out the door at all." R99's record review revealed an elopement assessment had not been completed by social services until 1/7/16, three days after R99 had eloped from the facility and eight days after his admission to the home. The elopement assessment indicated R99 was a new admission, had eloped from the facility since admission, and had made it to the Homestead. Indicated resident had long and short term memory loss and was disorientated times three. The elopement assessment was not fully completed by social services as the following sections were left blank: contributing conditions, behaviors, does resident verbalize any of the following and does resident have life experience which could contribute to	F 323	correction by 5/13/16. Social service and nursing staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by 5/30/16. An elopement drill will be conducted by 5/30/16. 4. The Director of Social Services and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: IDT will review all new admits and MDSs due via morning stand up report to determine elopement risk assessment was completed. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Social Services will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 5/30/16.	

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F 323	Continued From page 9	F 323		

elopement. Based on risk factors above, describe overall risk was answered, "Resident is a confused man and has lived at memory care at the Homestead. He made it inside of the building over to the Homestead."

R99's elopement incident, post incident review dated 1/4/16 included, "Elopement, Continues on 15 minute checks and will ask about re-evaluating his placement here."

R99's progress note dated 1/10/16, included, "Behavior: crying, repetitively asking to leave/call [family member (FM)-A]. Intervention: attempted to call [FM-A] to talk to patient. Left message for [FM-A] to call when able. Repeatedly reminded patient of time of day and that [FM-A] was called."

Also included, "Time and Frequency of Intervention: continuous redirection. Unsuccessful. Continued 15 minute checks for patient safety r/t suicidal threats. Evaluation: D/t [due to] patient's severe dementia he is unable to grasp concept of time. Resident Response: Crying, insistent he can go home. States that if he had the means he would 'jump off the building'."
R99's nursing note dated 1/15/16, included, "Behavior: attempting to elope unit, Intervention: redirection, offer food, toileting, Time and Frequency of Intervention: every time patient attempted to elope another intervention tried. Evaluation: Patient is unable to be redirected. Continues to search out exits to 'go home'. Resident Response: Continuous attempts to leave unit."

On 4/20/2016, at 12:34 p.m. the executive director (ED) stated it was the facility procedure to complete an elopement assessment within the

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F 323	Continued From page 10 first assessment period of the ARD (assessment reference date) unless there was reason a resident was identified at risk for wandering or if we admitted a resident that had a known wandering history. The ED stated in hindsight the facility should have completed an admission elopement assessment the day of admission to the facility as R99 had severe dementia and fit the criteria to be at risk for wandering as R99 was coming into a new environment. The ED confirmed the initial care plan did not address R99's severe dementia and did not address R99 was at risk for elopement form being in a new environment. The ED confirmed the facility failed to follow the elopement policy to complete an elopement assessment and initial care plan for elopement risk upon admission for R99. The wandering and Elopement Policy and Procedure with a revised date of February, 2010, included, "...6. Elopement assessment is completed for all who are placed on a secured unit, and whose situation and/or care needs warrant concern and/or potential for wandering. 7. A care plan identifying wandering and elopement risk will be implemented on admission and PRN [as needed]..."	F 323		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		5/30/16

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F 441	Continued From page 11 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an infection control program to include surveillance and investigation of infections that occurred in the facility which included R10. Also failed to have available and use personal protective equipment (PPE) in 3 of 3 laundry rooms when laundry staff had possible contact with soiled linens to prevent	F 441	1. Resident # 10 identified in this statement of deficiency had been clinically reassessed for contact precautions related to MRSA during annual survey, and it was deemed there was no precautions needed other than standard precautions after investigation. This resident was discharged from facility	

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	245626	A. BUILDING ______ B. WING ______	04/20/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 the spread of infection to self and others. Findings included Lack of Infection control program surveillance: Infection control logs were reviewed since August 2015. Logs from August through March 2016 lacked analysis of the infection data collected, corrective actions taken to correct possible infection control breaks, and preventive measures to decrease the infection rate. The logs also reflected a lack of tracking resolution of the infections. The April 2016 infection log was grossly incomplete and only indicated the resident's name, admit date, room number, the antibiotic and the start date of the antibiotic. During an interview on 4/20/16, registered nurse (RN)-B consultant had stated the facility had identified concerns with their infection control program a few weeks ago, and need for assignment adjustments and further education was needed for the infection control coordinator who was relatively new to that position. RN-B stated surveillance should be done daily. R10 lack of implementation of infection control program and surveillance to prevent the spread of infection: During the initial tour on 4/18/16, at 11:51 a.m. registered nurse (RN)-A indicated there were no resident's on isolation precautions. During an observation on 4/18/16, at 1:43 p.m. R10's room did not have an isolation cart outside the room. During an observation on 4/19/16, at 8:13 a.m. R10's room now had an isolation cart in front of her door. The door to R10's room informed staff to use contact precautions; gown, mask, and gloves. A small black plastic uncovered garbage can just inside R10's door contained a yellow isolation gown. Occupational Therapist (OT)-A	F 441	4/30/16. 2. The Director of Nursing and/or designee has implemented a plan/process for other residents potentially affected by this practice including: all residents were reviewed for infections and the infection control log was updated to track infections, and infection control program oversight has been assigned to Director of Education. 3. The Director of Nursing and/or designee has implemented measures to ensure that this practice does not recur, including: all residents were reviewed for infections and the infection control log was updated with current information for month of April and moving forward; all 3 of 3 laundry rooms were supplied with proper PPE for handling laundry; covered trash receptacles were obtained for isolation precaution procedure. A review of the revised policies by the Medical Director will be conducted to determine if policies meet current standards of practice. All staff were trained on plan of correction for this tag as of 5/13/16 including review of standard precautions, transmission based precautions, and use of PPE. Nursing staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by 5/30/16. 4. The Director of Nursing and /or designee will monitor the corrective	

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F 441	Continued From page 13 was in the room with a gown, mask, and gloves on. R10's room did not contain isolation receptacles for contaminated clothing and trash. At 8:25 a.m. licensed practical nurse (LPN)-A instructed surveyor to throw the used isolation gown into the uncovered trash receptacle. LPN-A then tied the bag and waited by the door for isolation receptacles. R10's wound clinic visit note dated 3/15/16 indicated a culture was taken that day of the calf wound then on 3/17/16 the culture report included the calf wound was was positive for methicillin resistant staphylococcus aureus (MRSA) on right calf wound. R10 was then admitted to the hospital for right hip dislocation on 3/15/15. R10 was discharged from the hospital to the facility on 3/22/16. R10's hospital discharge summary indicated aspiration of the right hip that showed cloudy amber fluid. Blood cultures were obtained and were negative after 48 hours, however would have a 6 week course of intravenous antibiotics. The hospital discharge summary did not include mention of the right lower leg wound that was positive for MRSA other than, "Wound consult service was asked to see the patient for her chronic decubitus ulcer and bilateral lower leg ulcerations." R10 was admitted to the facility on 3/22/16 with diagnoses that included orthopedic aftercare and personal history of MRSA according to the facility face sheet. Even though the open wound on calf had been positive for MRSA as of 3/15/16. R10's care plan last reviewed on 4/13/16 included, "history of chronic MRSA/VRE [Vancomycin-resistant Enterococcus, or vancomycin-resistant enterococci] colonization," "has open areas on both lower legs-stasis. Sees wound clinic for all of these. Has surgical incision to right hip with dressing," and "History of	F 441	actions to ensure the effectiveness of these actions, including: nursing will audit completion of infection control log and report to QAPI; assigned staff will do weekly environmental audit to monitor proper PPE; nursing will complete audits for any resident who is on isolation precautions as they occur to make sure infection control policies are being followed. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Nursing will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 5/30/16.	

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F 441	Continued From page 14 MRSA/VRE but not sure of site." R10's physician orders included; MRSA precautions with a start date of 4/13/16, care of right hip incision, wound care for wound on right lower leg (calf area), Cefepime (antibiotic) 2 grams (GM) intravenously one time a day until 4/29/16, and Vancomycin 500 milligrams (mg) intravenously one time day until 4/29/16. R10's admission physician's note dated 3/23/16 reported hospital findings of "blood cultures were negative." and "Intraoperative cultures were negative to date." and "chronic history of MRSA and VRE colonization." The physician's note had no mention of the positive MRSA wound infection found at the wound clinic on 3/15/16. R10's wound clinic visit note dated 4/13/16 included an order for, "MRSA precautions" From 3/22/16 through 4/19/16 the facility was not aware if MRSA was active in the right lower leg wound/calf. Cultures of the leg wound were not repeated until 4/13/16 and were negative for bacteria on 4/15/16. However, the facility did not receive the results of the negative culture until 4/19/16 at 9:19 a.m.(according to the fax time stamp) after surveyor requested the facilty call the wound clinic to obtain the culture results. March 2016's infection control log reflected admission date of 3/22/16, indicated right hip infection, date started was "n/a [not applicable]", culture taken was 3/22/16 and was negative. The log did not indicate the bacterium, but did indicate R10 received Vancomycin (antibiotic), and classification was indicated as "not infected." The log did not indicate the right lower leg wound positive for MRSA according to the wound test of calf taken on 3/15/16 and report was dated 3/17/16. April's infection control log did not reflect R10's infections or antibiotic use. Even though R10 was	F 441		

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F 441	Continued From page 15 on daily dose of Vancomycin. During an interview on 4/19/15, at 8:14 a.m. registered nurse (RN)-A stated the report from the wound clinic on 4/13/16 indicated to use MRSA precautions, however we don't have culture results that indicated precautions were necessary. RN-A questioned why the wound clinic would order MRSA precautions and not indicate what the culture results were. RN-A explained the record the facility had indicated R10 was colonized and the hospital discharge summary indicated a chronic history of MRSA and VRE colonization. RN-A stated, she was not aware of the location of the MRSA infection, but thought the infection was located in the outer aspect of the right lower extremity wound. When asked, "What kind of precautions should be in place for casual contact if the MRSA infection was in the wound?" RN-A stated, "I would say they [staff] have to go in with glove, gown, and mask for every [resident] contact." RN-A was then asked if R10 was allowed to come out of her room, RN-A reported she was not sure if R10 could come out of her room. During an interview on 4/19/16, at 8:25 a.m. LPN-A stated she was not aware of the location of the MRSA infection and stated, "From what I understood she was colonized." During an interview on 4/19/16, at 8:42 a.m. RN-B clinical consultant indicated while gathering documents for surveyors she saw the wound clinic note from 4/13/16 indicating the need for isolation precautions. RN-B then explained isolation precautions were put into place overnight while the record was reviewed to ensure a break in infection control was not occurring. RN-B stated record review indicated all cultures were negative, antibiotics were for the hip prosthesis, and if the MRSA was located in	F 441		

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F 441	Continued From page 16 the wound then only contact precautions would be required. During an interview on 4/19/16, at 8:50 a.m. Occupational therapist (OT)-A stated they had never previously used gown, gloves, and mask except the day she came back from her wound appointment on 4/13/16, then thought later the same day we were told we didn't have to use the gown, glove, mask, and to use universal precautions which consisted of thorough hand washing and gloves. We saw the cart out in hall again today and "gowned up" (followed universal precautions). During an interview on 4/19/16, at 9:21 a.m. RN-B stated the wound clinic indicated on 3/15/16 the wound was positive for MRSA and on 4/17/16 the culture indicated no growth. RN-B indicated if isolation precautions were used from 3/22/16-4/17/16, the infection control logs should have reflected that, however the logs are in progress. During an interview on 4/19/16, at 9:23 a.m. RN-A indicated since the hospital had indicated the resident was colonized with no active infection we were using hand washing and gloves. RN-A then verified the hospital did not do cultures on the right lower extremity wound, they did blood cultures and cultures from the hip. During an interview on 4/19/16, at 10:10 a.m. RN-B concluded the surveillance forms were not correct and reported there had been no other MRSA infections in the facility since 3/22/16. RN-B explained that R10 should have been put on isolation precautions according to the policy on admission, then education should have been provided to all staff and visitors, and nurse managers would make sure precautions were followed, and the infection control coordinator would closely follow wound cultures and	F 441		

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F 441	Continued From page 17 monitoring antibiotics closely for resistance. The infection control coordinator would also partner with the physician and recording information on the surveillance forms. Facility policy Infection Control Antibiotic Stewardship and MDRO's (Multidrug-resistant organisms are bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria). Guidelines for MRSA stated the purpose of the policy as, "To identify residents with active MRSA so that appropriate infection control measures are implemented to ensure the safety and well-being of all residents." The policy gave direction to, "Place a resident with active MRSA infection in a private room, using Contact Precautions." and "Wear gloves when entering the room. During the course of providing care for a resident, change gloves after having contact with infective material that may contain high concentrations of microorganisms." "Wear a gown when entering the room if you anticipate that your clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the resident is incontinent, or has diarrhea, an ileostomy, a colostomy or wound drainage not contained by a dressing." "Residents may leave their rooms and participate in social activities if wound drainage and body secretions are contained." The policy outlined instruction for isolation precautions and indicated they could be discontinued when the resident no longer exhibiting signs and symptoms of active infection, or when re-culturing results are negative for MRSA." The policy outlined education to staff and indicated all personnel should be instructed on appropriate precautions for residents colonized or	F 441		

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

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F 441	Continued From page 18 infected with multi-resistant micro-organisms and on the importance of hand hygiene and barrier precautions in preventing contact transmission. The policy also informed the resident's chart must be marked with identification that the resident has MRSA infection colonization. Lack of use and availability of personal protective equipment (PPE) in laundry rooms: During the laundry rooms tour on 4/20/16, at 8:23 a.m. with housekeeper, it was observed 3 of 3 laundry rooms did not have PPE available for staff. During an interview on 4/20/16, at 9:29 a.m. maintenance director stated, there was no gowns in the rooms and they are not being utilized. Facility provided a Pathway Health Services policy Handling Linens to Prevent and Control Infection dated 2015. The policy instructed, "Follow standard precautions for all used linen which is potentially contaminated," and "Provide appropriate PPE (gowns and gloves) available for workers to wear while sorting linens."	F 441		

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

F5626001

PRINTED: 05/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING 01 - **BUILDING 1** B. WING ______	**04/19/2016**

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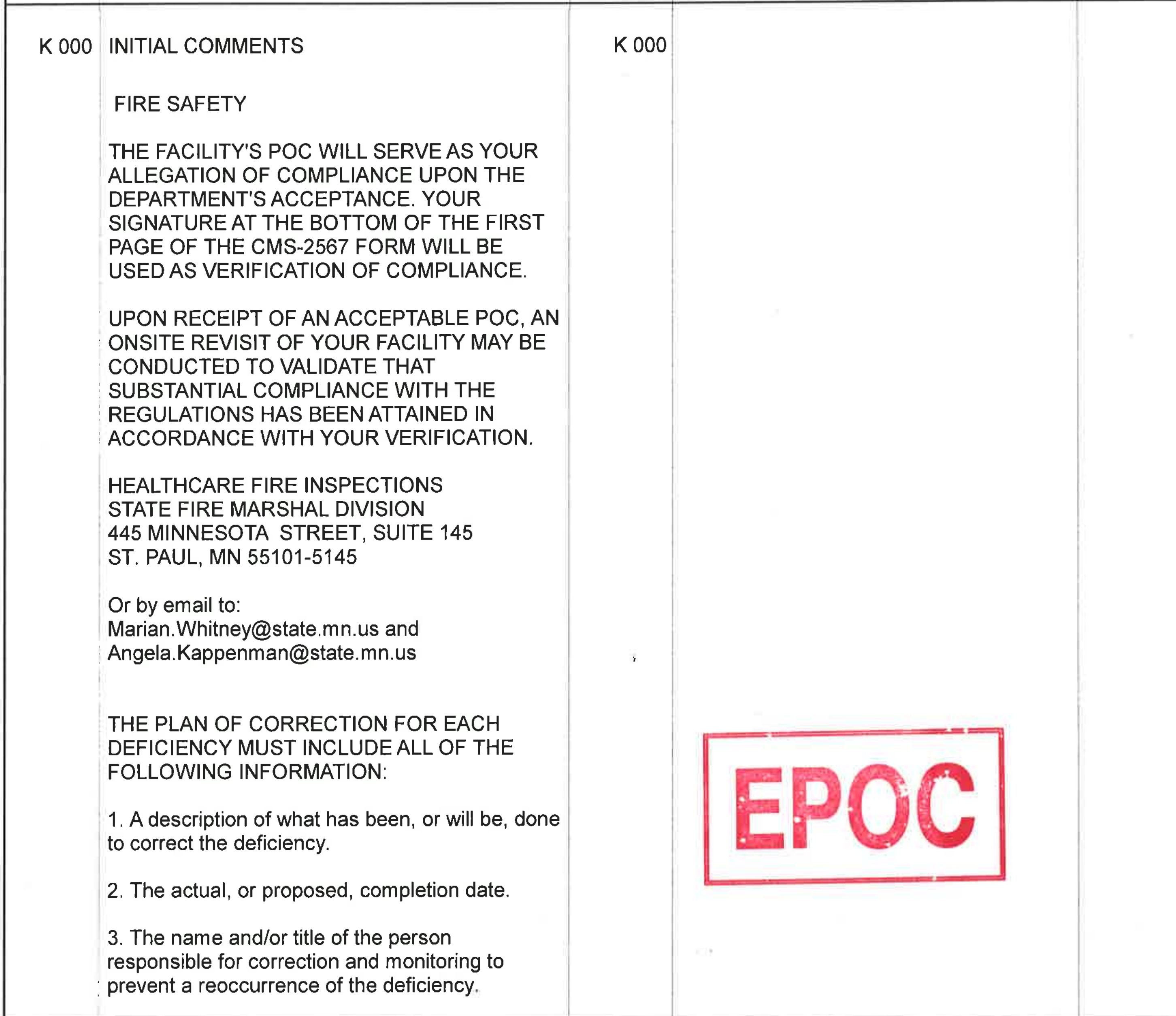
ROCHESTER REHABILITATION AND LIVING CENTER	**1900 BALLINGTON BOULEVARD NW** **ROCHESTER, MN 55901**



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K 000	INITIAL COMMENTS	K 000	EPOC	

FIRE SAFETY

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.

HEALTHCARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145

Or by email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/13/2016

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.

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

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	245626	A. BUILDING **01 - BUILDING 1** B. WING ______	**04/19/2016**

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K 000	Continued From page 1 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 4/19/2016, The Homestead at Rochester was NOT found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The Homestead at Rochester is a 1 story building with a partial basement. The facility was constructed in 2015 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 56 certified beds.	K 000		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: There is not record of a smoke detector sensitivity testing performed from the day it was installed. System was new in 2015.	K 054	1. Smoke detectors sensitivity testing records were pulled from the panel by Summit Companies. 2. Completetion date: 4/26/16 3. John Ellis, Director of Environmental	4/26/16

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K 054	Continued From page 2	K 054	Services	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: There is no record of the annual fire sprinkler testing preformed. There was no record of any quarterly inspection completed from new installation to present time.	K 062	1. Fire sprinkler testing was performed on wet and dry systems 2. Completion date: 4/29/16 3. John Ellis, Director of Environmental Services	4/29/16