Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 31, 2024

Administrator
Edenbrook Rochester West
2215 Highway 52 North
Rochester, MN 55901

Re: Reinspection Results
Event ID: 7VZF12

Dear Administrator:

On December 5, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 23, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 31, 2024

Administrator
Edenbrook Rochester West
2215 Highway 52 North
Rochester, MN 55901

RE: CCN: 245306
Cycle Start Date: October 23, 2024

Dear Administrator:

On December 5, 2024, 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.

Correction of the Life Safety Code deficiency cited under K918 at the time of the October 23, 2024, standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of April 30, 2025, has been approved or forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the October 23, 2024, standard survey, has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 12, 2024

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: CCN: 245306
Cycle Start Date: October 23, 2024

Dear Administrator:

On October 23, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 23, 2025 (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 April 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	10/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/21/24 through 10/23/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53069653C (MN107687). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to appropriately assess for broken/missing teeth and difficulty chewing for 1 of 1 (R24) resident. Findings include:	F 641	R24□s diet order was changed to include meat to be ground and care plan and orders were updated to reflect this change. Speech Therapy screen was completed. Residents who have missing teeth or	11/26/24

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

Electronically Signed | 11/19/2024

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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F 641	Continued From page 1 R24's 8/27/24, admission Minimum Data Set (MDS) assessment identified her cognition was moderately impaired. R24's diagnosis list identified diagnosis of moderate protein calorie malnutrition, paranoid schizophrenia, dementia, and weakness. R24's oral assessment dated 8/21/24, indicated R24 had her own teeth and does not wear dentures, has chewing problems and R24 would be a regular diet with thin liquids with a care plan intervention to provide diet as ordered. R24's Nutritional Assessment dated 8/26/24, identified R24 ate independently, was on a regular diet, had no difficulty chewing or swallowing, and would be given a supplement three times daily. The assessment summary identified the current diet order remains appropriate, resident appears to be tolerating diet texture and consistency, and current diet order/oral nutritional supplement order provides adequate calories/protein to meet estimate nutritional needs. The summary further identified R24 should continue current nutrition plan of care and care plan had been reviewed and updated. R24's 8/21/24, care plan item identified she was at risk for inadequate intake related to recent hospitalization due to dizziness, with interventions of eating independently, provide diet as ordered, and record weight per facility protocol/MD [medical doctor] orders. During an observation and interview on 10/22/24 at 12:40 p.m., R24 was seated at the edge of her bed with an overbed table in front of her with a meal tray on the table. Her plate had a whole potato with unopened packet of sour cream and	F 641	difficulty chewing have the potential to be affected by this practice. These residents were identified through review of admission and MDS assessments. Residents were interviewed to determine if they were having difficulty with current diet order. Diet orders were modified and care plans were updated if indicated by interviews. Don or designee provided Education to CNAs and Nurses to assist resident with set up of meal tray beginning 11/15/2024. Licensed nurses were educated on notifying Speech therapy, dietary of residents with missing teeth or difficulty swallowing. Don or designee will complete audits for compliance with diet orders, resident□s ability to consume foods served, and assistance with tray set up three times per week for four weeks, two times per week for four weeks and one time per week for one month. These audits will begin the week of November 18. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 641	Continued From page 2 butter on the side, R24 attempted to open the sour cream but was unable to. Included on the plate was an open-faced chicken sandwich with large bite size pieces of chicken mixed with gravy on top of a bun, green beans, and a mixed fruit cup on the side. R24 placed a bite of the chicken in her mouth, chewed it up and spit it back out on her spoon. She placed the chewed food to the side of her plate then took another bite, chewed the food and then again spit it out on the spoon and laid it to the side of her plate. R24 said she cannot chew the meat stating, "this would be good if it was done right, the sauce is good, but I can't chew the meat". During the observation a nursing assistant (NA)-A looked into the room and said she was just checking to see if R24 was done eating, she then closed the door. During and interview on 10/22/24 at 12:54 p.m., NA-A said she offered assistance to R24 when she dropped of her meal tray, she said R24 doesn't like people to help her, she identified she could have opened her sour cream prior to bringing the tray into her room but she did not think of that at the time. During an observation and interview on 10/23/24 at 8:53 a.m., R24 identified she has difficulty chewing, she opened her mouth to reveal no top teeth and several missing lower teeth. During an observation and interview on 10/23/24 at 12:33 p.m., R24, meal tray was on the overbed table in front of her, food items included whole boneless, chicken breast, mixed vegetables, and a dinner roll. R24 looks at her plate and stated "same old same old", R24 points to the chicken breast and states "I can't eat that, I don't have any top teeth. I need a blender so I can blend my	F 641		

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F 641	Continued From page 3 food up so I can eat it". R24 said it was not anyone fault she can't eat the food, it's just her teeth. She asked surveyor if someone could give her a ride to the store to get a blender. During an interview on 10/23/24 at 3:24 p.m., registered dietitian (RD), identified she completes the nutritional assessment for residents at the facility. She determines the need for a mechanically altered diet by looking at the doctor orders and reviewing the nursing progress notes or from feedback at the interdisciplinary team meeting (IDT). RD identified she had completed a preference assessment with R24, and she had told her staff cut up her food. RD stated, "I didn't really pursue it much more since that". RD identified they do not observe the resident eating as part of their assessment and agree R24 should have been evaluated by speech therapy if she had missing teeth and difficulty chewing. The RD identified she works for the facility 8 hours a week, of those hours she currently works 5 hours every other week on site and the rest of the hours are completed remotely. The facility provide Nutritional Assessment guidelines from the Food & Nutrition Services which identified the assessment process includes identifying and assessing the resident's nutritional status and risk factors, evaluating the assessment information, developing, and consistently implementing pertinent approaches, monitoring the effectiveness of interventions, and revising them as needed. The assessment should be completed with residents who are at risk for unplanned weight loss or compromised nutritional status. The guidelines identify the elements of the assessment which includes general appearance such as cognitive status, affect, oral health, and	F 641		

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F 641	Continued From page 4 dentition.	F 641		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an insulin FlexPen was appropriately primed prior to insulin administration for 1 of 2 residents (R14) who received sliding scale (SS) insulin. Findings include: During an observation and interview on 10/22/24 at 4:32 p.m., registered nurse (RN)-A prepared to administer R14's SS insulin dose. R14's blood glucose (BG) reading checked on 10/22/24 at 4:26 p.m. was 264. The physician orders for SS Novolog Aspart insulin (FlexPen) identified the dose to be administered as 8 units. RN-A checked the pen against the MAR, removed the pen cap, dialed the pen to 2 units and depressed the plunger. She then obtained a package containing the needle for the pen, and additional supplies and preceded to R14's room. RN-A performed hand hygiene, applied gloves, wiped the end of the pen with an alcohol pad and attached the needle. She then dialed the pen to 8 units, and prepared to administer the insulin dose. RN-A was interrupted and she and the surveyor exited the room, where RN-A was asked about priming the pen without the needle attached. She responded was the way she had always done it and reported she was not aware	F 760	R14 received correct amount of insulin after nurse was made aware of improper priming procedure. Care plan was reviewed and updated as needed. Residents who receive insulin have the potential to be affected by this practice. Beginning October 31, nurses were educated and competencies were completed by DON or designee to ensure proper administration procedures are followed with administration of insulin pens. Don or designee will complete direct observation of insulin administration audits three times per week for four weeks, two times per week for four weeks and one time per week for one month. These audits will begin the week of November 18. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	11/26/24

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F 760	Continued From page 5 the needle should be attached prior to priming the pen. RN-A responded she was glad to learn this, and stated she had received training which included medication administration, but she was not aware of the FlexPen package insert detailing the correct method of applying the needle, then priming with 2 units to remove the air before dialing the ordered insulin dose. Review of the manufacture's steps for use of a FlexPen included: 1.) check the label to ensure the pen contains the ordered form of insulin 2.) Pull off the pen cap 3.) Pull off the outer needle cap. Keep it to remove the needle from the pen after injection, pull off the inner needle cap and dispose of it. 4.) Turn the dose selector to 2 units 5.) Hold the FlexPen with the needle pointing upwards. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. 6.) Keep the needle upwards and press the push-button all the way in. The dose selector should return to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If a drop still does not appear, you must use a new FlexPen. 7.) Turn the dose selector to select the number of units you need to inject. 8.) Push the needle into the skin, press the dose button until you reel or hear a click and the dose indication lines up with 0. Hold for 6 seconds and remove it. 9.) Guide the needle back into the outer needle cap and when completely on unscrew the needle and dispose of in a sharps container.	F 760		

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F 760	Continued From page 6 Interview on 10/22/24 at 4:45 p.m., director of nursing (DON) and the corporate nursing consultant who was also in attendance identified the facility had a policy on administration of medication which included insulin's, and staff had all been trained on medication administration. She reported her expectation for nursing staff to read and follow the policy, and/or manufacture's instructions for use of an insulin pen, in addition to any other medication. Review of the January 2022 Medication Administration Subcutaneous Insulin from the Nursing Care Center Pharmacy & Procedure Manual Contained photo instructions on administration of insulin with a pen. The policy clearly explained how to attach and detach the needle safely, prime the pen, administer the ordered insulin dose, and safely remove the needle following the administration.	F 760		
F 812 SS=E	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.	F 812		11/26/24

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F 812	Continued From page 7 §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 ensure food temperatures were monitored consistently prior to serving to prevent risk of food born illness. The facility further failed to maintain a clean refrigerator and freezer for food storage. This had the potential to affect all 28 residents residing at the facility. Findings include: During dining/kitchen tour on 10/21/24 at 2:30 p.m., with dietary manager (DM) identified resident refrigerator in the dining room adjacent to the kitchen was to have loose debris laying on the bottom , unknown sticky substance spilled on bottom and on the shelves. In addition, items were not labeled to identify what items belonged to what residents. Observation of the freezer located in the basement of the facility had loose frozen carrots on the bottom, looked like ice buildup on top shelf, and frost around the door. DM reported cleaning the refrigerator and the freezer are shared by nursing and dietary staff. DM revealed there was no cleaning log or schedule to ensure completion. DM further identified they are to be getting a new freezer in the basement and is why it is has not been cleaned. During the evening meal on 10/21/24 at 5:07 p.m., cook (C-A) who checked the temperature	F 812	Food that did not meet standard for temperature guidelines was heated to acceptable limits. Residents who receive meals at the facility have the potential to be affected by this practice. Dietary policy and procedures for monitoring and recording food temperatures and storage of food items were reviewed by the interdisciplinary team with no modification required. Executive Director or Designee presented education and reviewed policy with dietary staff beginning 11/15/2024. Food safety and palatability were reviewed with staff and food storage and cleanliness of storage areas were reviewed. Executive Director or designee will complete audits of compliance with obtaining food temperatures and maintaining standards of practice for food storage three times per week for four weeks, two times per week for four weeks and one time per week for one month. These audits will begin the week of November 18. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	10/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 8 of all food on the steam table. The temperature of the puree pasta was 98.9 and the puree ground beef was 142.7. C-A recorded the temperatures on the Service Line Checklist form and continued set up the area in preparation for serving. C-A then started to dish up the meal after looking at the meal slips. C-A proceeded to dish up puree pasts and was about to place it on the plate when surveyor asked C-A what the holding temperature for the food on the steam table should be and Cook A replied "140." Surveyor asked about the temperature of the pasta being 98.9 and C-A paused and said he needed to heat it up. During an observation on 10/22/24 at 11:50 a.m., DM-B was dishing up the noon meal. DM dished up a plate of puree food included chicken, mashed potatoes, gravy, and vegetables. DM took temperature of the food on the steam table; puree chicken at 111 degrees and the mashed potatoes at 123 degrees. DM indicated the holding temperature should be 145 degrees and he then proceeded to place the plate in the microwave to warm it up. Service Line forms which contained the food temperatures reviewed for October 1, 2024 through noon meal of October 22, 2024 indicated: 10/4/24 One temperature documented for hot cereal and not other temperatures monitored. 10/7/24 All meals had documentation of temperature monitoring completed. 10/8/24 Breakfast was monitored, lunch main entree was monitored, but no other food temperatures were recorded. 10/9/24 All meals temperatures were documented. 10/10/24 All meals temperatures were documented.	F 812	recommendations.	

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F 812	Continued From page 9 10/11/24 Breakfast and lunch had completed temperatures logged, however no other temperatures logged for dinner. 10/13/24 All meals had documented temperatures. 10/14/24 No temperatures for pureed foods at lunch and dinner. 10/15/24 All meals had documented temperatures. 10/16/24 All meals had documented temperatures. 10/17/24 Pureed food (broccoli) had temperature monitored for lunch and the alternate puree was monitored also for dinner. 10/18/24 Only pureed meat was monitored for temperature at lunch and no pureed food monitored at dinner. 10/19/24 All meals had temperatures monitored. 10/20/24 No temperatures were monitored for breakfast or lunch. No pureed food monitored for temperature for dinner 10/21/24 Lunch had no meat or starch pureed temperature monitored. 10/22/24 Breakfast temperature was monitored, and lunch was not. And six days no temperatures taken of food prior to serving. During an interview on 10/22/24 at 12:10 p.m., DM-B confirmed he had not checked the temperature of the food prior to dishing up for service. During an interview on 10/23/24 at 2:15 p.m., Regional Dietary Manager (RDM-C) indicated the expectation was for the cook to monitor food temperatures prior to serving the meal to ensure safe serving temperatures.	F 812		

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F 812	Continued From page 10 During an interview on 10/23/24 at 3:21 p.m., dietician indicated their role was to oversee sanitation audits, review temperature logs, and assess residents for dietary needs. The dietician reported the cleanliness of the resident refrigerator has been a concern and she has been monitoring this. She confirmed food not held at appropriate holding temperature could be a risk to residents for food born illness. She identified her expectations would be food temperatures were monitored prior to being served to assure the proper temperature was maintained. Interview on 10/23/24 at 4:45 p.m., director of nursing indicated she would expect kitchen staff monitor the food temperatures to assure appropriate safe serving temperatures to prevent food born illnesses.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		11/26/24

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F 880	Continued From page 11 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 12 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure utilization of proper personal protective equipment (PPE) with cares for 1 of 2 residents (R8) evaluated for enhanced barrier precautions (EBP). Findings include: R8's quarterly Minimum Data Set dated 9/25/24 indicated R8 was cognitively intact with no behaviors, limited range of motion to both upper and lower extremities, frequent incontinence of bowel and bladder, G-tube (tube surgically placed in stomach), and tube feeding (liquid nutrition provided via g-tube) R8's face sheet indicated diagnoses of Parkinson's disease, severe protein-calorie malnutrition, nutritional anemia, and gastrostomy status. R8's orders indicated check tube placement before initiation of formula, medication administration, and flushing tube every 8 hours, flush tube with 20-30 ml of water before and after medications, check and record residuals, Compleat (brand of liquid nutrition) intermittent	F 880	R8 has been free of signs or symptoms of infection related to this practice. Infection Preventionist validated that signage was on resident□s door and that supplies were readily available when alerted of the concern. R8 care plan was updated to include infection control needs/enhanced barrier precautions. Residents who require enhanced barrier precautions have the potential to be affected by this practice. Care plans were reviewed and verified infection control/ enhanced barrier care plans were in place for like residents. Validated signage was on doors of those residents for enhanced barrier precautions and carts were readily available with supplies. Infection Preventionist or designee provided education to direct care nursing staff on the rationale for enhanced barrier precautions and provided a CDC pocket guide resource for staff to refer to if a resident is on enhanced barrier precautions.	

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F 880	Continued From page 13 gravity 2.5 cans/day. ½ can at 9 am, 1 can at 2 pm, and 1 can at 9 pm. Water flushes of 90 ml before and after feeding. It also indicated enhanced barrier precautions d/t tube feeding. R8's careplan indicated risk for inadequate intake related to Parkinson's disease and need for supplemental enteral nutrition, incontinence of urine/bowel, assist with daily hygiene, grooming, dressing, oral cares and eating as needed. Bed mobility assist of 1-2, EZ stand lift (brand of lift used to assist residents to a standing position) for transfers and need for physical assist with transfers related to physical limitations. It also indicated feeding tube related to need for nutritional support. During observation and interview on 10/23/24 at 8:10 a.m., NA-A was wearing gloves and a hospital gown while providing cares for R8. NA-A assisted resident to a sitting position on the edge of bed. NA-A positioned the EZ stand in front of resident. NA-A assisted R8 to standing position and transferred the resident to the wheelchair. NA-A removed the resident's gown, provided underarm care, and assisted R8 with donning undergarments and shirt. NA-A then removed linens off bed and placed them on the floor and straightened remaining linens. NA-A picked up linens off the floor and placed them in an empty bag. NA-A removed hospital gown by pulling it over their head placing it in dirty laundry bag, removed gloves and washed hands. NA-A put on new gloves, gathered garbage and linens, and placed them in soiled utility room. During interview, NA-A stated residents are placed on EBP if they have devices such as catheters and g-tubes. NA-A stated staff would wear blue plastic gowns and gloves for incontinence cares	F 880	Director of Nursing or designee will complete audits for compliance with standards three times per week for four weeks, two times per week for four weeks and one time per week for one month. These audits will begin the week of November 18. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 880	Continued From page 14 and other close contact with residents. NA-A confirmed wearing a hospital gown and should have worn a disposable blue gown. During interview on 10/23/24 at 9:28 a.m., the infection preventionist (IP) stated EBP are implemented for residents with catheters, g-tubes, central lines, and some wounds to prevent the spread of multidrug resistance organisms (MDROs). PPE is required for resident cares and transfers. The IP stated signs are placed on the residents' doors identifying the level of precautions, the type of PPE to be warn, and the resident interactions require PPE. The IP stated the expectation is for staff to read the signs on a resident's door and apply the appropriate PPE prior to entering the residents' room. The IP confirmed NA-A should have worn a blue disposable gown to provide cares to R8. During interview on 10/23/24 at 11:40 a.m., the director of nursing (DON) stated staff are expected to wear the proper PPE for residents on transmission-based precautions to prevent the spread of MDRO's. The DON confirmed NA-A should have worn a disposable blue plastic gown when providing cares to R8. A policy titled "Enhanced Barrier Precautions" dated 8/8/24, indicated EBP is implemented for the prevention of transmission of MDRO's. EBP is initiated for residents with chronic wounds and/or indwelling medical devices such as central lines, urinary catheters, feeding tubes and tracheostomies/ventilator tubes. PPE (gowns and gloves) are to be donned for high-contact resident care activities such as dressing, bathing, transferring, hygiene, changing linens, and changing briefs/assisting with toileting. It is also	F 880		

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F 880	Continued From page 15 required for indwelling device care and wound care. A policy titled "Personal Protective Equipment" dated 3/17/23 indicated the facility promotes appropriate use of PPE to prevent the transmission of pathogens to residents, visitors, and other staff. Gowns are worn to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material. Dispose of gowns into the appropriate waste receptacle.	F 880		

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	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2024**

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EDENBROOK ROCHESTER WEST	**2215 HIGHWAY 52 NORTH** **ROCHESTER, MN 55901**

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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 10/23/2024. At the time of this survey, ROCHESTER HEALTH SERVICES WEST 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 | 11/21/2024

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

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K 000	Continued From page 1 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 HEALTH SERVICES WEST is a 1 story building with partial basement. ROCHESTER HEALTH SERVICES WEST was built in 1961 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm	K 000		

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K 000	Continued From page 2 system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9, 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed during documentation review that no documentation was presented for review to confirm that 30-second monthly and 90-minute annual emergency light testing is being completed. An interview with the acting Maintenance Director verified this deficient finding at the time of discovery.	K 291	The Maintenance Director will complete the 90 minute annual testing. Once complete a schedule will be made for the monthly 30-second testing of emergencylight fixtures. The testing is be placed on the monthly preventive maintenance program and will be verified to list each emergency light separately.The Maintenance Director is responsible to ensure compliance.	11/27/24

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K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associate to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 9.2.3, and NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2. This deficient finding could have a widespread	K 324	A documentation review was completed with the vendor assigned to complete ansul inspections. Complete records have been obtained and any out of compliance inspects will be completed to return faciity to full compliance. The Director of Maintenance will be responsible for ongoing compliance.	11/27/24

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K 324	Continued From page 4 impact on the residents within the facility. Findings Include: On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed during documentation review that no documentation was presented for review to confirm that ansul system inspection has been completed since 03/27/2024. An interview with the acting Maintenance Director verified this deficient finding at the time of discovery.	K 324		
K 353 SS=F	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, documentation review,	K 353	A documentation review was completed	11/27/24

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EDENBROOK ROCHESTER WEST	**2215 HIGHWAY 52 NORTH** **ROCHESTER, MN 55901**

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K 353	Continued From page 5 and staff interview the facility failed to inspect and maintain the sprinkler system and associated records in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 5.2, 5.2.1.1.2, These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed by observation that sprinkler head(s) located in the Kitchen / Dishwashing areas exhibiting signs of debris loading. 2. On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed by observation that sprinkler head(s) located in the West Dining Room exhibited signs of debris loading. 3. On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed during documentation review that no documentation was presented for review to confirm that Sprinkler System testing had been completed for Q3 of 2024. An interview with the acting Maintenance Director verified these deficient findings at the time of discovery.	K 353	with the vendor assigned to complete sprinkler inspections. Complete records have been obtained and any out of compliance inspects will be completed to return faciity to full compliance. The Director of Maintenance will be responsible for ongoing compliance.	
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		11/27/24

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	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2024**

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K 355	Continued From page 6 NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed during documentation review that no documentation was presented for review to confirm that all fire extinguishers are being inspected / documented monthly. An interview with the acting Maintenance Director verified this deficient finding at the time of discovery.	K 355	the Mainteance Director will conduct an inspection of fire estiguishers and create a schedule for ongoing monthly inspections. Findings will be reviewed at monthly QAPI meetings for accuracy, completion and timeliness. The Director of Maintenance will be responsible for ongoing compliance.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window	K 374		11/27/24

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K 374	Continued From page 7 assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed by observation that the North and South smoke barrier door assemblies exhibited an airgap(s) greater than 1/8 inch, which would allow the passage of smoke. An interview with the acting Maintenance Director verified this deficient finding at the time of discovery.	K 374	The North and South smoke barrier door assemblies will be fitted with {HELP with what we will attach to cover the gap] to ensure the gaps do no exceed 1/8 inch. the maintenance director will be responsible for completion and ongoing compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		11/27/24

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K 521	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and staff interview, it was revealed that the facility is using the corridors as an air plenum which is not in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.5.2 and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed by observation, documentation review and staff interview that the ventilation system in the 1961 building utilized the egress corridors as a return air plenum for the building HVAC system. An interview with the acting Maintenance Director verified this deficient finding at the time of discovery.	K 521	The facility is requesting an ongoing/continuing waiver for K521.	
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	K 712		11/27/24

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K 712	Continued From page 9 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 a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 10/23/2024 between 9:15 AM and 12:15 PM, it was revealed by review of available documentation that no documentation was presented for review to confirm that fire drills had been completed for: 1st Shift - Q3; 2nd Shift - Q2 & Q3; 3rd Shift - Q3. An interview with the acting Maintenance Director verified these deficient findings at the time of discovery.	K 712	The Maintenance Director will utilize the TELS system for ensuring fire drills are completed as required of one shift per quarter. Documentation from the fire drill will be placed in the LSC binder for thefacility. Monthly fire drills will be reviewed at the QAPI meeting to evaluate compliance.The Maintenance Director and NHA isresponsible to ensure compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		4/30/25

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K 918	Continued From page 10 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.1, 8.3, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/23/2024 between 9:15 AM and 12:15 PM,	K 918	The facility is requesting a temporary waiver for K918.	

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K 918	Continued From page 11 it was revealed by a review of available documentation that the facility Gen Set had been serviced 04/01/2024. Vendor documentation included technician notations of needed repairs. No vendor follow-up documentation provided for review to confirm that repairs have been completed. An interview with the acting Maintenance Director verified this deficient finding at the time of discovery.	K 918		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 12, 2024

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: 7VZF11

Dear Administrator:

The above facility was surveyed on October 20, 2024, through October 23, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	10/23/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/21/24-10/23/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with NO deficiencies cited: H53069653C (MN107687). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to appropriately assess for broken/missing teeth and difficulty chewing for 1 of 1 (R24) resident. Findings include: R24's 8/27/24, admission Minimum Data Set (MDS) assessment identified her cognition was moderately impaired. R24's diagnosis list identified diagnosis of moderate protein calorie malnutrition, paranoid schizophrenia, dementia, and weakness. R24's oral assessment dated 8/21/24, indicated R24 had her own teeth and does not wear	2 965	Corrected	11/26/24

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2 965	Continued From page 3 dentures, has chewing problems and R24 would be a regular diet with thin liquids with a care plan intervention to provide diet as ordered. R24's Nutritional Assessment dated 8/26/24, identified R24 ate independently, was on a regular diet, had no difficulty chewing or swallowing, and would be given a supplement three times daily. The assessment summary identified the current diet order remains appropriate, resident appears to be tolerating diet texture and consistency, and current diet order/oral nutritional supplement order provides adequate calories/protein to meet estimate nutritional needs. The summary further identified R24 should continue current nutrition plan of care and care plan had been reviewed and updated. R24's 8/21/24, care plan item identified she was at risk for inadequate intake related to recent hospitalization due to dizziness, with interventions of eating independently, provide diet as ordered, and record weight per facility protocol/MD [medical doctor] orders. During an observation and interview on 10/22/24 at 12:40 p.m., R24 was seated at the edge of her bed with an overbed table in front of her with a meal tray on the table. Her plate had a whole potato with unopened packet of sour cream and butter on the side, R24 attempted to open the sour cream but was unable to. Included on the plate was an open-faced chicken sandwich with large bite size pieces of chicken mixed with gravy on top of a bun, green beans, and a mixed fruit cup on the side. R24 placed a bite of the chicken in her mouth, chewed it up and spit it back out on her spoon. She placed the chewed food to the side of her plate then took another bite, chewed the food and then again spit it out on the spoon	2 965		

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2 965	Continued From page 4 and laid it to the side of her plate. R24 said she cannot chew the meat stating, "this would be good if it was done right, the sauce is good, but I can't chew the meat". During the observation a nursing assistant (NA)-A looked into the room and said she was just checking to see if R24 was done eating, she then closed the door. During and interview on 10/22/24 at 12:54 p.m., NA-A said she offered assistance to R24 when she dropped of her meal tray, she said R24 doesn't like people to help her, she identified she could have opened her sour cream prior to bringing the tray into her room but she did not think of that at the time. During an observation and interview on 10/23/24 at 8:53 a.m., R24 identified she has difficulty chewing, she opened her mouth to reveal no top teeth and several missing lower teeth. During an observation and interview on 10/23/24 at 12:33 p.m., R24, meal tray was on the overbed table in front of her, food items included whole boneless, chicken breast, mixed vegetables, and a dinner roll. R24 looks at her plate and stated "same old same old", R24 points to the chicken breast and states "I can't eat that, I don't have any top teeth. I need a blender so I can blend my food up so I can eat it". R24 said it was not anyone fault she can't eat the food, it's just her teeth. She asked surveyor if someone could give her a ride to the store to get a blender. During an interview on 10/23/24 at 3:24 p.m., registered dietitian (RD), identified she completes the nutritional assessment for residents at the facility. She determines the need for a mechanically altered diet by looking at the doctor orders and reviewing the nursing progress notes	2 965		

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(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) COMPLETE DATE
2 965	Continued From page 5 or from feedback at the interdisciplinary team meeting (IDT). RD identified she had completed a preference assessment with R24, and she had told her staff cut up her food. RD stated, "I didn't really pursue it much more since that". RD identified they do not observe the resident eating as part of their assessment and agree R24 should have been evaluated by speech therapy if she had missing teeth and difficulty chewing. The RD identified she works for the facility 8 hours a week, of those hours she currently works 5 hours every other week on site and the rest of the hours are completed remotely. The facility provide Nutritional Assessment guidelines from the Food & Nutrition Services which identified the assessment process includes identifying and assessing the resident's nutritional status and risk factors, evaluating the assessment information, developing, and consistently implementing pertinent approaches, monitoring the effectiveness of interventions, and revising them as needed. The assessment should be completed with residents who are at risk for unplanned weight loss or compromised nutritional status. The guidelines identify the elements of the assessment which includes general appearance such as cognitive status, affect, oral health, and dentition. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures related to assessment of nutritional needs, care plan interventions, monitoring for residents with poor nutritional status. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. The	2 965		

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2 965	Continued From page 6 DON or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure food temperatures were monitored consistently prior to serving to prevent risk of food born illness. The facility further failed to maintain a clean refrigerator and freezer for food storage. This had the potential to affect all 28 residents residing at the facility. Findings include: During dining/kitchen tour on 10/21/24 at 2:30 p.m., with dietary manager (DM) identified resident refrigerator in the dining room adjacent to the kitchen was to have loose debris laying on the bottom , unknown sticky substance spilled on bottom and on the shelves. In addition, items	21025	Corrected	11/26/24

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21025	Continued From page 7 were not labeled to identify what items belonged to what residents. Observation of the freezer located in the basement of the facility had loose frozen carrots on the bottom, looked like ice buildup on top shelf, and frost around the door. DM reported cleaning the refrigerator and the freezer are shared by nursing and dietary staff. DM revealed there was no cleaning log or schedule to ensure completion. DM further identified they are to be getting a new freezer in the basement and is why it is has not been cleaned. During the evening meal on 10/21/24 at 5:07 p.m., cook (C-A) who checked the temperature of all food on the steam table. The temperature of the puree pasta was 98.9 and the puree ground beef was 142.7. C-A recorded the temperatures on the Service Line Checklist form and continued set up the area in preparation for serving. C-A then started to dish up the meal after looking at the meal slips. C-A proceeded to dish up puree pasts and was about to place it on the plate when surveyor asked C-A what the holding temperature for the food on the steam table should be and Cook A replied "140." Surveyor asked about the temperature of the pasta being 98.9 and C-A paused and said he needed to heat it up. During an observation on 10/22/24 at 11:50 a.m., DM-B was dishing up the noon meal. DM dished up a plate of puree food included chicken, mashed potatoes, gravy, and vegetables. DM took temperature of the food on the steam table; puree chicken at 111 degrees and the mashed potatoes at 123 degrees. DM indicated the holding temperature should be 145 degrees and he then proceeded to place the plate in the microwave to warm it up.	21025		

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21025	Continued From page 8 Service Line forms which contained the food temperatures reviewed for October 1, 2024 through noon meal of October 22, 2024 indicated: 10/4/24 One temperature documented for hot cereal and not other temperatures monitored. 10/7/24 All meals had documentation of temperature monitoring completed. 10/8/24 Breakfast was monitored, lunch main entree was monitored, but no other food temperatures were recorded. 10/9/24 All meals temperatures were documented. 10/10/24 All meals temperatures were documented. 10/11/24 Breakfast and lunch had completed temperatures logged, however no other temperatures logged for dinner. 10/13/24 All meals had documented temperatures. 10/14/24 No temperatures for pureed foods at lunch and dinner. 10/15/24 All meals had documented temperatures. 10/16/24 All meals had documented temperatures. 10/17/24 Pureed food (broccoli) had temperature monitored for lunch and the alternate puree was monitored also for dinner. 10/18/24 Only pureed meat was monitored for temperature at lunch and no pureed food monitored at dinner. 10/19/24 All meals had temperatures monitored. 10/20/24 No temperatures were monitored for breakfast or lunch. No pureed food monitored for temperature for dinner 10/21/24 Lunch had no meat or starch pureed temperature monitored. 10/22/24 Breakfast temperature was monitored, and lunch was not. And six days no temperatures taken of food prior	21025		

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21025	Continued From page 9 to serving. During an interview on 10/22/24 at 12:10 p.m., DM-B confirmed he had not checked the temperature of the food prior to dishing up for service. During an interview on 10/23/24 at 2:15 p.m., Regional Dietary Manager (RDM-C) indicated the expectation was for the cook to monitor food temperatures prior to serving the meal to ensure safe serving temperatures. During an interview on 10/23/24 at 3:21 p.m., dietician indicated their role was to oversee sanitation audits, review temperature logs, and assess residents for dietary needs. The dietician reported the cleanliness of the resident refrigerator has been a concern and she has been monitoring this. She confirmed food not held at appropriate holding temperature could be a risk to residents for food born illness. She identified her expectations would be food temperatures were monitored prior to being served to assure the proper temperature was maintained. Interview on 10/23/24 at 4:45 p.m., director of nursing indicated she would expect kitchen staff monitor the food temperatures to assure appropriate safe serving temperatures to prevent food born illnesses. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure the cook or dietary staff are completing temperature monitoring of food prior to food service. The facility could update or	21025		

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21025	Continued From page 10 create policies and procedures, and educate staff on facility policy of food temperature monitoring and required safe holding temperatures on the steam table in preparation and serving of meals. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure temperature monitoring was performed and resident meals were within appropriate temperature. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of	21390		11/26/24

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21390	Continued From page 11 employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure utilization of proper personal protective equipment (PPE) with cares for 1 of 2 residents (R8) evaluated for enhanced barrier precautions (EBP). Findings include: R8's quarterly Minimum Data Set dated 9/25/24 indicated R8 was cognitively intact with no behaviors, limited range of motion to both upper and lower extremities, frequent incontinence of bowel and bladder, G-tube (tube surgically placed in stomach), and tube feeding (liquid nutrition provided via g-tube) R8's face sheet indicated diagnoses of Parkinson's disease, severe protein-calorie malnutrition, nutritional anemia, and gastrostomy status. R8's orders indicated check tube placement before initiation of formula, medication administration, and flushing tube every 8 hours, flush tube with 20-30 ml of water before and after medications, check and record residuals,	21390	Corrected	

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21390	Continued From page 12 Compleat (brand of liquid nutrition) intermittent gravity 2.5 cans/day. ½ can at 9 am, 1 can at 2 pm, and 1 can at 9 pm. Water flushes of 90 ml before and after feeding. It also indicated enhanced barrier precautions d/t tube feeding. R8's careplan indicated risk for inadequate intake related to Parkinson's disease and need for supplemental enteral nutrition, incontinence of urine/bowel, assist with daily hygiene, grooming, dressing, oral cares and eating as needed. Bed mobility assist of 1-2, EZ stand lift (brand of lift used to assist residents to a standing position) for transfers and need for physical assist with transfers related to physical limitations. It also indicated feeding tube related to need for nutritional support. During observation and interview on 10/23/24 at 8:10 a.m., NA-A was wearing gloves and a hospital gown while providing cares for R8. NA-A assisted resident to a sitting position on the edge of bed. NA-A positioned the EZ stand in front of resident. NA-A assisted R8 to standing position and transferred the resident to the wheelchair. NA-A removed the resident's gown, provided underarm care, and assisted R8 with donning undergarments and shirt. NA-A then removed linens off bed and placed them on the floor and straightened remaining linens. NA-A picked up linens off the floor and placed them in an empty bag. NA-A removed hospital gown by pulling it over their head placing it in dirty laundry bag, removed gloves and washed hands. NA-A put on new gloves, gathered garbage and linens, and placed them in soiled utility room. During interview, NA-A stated residents are placed on EBP if they have devices such as catheters and g-tubes. NA-A stated staff would wear blue plastic gowns and gloves for incontinence cares	21390		

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21390	Continued From page 13 and other close contact with residents. NA-A confirmed wearing a hospital gown and should have worn a disposable blue gown. During interview on 10/23/24 at 9:28 a.m., the infection preventionist (IP) stated EBP are implemented for residents with catheters, g-tubes, central lines, and some wounds to prevent the spread of multidrug resistance organisms (MDROs). PPE is required for resident cares and transfers. The IP stated signs are placed on the residents' doors identifying the level of precautions, the type of PPE to be warn, and the resident interactions require PPE. The IP stated the expectation is for staff to read the signs on a resident's door and apply the appropriate PPE prior to entering the residents' room. The IP confirmed NA-A should have worn a blue disposable gown to provide cares to R8. During interview on 10/23/24 at 11:40 a.m., the director of nursing (DON) stated staff are expected to wear the proper PPE for residents on transmission-based precautions to prevent the spread of MDRO's. The DON confirmed NA-A should have worn a disposable blue plastic gown when providing cares to R8. A policy titled "Enhanced Barrier Precautions" dated 8/8/24, indicated EBP is implemented for the prevention of transmission of MDRO's. EBP is initiated for residents with chronic wounds and/or indwelling medical devices such as central lines, urinary catheters, feeding tubes and tracheostomies/ventilator tubes. PPE (gowns and gloves) are to be donned for high-contact resident care activities such as dressing, bathing, transferring, hygiene, changing linens, and changing briefs/assisting with toileting. It is also required for indwelling device care and wound	21390		

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21390	Continued From page 14 care. A policy titled "Personal Protective Equipment" dated 3/17/23 indicated the facility promotes appropriate use of PPE to prevent the transmission of pathogens to residents, visitors, and other staff. Gowns are worn to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material. Dispose of gowns into the appropriate waste receptacle. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could review and revise policies and procedures in relation to the facility's infection control program. The administrator or designee could provide education to all facility staff on infection control and appropriate personal protective equipment. The administrator or designee could do weekly/monthly audits for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		11/26/24

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21426	Continued From page 15 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 employees (E)-4 records reviewed who provides direct care to facility residents were free of tuberculosis (TB). This practice had the potential to affect all 30 residents, staff, and visitors in the facility. Findings include: E-4 was hired 7/3/24, lacked evidence a two-step testing for TB had been administered upon hire. During interview on 10/22/2024 at 4:01 p.m., the infection preventionist (IP) stated the facility does symptom screening on all new hires. IP stated the facility would normally do skin testing however, since TB risk assessment shows low risk, employees do not require serial testing. IP confirmed E-4 did not receive the two-step series because they thought "serial testing" referred to two-step testing and "baseline testing" referred to symptom screening. IP confirmed E-4 should have had a two-step skin testing. During interview on 10/23/2024 at 2:52 p.m., the IP stated E-4 had previously been employed at a	21426	Corrected	

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21426	Continued From page 16 staffing agency prior to employment at this facility. The IP and E-4 reached out to the previous employer to obtain record of testing. IP confirmed the current employer did not have record of E-4's previous two-step testing. An email communication received 10/24/24 at 11:15 a.m., from the IP, contained documentation of E-4's previous two-step results dated 2/27/24 and 3/17/24. Although current employers are required to administer a skin test upon hire. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure tuberculin screening procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		