Please note that the Health and Life Safety Code Surveys are being processed in seperate enforcement cycles. This letter is for the Health Survey enforcement cycle.

Electronically Submitted
May 13, 2022

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

RE: CCN: 245306
Cycle Start Date: April 27, 2022

Dear Administrator:

On April 27, 2022, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 21, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

On April 27, 2022, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal

regulations at 42 CFR § 488.417(a), effective May 28, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 28, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 28, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Rochester Health Services West is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs

for two years effective April 27, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 27, 2022 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing

request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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
E 000	Initial Comments On 4/18/22 through 4/27/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/18/22 through 4/27/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5306078C(MN82516); however NO deficiencies were cited due to actions implemented by the facility prior to survey The following complaint was found to be UNSUBSTANTIATED: H5306077C(MN81831). Based on observation, interview and document review, the facility failed to thoroughly investigate allegations of abuse and neglect made by 4 residents (R9, R24, R5, and R17) about 1 nursing assistant (NA-A) and an unidentified NA. This resulted in an immediate jeopardy for R9, R24, R5 and R17 who expressed distress and psychosocial harm as they had not been	F 000		

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

Electronically Signed — 05/23/2022

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
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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	Continued From page 1	F 000		

protected from NA-A being verbally abusive towards them and rough with them.

The IJ began on 4/20/22, when it was identified NA-A had multiple accusations of rough and verbally abusive behavior and neglectful behaviors made against her and the facility had not thoroughly investigated or protected residents during an investigation. The administrator and director of nursing (DON) of the facility were notified of the IJ on 4/20/22, at 2:13 p.m. The IJ was removed on 4/21/22 at 5:00 p.m., but noncompliance remained at the lower scope and severity level of G - isolated scope and severity level, with actual harm that is not immediate.

In addition:

Based on observation, interview and document review the facility failed to ensure infection control procedures were implemented to reduce the risk and spread of an unknown gastrointestinal (GI) illness in the facility resulting in 10 of 28 residents (R82, R27, R1, R20, R18, R19, R26, R15, R13, and R9) developing GI symptoms and the facility lacked any investigation of causal factors and or testing for pathogen. In addition, the facility failed to implement timely isolation of symptomatic residents, and failed to perform hand hygiene following care of symptomatic residents, placing this vulnerable population of residents and health care workers at risk of serious illness. Further, the facility failed to use sanitary practices when passing ice water to residents, using bare hands and a cup inside with the ice to scoop, this had the potential to affect all 28 residents currently residing in the facility.

The immediate jeopardy (IJ) began on 4/12/22

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 ______	C 04/27/2022

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	Continued From page 2 when the facility failed to ensure infection control procedures were implemented related to signs and symptoms of GI illness to reduce the risk of spread of unknown GI illness and was identified on 4/22/22. The administrator and director of nursing (DON) were notified of the IJ on 4/22/22, at 1:31 p.m. The IJ was removed on 4/27/22 at 1:07 p.m. when the facility ensured all residents with symptoms of GI illness were placed on transmission-based precautions with signage in place. All residents were screened for signs of GI illness, the physician was notified, policies and procedures were reviewed, all staff were educated, high touch areas were disinfected, tracking was started for employee call in's, and audits of handwashing were started. However, the non-compliance remained at the lower scope and severity of an F -widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted from 4/20/22 to 4/27/22. 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		

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 ______	C 04/27/2022

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 554	Continued From page 3	F 554		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R24) observed to self-administer nebulizer medications. Findings include: R24's significant change Minimum Data Set (MDS) dated 4/8/22, included cognitively intact with diagnoses including schizoaffective disorder, anxiety disorder, congested heart failure (CHF), chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, asthma, pulmonary embolism, and obstructive sleep apnea. R24 required extensive assistance from staff for dressing and personal hygiene. R24's Order Summary Report dated 4/24/22, included Ipratropium-Albuterol Solution (medicine that is used to treat air flow blockage and prevent worsening of COPD, asthma or other lung diseases) 0.5-2.5 (3) mg/3 ml 1 vial inhale orally four times a day for shortness of breath. The physician orders lacked self-administration of medications. R24's care plan dated 6/1/21, included R24 had risk for respiratory impairment related to CHF, COPD, sleep apnea, and asthma, but	F 554	F 554 A medication self-administration assessment was completed for R 24 and physician orders updated based on results of assessment on May 17, 2022 Residents who self-administer nebulizers after nurse set up of device have the potential to be impacted by the alleged practice. Self-administration assessments were completed for like residents and physician orders updated based on results of the assessment beginning May 17, 2022. The director of nursing or designee provided education to licensed nurses beginning May 18, 2022, on the need to complete a self-administration assessment and update physician orders for residents who complete nebulizers after nurse sets up administration of nebulizer for resident. Education included information on remaining with residents who are unable to maintain position of handheld nebulizer or mask nebulizer. Audits for compliance with professional standards for self-administration of nebulizer treatments will be completed weekly for four weeks through direct observation and review of documentation by the director of nursing or designee.	6/2/22

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 ______	C 04/27/2022

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 554	Continued From page 4 interventions had not included self-administration of medications. During an observation and interview on 4/18/22, at 6:32 p.m. R24's nebulizer equipment in room was set up on nightstand table with clear fluid in chamber and moisture bubbles. R24 stated facility staff have her hold nebulizer treatment onto face while it is administering and she's supposed to turn on call light when the medication is done dispensing. During an observation and interview on 4/22/22, at 11:55 a.m. R24 was observed holding nebulizer equipment up to face without a nurse present. R24 stated the nurse told her to press her call light button when medication was finished administering. When interviewed on 4/22/22, at 12:32 p.m. registered nurse (RN)-B confirmed R24 did not have a current self-administration of medications order or an assessment completed by the interdisciplinary team from physician and stated R24 had self-administered the noon dose. When interviewed on 4/25/22, at 11:05 a.m. director of nursing (DON) stated residents should not self-administer nebulizer's without a nursing assessment to observe for safe administration and a current physician's order. The facility policy titled Medication Self Administration dated 6/1/17 indicated, residents are not permitted to administer or retain any medication in his or her room unless their attending physician writes an order for self-administration of the medication, and the resident is assessed.	F 554	Audits will be initiated the week of May 23, 2022. The results of the audits will be forwarded to the facility quality committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to thoroughly investigate allegations of abuse and neglect made by 4 residents (R9, R24, R5, and R17) about 1 nursing assistant (NA-A) and an unidentified NA. This resulted in an immediate jeopardy for R9, R24, R5 and R17 who expressed distress and psychosocial harm as they had not been protected from NA-A being verbally abusive towards them and rough with them. The IJ began on 4/20/22, when it was identified NA-A had multiple accusations of rough and verbally abusive behavior and neglectful behaviors made against her and the facility had not thoroughly investigated or protected residents during an investigation. The administrator and director of nursing (DON) of the facility were notified of the IJ on 4/20/22, at 2:13 p.m. The IJ was removed on 4/21/22 at 5:00 p.m., but	F 600	F 600 R 17, and R24s allegations were investigated beginning 4/19/22 with final reports submitted by required time frame. R5 and R9 allegations were reported on 04/19/22 with final reports submitted within required time frame. Employee NA-A and NA-B are no longer employed at the facility. R5, R9, and R 24 continue to have weekly PHQ-9 assessments completed and have demonstrated scores at or below usual baseline. R 17 has chosen not to complete repeat PHQ9 assessments. Residents who receive care and services at the facility have the potential to be impacted by the alleged practice. Audits are completed five times weekly during morning meeting to determine if any reported grievances need to be elevated	6/2/22

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 ______	C 04/27/2022

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 600	Continued From page 6	F 600		

noncompliance remained at the lower scope and severity level of G - isolated scope and severity level, with actual harm that is not immediate.

Findings include:

R9's quarterly Minimum Data Set (MDS) dated 2/10/22, included cognitively intact with diagnoses including cerebral palsy and recurrent major depressive disorder. No behaviors or rejection of cares were noted.

R9's care plan revised 8/3/21, indicated R9 was a vulnerable adult and at risk for potential abuse related to being a long term resident that utilized adaptive equipment and required staff assistance for activities of daily living (ADL's). R9's care plan indicated facility staff would be educated on reporting abuse and would redirect from potentially dangerous situations. R19 should remain free of retaliation if alleged abuse was reported. Facility staff would observe for changes in mood, behavior, psychosocial needs and cognition. R9's care plan also included, "Has verbalized specific staff that she prefers not to provide care to her." The only interventions for this included, it would be reviewed at care conferences how it was going and, "Staff have been made aware of resident preferences."

During an observation and interview on 4/18/22, at 3:41 p.m. R9 stated nursing assistant (NA)-A was, "such a smartass and does not listen to her residents." R9 stated NA-A told her, "don't tell me what to do!" R9 stated NA-A is two faced; stating one minute she is really sweet and the next time she will turn a cheek on you. R9 disclosed NA-A and activities aide (ACT)-B were family members. R9 had asked ACT-B to assist her with elevating

to abuse investigations. Abuse investigations are reviewed by the facility interdisciplinary team and approved by the Director of Clinical Services or Vice President of Operations prior to submitting the five-day report.
The leadership team was educated during an ad hoc Quality Assurance meeting regarding reporting requirements by the clinical support team on April 20, 2022. Education was presented by the Executive Director or designee beginning April 20, 2022, to facility staff on the guidelines for reporting and investigating allegations of abuse. Post-tests to validate understanding were completed beginning April 20, 2022. Education was repeated by the Director of Nursing or designee to direct care staff beginning May 18, 2022. The Executive Director or designee completes audits three times weekly for twelve weeks or until substantial compliance is achieved. Audits were initiated April 20, 2022. Results of audits will be forwarded to the facility quality committee for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 600	Continued From page 7	F 600		

legs from floor to bed. NA-A entered R9's room on 4/11/22, and yelled at ACT-B for assisting resident's legs into bed, stating "you can't do that, you don't know what you're doing, and you're not doing it right." R9 stated NA-A, "threw," her legs into bed and it hurt her legs and hurt her pride. R9 stated she felt NA-A treated her legs roughly on purpose. R9 stated she did not report the incident to management, but thought ACT-B would have notified them. R9 stated NA-A would often make her feel, "less than human and as someone without a brain," when providing cares to her. NA-A would often tell R9 she did not know what she was doing when it came to her own cares, well-being, and knowing her own body. R9 was observed teary eyed and saddened when speaking to surveyor about the incident. R9 stated she felt NA-A verbally abused her and physically hurt her legs. R9 stated she knew her own body, she has full cognition, and has to tell NA's how to do their jobs as most of them are improperly trained at facility.

When interviewed on 4/19/22, at 8:24 a.m. R9 stated NA-A is, "just a thorn in my side." R9 stated she wished NA-A wasn't even at the facility as she gets very nervous when NA-A is around her. R9 stated she has told facility staff about NA-A's, "psychosocial mistreatment, verbal abuse, and being rough," with her. R9 stated she had informed other NA's, activity staff, and the director of nursing (DON) but nothing was ever done about it. R9 stated she felt the DON, "didn't do anything at all, to be honest." R9 stated she cringed at the sight of seeing NA-A out in the north hallway, "let alone, when she comes into my room." R9 was observed shaking and teary eyed again after repeating incident.

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 ______	C 04/27/2022

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 600	Continued From page 8	F 600		

Continued From page 8

When interviewed on 4/19/22, at 8:56 a.m. activities director (AD)-A stated she was unaware of the situation involving R9, NA-A, and ACT-B as ACT-B did not mention it to her. AD-A stated ACT-B should not have been completing activities of daily living (ADL's) such as assisting legs into bed for R9. ACT-B was not available for interview.

When interviewed on 4/19/22, at 9:25 a.m. the director of nursing (DON) stated she was unaware of an incident involving R9, NA-A, and ACT-B where R9 made an accusation NA-A had verbally abused her and provided rough treatment by throwing her legs into bed roughly. DON stated numerous times the facility was immediately suspending NA-A pending an internal investigation. DON stated she was going to notify the facility management team and start an investigations right away. DON stated R9 and NA-A had a concern approximately one year ago, but there were no recent concerns noted. The DON was notified R9 was very tearful when talking about NA-A and R9 stated she cringes at the sight of NA-A. DON confirmed again NA-A would be suspended.

A facility reported incident dated 8/19/21, identified R9 had reported NA-A and another NA had transferred her roughly, this was found to be unsubstantiated by the facility investigation.

When interviewed on 4/20/22, at 7:56 a.m. licensed practical nurse (LPN)-A stated she had no knowledge of R9 making any allegations against NA-A.

When interviewed on 4/20/22, at 8:19 a.m. environmental services manager (EVS)-A stated

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 ______	C 04/27/2022

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 600	Continued From page 9	F 600		

R9 shared with her an incident that occurred sometime in the past month but was uncertain of exact date. EVS-A brought laundry to R9'S room the following morning. R9 informed EVS-A an incident happened the evening prior when NA-A was working. NA-A yelled at R9 telling her, "No we are going to do it my way, not your way." EVS-A stated R9 was visibly upset about this, raised her voice, and shook as she spoke about it. EVS-A immediately reported it to the DON, but did not know if anything had been done about it. EVS-A reported DON has bimonthly nursing staff meetings so EVS-A assumed it was addressed. EVS-A stated she has heard, "through the grapevine," that NA-A can be rough with residents at the facility, but had not witnessed this herself.

When interviewed on 4/20/22, at 9:30 a.m. SW stated she had witnessed NA-A, "rushing," resident cares and has told NA-A to slow down. Once in December 2021, NA-A was putting on R9's shoes, "so quick it hurt her." SW had told NA-A to slow down and NA-A got defensive. SW had stayed in R9's room afterwards and R9 told her, "I was so thankful you stayed in the room and were here." SW stated R9 had confided in her that she was, "terrified," of NA-A. SW stated she had reported the episode to registered nurse (RN)-D, however, RN-D told NA-A and then NA-A came back to her and NA-A became upset and told SW, "this is none of your business."

When interviewed on 4/20/22, at 10:20 a.m. the DON stated R9 and NA-A had, "prior encounters and had gone back and forth many times." R9 did not like NA-A because she was, "loud, brassy, and a know it all." NA-A had been moved to the other hallway (south) at one time as R9 did not want NA-A on her hallway (north) nor providing

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 ______	C 04/27/2022

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 600	Continued From page 10 cares for her. The DON stated R9 was, "strong-minded," "needs to be in control," and tells staff how she likes things done and does not like to it if anyone gives their own opinion. The DON stated NA-A, "clashes with any resident who required delicate care." The DON stated there were residents on the other hall that would be considered delicate too and NA-A was eventually moved back to the hall where R9 resides. When interviewed on 4/20/22, at 1:40 p.m. the administrator stated she was unaware of incident involving R9, ACT-B, and NA-A. The DON typically does the initial report to the state agency, but stated she kept a full paper copy of all incidences reported. The administrator had not allegations of abuse from R9. When interviewed on 4/21/22, at 8:51 a.m. R9 stated she cringed every single time NA-A was working and especially if she was assigned to the north hall. R9 stated NA-A caused her a great deal of pain when she, "grabbed," her legs and no other staff has ever done this to her before. R9 stated she found out today that NA-A was not coming back and she was happy she would not be abused again. R9 stated she was "about at the end of her rope" with the cares she received from NA-A. R9 stated she was treated with much disrespect and this made her feel mad. When interviewed on 4/25/22, at 9:25 a.m. R9 stated knowing NA-A was gone that it took a big load off of her shoulders. R9 stated she cried many times behind closed doors from the treatment she received from NA-A. R9 stated facility staff were aware NA-A was not welcome inside her resident room, but for some reason NA-A consistently worked on north hall. R9 stated	F 600		

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 ______	C 04/27/2022

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 600	Continued From page 11	F 600		

NA-A was rough and would, "just yank my legs which caused severe pain in my back and legs." R9 stated she almost slipped off the edge of her bed once as NA-A, "yanked on me so hard and fast." R9 stated she told multiple facility staff which included NA's, SW, and DON that she preferred NA-A to not be in her room, but this never happened as R9 felt she was never heard by facility staff. R9 stated she kept quiet for a long time until she could not take it anymore as the treatment only got worse. R9 stated she felt NA-A verbally and physically abused her at facility.

R24's significant change MDS dated 4/8/22, included cognitively intact with diagnoses including schizoaffective disorder, anxiety disorder, fibromyalgia, rheumatoid arthritis, and chronic pain syndrome. No behaviors or rejection of cares were noted.

R24's care plan dated 4/16/21, indicated R24 was a vulnerable adult at risk for potential abuse due to requiring assistance for all activities of daily living (ADL's) and some assistance for decision making. R24's care plan indicated the facility staff were educated on reporting abuse and would redirect from potentially dangerous situations. R19 should remain free of retaliation if alleged abuse was reported. Facility staff would observe for changes in mood, behavior, psychosocial needs and cognition.

When interviewed on 4/18/21, at 6:05 p.m. R24 stated some of the nursing assistants (NA) were, "rough and tough." R24 stated she told them to be more gentle as it really hurt her. R24 stated an unnamed NA recently refused to get her a bedpan to have a bowel movement. NA instructed

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 ______	C 04/27/2022

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 600	Continued From page 12	F 600		

R24 to just go in her depends and they would change her afterwards. R24 stated the NA told her the bedpan was not big enough for her and the facility does not utilize bedpans. R24 stated she did not want to go in her pants and this was not okay with her. R24 would not provide specific information on who this NA was. R24 was observed to be teary eyed during interview and appeared to be hesitant in providing information specific to NA.

When interviewed on 4/19/22, at 3:27 p.m. R24 stated she spoke to SW earlier today and informed her of the NA's name but was unwilling to share information as her roommate was in the room. R24 informed surveyor NA was a female.

When interviewed on 4/19/22, at 4:43 p.m. SW stated R24 informed her the alleged perpetrator was NA-A and was very focused on this NA.

When interviewed on 4/21/22, at 1:36 p.m. R24 stated the NA she had concerns with was NA-A. R24 stated NA-A on multiple occasions would grab her arm so hard it would hurt. Once she grabbed her arm so hard it lifted her right off the bed. R24 also stated NA-A would scrub so hard on her, "private parts," that she felt like, "a scrubbing board." R24 stated NA-A had left bruises on her arms and legs at times. R24 stated having to be cared for by NA-A had, "taken a toll," on her mental health and she was depressed over it. Once R24 requested to be boosted up in bed by NA-A and NA-A told her to do it herself. When R24 told NA-A she was unable to do that, NA-A told her if she didn't stay in bed all the time, she would be able to do it. At that point R24 tried to explain her medical condition to NA-A and NA-A just walked out of the

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 ______	C 04/27/2022

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 600	Continued From page 13	F 600		

room while she was speaking. R24 stated she didn't know why NA-A was so rough and mean to her. "I feel like a big fat nobody." R24 had tears in her eyes. R24 had not reported it, stating every time she would say something, NA-A would be take it out on her. R24 stated she felt she had been physically and verbally abused by NA-A on multiple occasions.

When interviewed on 4/22/22, at 8:45 a.m. NA-B stated R24 had no behavioral concerns other than refusing cares at times. NA-A stated R24 could be, "needy" at times and demanding on staff.

R5's annual MDS dated 4/19/22, identified R5 had had a slight decline in his cognitive score from being fully cognitively intact in January, to being moderately impaired, and also exhibited mild depression. The MDS indicated R5 did require assistance with his activities of daily living skills (ADLs).

R5's care plan had a focus problem area dated 4/16/20: ADL self-care deficit related to: physical limitations. Associated interventions prompted NAs to provide assistance with his daily cares including bathing and hygiene, but did not indicate how many persons were required to assist with his care. Additionally, R5's care plan indicated: Resident was at risk for potential abuse due to requiring assistance with mobility and ADL's. The goal indicated he would be safe and free from abuse during his stay. Associated interventions indicated staff would be educated and R5 would be encouraged to verbalize concerns of problems.

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 ______	C 04/27/2022

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 600	Continued From page 14	F 600		

When interviewed on 4/19/22, 9:30 a.m. R5 stated there was a nursing assistant, that he was only able to describe as a black woman (her name possibly starting with a "T") who would not respond to his request for assistance to clean up after a bowel movement. R5 stated, "she will say, 'I need to find someone to help me', but then she will leave and it will be an hour or so." R5 stated the NA might come back and say she had not found anyone to help and would leave again. R5 felt he had waited up to four hours for help. R5 stated he was able to turn himself in bed so cares could be provided, and his ability to turn was observed during the interview. R5 stated he had asked for someone in leadership to come talk with him, but felt they did not respond to his requests. R5 also reported that he had complained to a NA about his care, feeling it was rough and caused him pain. R5 further reported, the NA responded to him in a mocking tone and said, "why don't you call the ombudsman or your caseworker?" R5 was unable to recall the name of the NA. R5 stated he had called his personal representative to report his concerns since he felt no-one was responding to his request to talk. R5 felt he had been treated roughly and rudely on multiple occasions by this NA.

On 4/19/22, 4:31 p.m. the administrator brought in evidence of a past investigation related to R5, and also the nursing schedule for 4/7/22 through 4/10/22 that had been reviewed in response to R5's allegations. The administrator stated the only person with a name starting with "T" had worked on 4/7/22 prior to R5's stated concerns, and stated that individual did not fit the description, so they had no one they could suspend while they investigated. Administrator and DON were both present and stated they had

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 ______	C 04/27/2022

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 600	Continued From page 15	F 600		

not yet spoken with R5 since receiving the reported concern at 10:47 a.m. because the facility worked with R5's representative, a case worker-advocate (CW) instead, saying that was "what he [R5] was comfortable with." The administrator was unaware R5 had requested management speak with him, but no one ever came.

A review of a Grievance/Complaint form dated 4/13/22 indicated the facility had received a concern from R5's CW. It indicated the complaint was provided to the administrator and social worker (SW). The grievance outlined R5's concerns with the NA (a person of color, name starting with "T") turning off the call-light after he had requested assistance, and included a statement that NA had indicated lack of knowledge of how to change a bed with a resident in it [standard of care for NA]. Grievance indicated NA did not return for four hours. Also, the form included a grievance that the same NA took two hours to bring a glass of ice, and also the same NA had told R5 to "hurry up" as NA was scheduled to leave soon as it was almost 10 p.m.

A subsequent review of the nursing schedule for 4/8/22 and 4/9/22 did not show any nursing assistants with a name starting with the letter "T."

When interviewed on, 4/20/22, 8:54 a.m. CW, providing support to R5, stated R5 had had similar concerns in the past. In the last week or so, R5 had stated a similar complaint of a person not providing care when he had turned his light on for assistance after he had a BM. R5 had reported rude, mocking and disrespectful behavior by a nursing assistant to CW. CW stated, "Last week we talked to SW 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 ______	C 04/27/2022

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 600	Continued From page 16	F 600		

administrator to file a grievance. I didn't know another way to file a complaint." CW said R5 had requested to talk to anyone in leadership, the administrator, DON, but said no-one had responded to his request. CW stated she assisted R5 by calling the facility to file a grievance on 4/12/22. In response to that call, CW said the facility indicated they would investigate his concerns, pull a call-light report and try to talk with the staff person to address R5's concerns. CW also said R5 could not recall the name of the NA, but it might have started with a "T," and the incident had occurred possibly Friday 4/8/22 or Saturday 4/9/22 during the evening shift. CW stated she attempted to advocate for R5, but felt it was difficult as the facility did not often reach out to her and she felt there was little change in response to any concerns brought forward.

When interviewed on 4/20/22, at 9:30 a.m. SW stated she had spoken to R5's CW on 4/12/22, CW had been concerned because an aide had turned off his call light, was not attentive, would not give him ice and made him wait 4 hours in soiled undergarment before changing him. SW stated the CW was reporting neglect and this should have been reported to the state agency and investigated.

When interviewed on, 4/25/22, 8:20 a.m. NA-F stated she usually took care of R5 in the morning and R5 would require a total change of bed linen almost every morning due to accidents with his urinal use. NA-F stated R5 did not get out of bed at that time because it was too painful for him to use the Hoyer lift, but his arms were strong. NA-F stated R5 only required a boost on his back or bottom to fully turn in bed. NA-F stated she could

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 _______	C 04/27/2022

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 600	Continued From page 17	F 600		

easily change the linens and provide personal cares to R5 independently without assistance. NA-F stated that R5 sometimes had refused to have cares completed, but one person could provide those cares when he was accepting of them.

When interviewed on 4/25/22, 9:33 a.m. R5 again expressed distress about being left in BM unattended, and being talked to in a mocking tone of voice and stated it made him feel, "so, so ...I felt uncared for, like you're, like you're not good enough." R5 had difficulty speaking this, turned away and had tears in his eyes.

R17's significant change MDS dated 2/24/22, identified cognitively intact and had no behavior problems. R17 required extensive staff assistance for most activities of daily living (ADL's) except could feed self with set up. R17 diagnosis included heart, kidney and respiratory failure.

R17's care plan dated 9/23/21, included paranoia/suspiciousness related to life experiences history of unhealthy relationships. R17's goal was to feel safe and secure in the environment. Staff were directed to, use consistent daily routine and caregivers, praise for acceptable behavior and explain procedures. Another care plan area was, ruminating and catastophizing behavior. Staff were directed to keep details to a minimum, remain positive, and ask if would like to be left alone for a while. In addition, the care plan identified R17 as a vulnerable adult and was at risk for abuse. Staff were to be educated on abuse reporting and R17 would be encouraged to verbalize concerns or

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 ______	C 04/27/2022

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 600		F 600		

Continued From page 18
problems.

When interviewed on 4/18/22, at 2:31 p.m. R17 stated she was unsure of the date, but there was an incident which occurred possibly in August or September 2021 with NA-A. R17 stated she was unsure of the date, but she had been stronger and had been able to get up to the toilet. R17 said she had not been able to get fully seated on the toilet stool and had dribbled on it, so asked NA-A for paper towels to clean it. Then R17 said she realized she had not finished urinating and asked NA-A to wait. R17 reported that NA-A had said, "Jesus Christ [R17's name]." R17 stated there had been another incident with NA-A where NA-A had come to collect her meal tray while R17 was on the toilet, and R17 had told her she was not yet done with the tray, and heard NA-A say, "that figures." R17 stated she still had her beverages to drink, a dish of sweet potatoes and dessert left. R17 said, "sweet potatoes are my favorite thing." When R17 returned to her room she found NA-A had removed the tray but left her beverages and dessert. R17 said she told NA-A that she was not done with the sweet potatoes and NA-A left the room, cursing under her breath, saying, "Fuck you," and slammed the door. R17 said she had tried to talk with NA-A about her treatment and told NA-A she could not talk to her like that. R17 said NA-A had replied, "look at the way you talk to me!" R17 said she did report NA-A's behavior to the DON. R17 said the DON sat on the foot of the bed with her head in her hands and said, "I'm just so short [staffing]." R17 said she had replied, "are you going to have someone so abusive work here?"

A facility reported incident dated 6/14/21, identified, "Today the resident stated to facility

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 ______	C 04/27/2022

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 600	Continued From page 19	F 600		

interim Administrator that on Monday night around 6 pm, she was abused. The resident stated the evening aide came into the room, took her dinner tray, walked out of her room and slammed the door. The resident stated she repeatedly asked/told the aide she wasn't done eating yet. The alleged staff member, identified as NA-A, had been suspended pending investigation. The investigative report dated 6/23/21, identified NA-A had claimed she had been polite to R17. The facility assigned NA-A to a different group of residents and assigend R17 to, "Cares in Pairs."

When interviewed on 4/20/22, 2:53 PM R17 reported the DON and social worker (SW) had come to talk to her. R17 said the DON had asked if NA-A had left any bruises, R5 said, "I said, 'no, it was verbal abuse,' I don't know why she can't remember it!"

When interviewed on 4/22/22, 11:07 a.m. R17 voiced frustrated on her interactions with NA-A in the past, stating how angry she felt about it, and that she felt it was abusive behavior and the facility did not protect her from being cared for by NA-A.

On 4/25/22, 9:40 a.m. R17 stated she wanted to talk about her experience with NA-A again. R17 repeated that she had reported the incident, and described her feelings about how she had been treated. R17 said, "I felt like I was going to throw up. I didn't feel safe. Each time she came in, I thought she would say nasty things to me. It pissed me off, and made me feel angry. When I tried to talk to her in the past, it was like a power play. She [NA-A] said, 'oh, [R17] get real!" R17 shrugged her shoulders.

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 ______	C 04/27/2022

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 600	Continued From page 20	F 600		

An anonymous staff member had filed a complaint on 3/8/22, on behalf of all residents indicating NA-A was providing, "rough treatment" to residents and would often refuse to assist them. Another separate complaint from a staff member was also filed on 3/8/22, identified NA-A was, "rough and rude" to residents and would refuse to assist them with cares. It was unknown if either of these staff members had reported their concerns to the DON or administrator as required in the facility policy as they did not leave contact information.

When interviewed on 4/20/22, at 8:00 a.m. RN-A stated she had witnessed NA-A treat residents poorly. RN-A stated NA-A was short with the residents and would not listen to their needs. A couple months ago two residents, R99 and R5 had complained about NA-A and had reported the concerns to the DON. NA-A was then not allowed in R5's, R17's, or R9's room, because they did not like how NA-A treated them. However, because of scheduling NA-A was actually still caring for those residents. RN-A had witnessed sometime in December of 2021, NA-A was talking in harsh tones to residents, she did not remember who, and RN-A had confronted NA-A, but NA-A told her the residents had behaviors. RN-A did not send NA-A home or provide continuous supervision. RN-A stated the executive director had a conversation with NA-A. NA-A then confronted RN-A. cornering her in a room and slamming the door and yelled at her, "if you have a problem with me, we don't need to get leadership involved." In the past couple weeks RN-A had witnessed NA-A tell R18, "You don't have to use the bathroom, you can wait until it is the right time." RN-A stated there had been

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 ______	C 04/27/2022

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 600	Continued From page 21	F 600		

multiple times NA-A had been reported to the DON.

When interviewed on 4/20/22, at 8:53 a.m. NA-A stated the facility had called her yesterday and made her aware of allegations pertaining to R9, but they were not specific. NA-A stated back in December 2021, the executive director told her she had a poor bedside manner and talked to her about communication and not rushing residents. NA-A denied being rough with, abusing or neglecting any resident. NA-A stated, "if we are honest, I feel it's a racist thing." NA-A stated she was not supposed to care for R9 or R17, but sometimes she was the only one available to care for them, so she did. NA-A stated she felt multiple residents were alleging neglect of care, being rough/physically abuse or verbally abusive towards them because she, "speaks loud," is efficient with her work and "dictative." NA-A stated she has never refused to take residents to the bathroom, but reminds them when they had just been there or it wasn't time to go yet.

The administrator and director of nursing (DON) of the facility were notified of the IJ on 4/20/22, at 2:13 p.m.

On 4/21/22, Between 8:30 a.m. and 10:00 a.m. LPN-A, NA-B, MAINT, HSK-A, EVS-A had been interviewed and had not recieved education on the abuse policy and abuse reporting prior to starting their shift. However, by noon all staff working had been educated.

The immediate jeopardy that began on 4/20/22, was removed on 4/21/22, when the facility

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 ______	C 04/27/2022

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 600	Continued From page 22 removed NA-A from working with residents and she subsequently resigned; psychosocial assessments were completed with affected residents, investigations into the allegations were started to include interviews with staff and other residents, staff were educated prior to working their next shift to include reporting of allegations of abuse, investigating and on their abuse policy and audits of grievances were reviewed to ensure none met the definition of abuse for reporting. However, the noncompliance remained at the lower scope and severity level of a G, actual harm that is not immediate jeopardy because R9 and R24 both had expressed they had lived in fear due to the abuse not being addressed by the facility and it had affected their psychosocial wellbeing. Actions taken by the facility were verified through interview of LPN-A, NA-B, MAINT, HSK-A, EVS-A, SW, RN-A and NA-C, and review of psychosocial assessments and documentation of staff being trained on abuse. A facility policy dated March 2018, titled Abuse Prevention Program included, residents have the right to remain free from abuse and neglect. Upon receiving an allegation of abuse, the staff member receiving the allegation must immediately notify the supervisor on duty. The supervisor will immediately notify the administrator or designee. The alleged perpetrator will be asked to leave the facility immediately and be escorted out of the facility. If necessary law enforcement would be notified. If an employee, they would be suspended immediately pending investigation. The resident would have a full physical assessment and psychosocial support as needed. The administrator or designee would report the allegation to the state agency within 2 hours. All	F 600		

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 ______	C **04/27/2022**

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 600	Continued From page 23 facility staff would be inserviced on the abuse prevention policy.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the state agency allegations of neglect, physical and verbal abuse	F 609	F 609 R5 and R9 allegations were reported on 04/19/2022 and final reports submitted	6/2/22

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 ______	C 04/27/2022

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 609 Continued From page 24

immediately and no later than 2 hours, for 2 of 4 resident (R5 and R9) reviewed for abuse.

Findings include:

R5's annual Minimum Data Set (MDS) dated 4/19/22, R5 had had a slight decline in his cognitive score from being fully cognitively intact in January, to being moderately impaired, and also exhibited mild depression. The MDS indicated R5 did require assistance with his everyday living skills (ADLs).

When interviewed on 4/19/22, 9:30 a.m. R5 stated there was a nursing assistant (NA)who would not respond to his request for assistance to clean up after a bowel movement. R5 stated, "she will say, 'I need to find someone to help me', but then she will leave and it will be an hour or so." R5 stated the NA might come back and say she had not found anyone to help and would leave again. R5 felt he had waited up to four hours for help. R5 stated he had asked for someone in leadership to come talk with him, but felt they did not respond to his requests. R5 also reported that he had complained to a NA about his care, feeling it was rough and caused him pain; R5 further reported, the NA responded to him in a mocking tone and said, "why don't you call the ombudsman or your caseworker?" R5 stated he had called his personal representative to report his concerns since he felt no-one was responding to his request to talk.

On 4/19/22, 10:47 a.m. after being provided information related to R5 and R17's report, the director of nursing (DON) stated she was unaware of either R5's concerns or R17's and said, "okay, I am going to tell the ED (executive

F 609

within regulatory guidelines. PHQ 9 assessments have been completed weekly since 4/19/2022 with scores remaining at or above their usual baseline.
Residents who receive care and services at the facility have the potential to be impacted by the alleged practice. Audits are completed five times weekly during morning meeting to determine if any reported grievances need to be elevated to abuse investigations. Abuse investigations are reviewed by the facility interdisciplinary team and approved by the Director of Clinical Services or Vice President of Operations prior to submitting the five-day report. Allegations that have the potential to be
The leadership team was educated during an ad hoc Quality Assurance meeting regarding reporting requirements by the clinical support team on April 20, 2022. Education was presented by the Executive Director or designee beginning April 20, 2022, to facility staff on the guidelines for reporting and investigating allegations of abuse. Post-tests to validate understanding were completed beginning April 20, 2022. Education was repeated by the Director of Nursing or designee to direct care staff beginning May 18, 2022. The Executive Director or designee completes audits for compliance with reporting requirements three times weekly for twelve weeks or until substantial compliance is achieved. Audits were initiated April 20, 2022 and are ongoing at this time. Results of audits will be forwarded to the facility quality committee

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 ______	C 04/27/2022

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 609	Continued From page 25	F 609		

director-administrator) right now and interview these people."

On 4/19/22, 11:35 a.m. the facility administrator and DON asked if they had missed anything of priority for the survey. Administrator and DON then stated they were going to go at that time and talk to residents who had reported concerns with mistreatment and start investigating.

On 4/19/22, 4:31 p.m. Administrator and DON came to the survey team and stated they had not yet spoken with R5 since receiving the reported concern at 10:47 a.m. because the facility worked with R5's representative, a case worker-advocate (CW) instead, saying that was "what he [R5] was comfortable with."

A review of a Grievance/Complaint form dated 4/13/22 indicated facility had received a concern from R5's CW. It indicated the complaint was provided to the administrator and social worker (SW). The grievance outlined R5's concerns with the NA turning off the call-light after he had requested assistance. Grievance indicated NA did not return for four hours. Also, the form included a grievance that the same NA took two hours to bring a glass of ice, and also the same NA had told R5 to "hurry up" as NA was scheduled to leave soon as it was almost 10 p.m.

When interviewed on, 4/20/22, 8:54 a.m. CW, providing support to R5, stated R5 had had similar concerns in the past. In the last week or so, R5 had stated a similar complaint of a person not providing care when he had turned his light on for assistance after he had a BM; R5 had reported rude, mocking and disrespectful behavior to CW. CW stated, "Last week we

for review and recommendations.

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 ______	C 04/27/2022

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 609		F 609		

Continued From page 26
talked to SW and administrator to file a grievance. I didn't know another way to file a complaint." CW said R5 had requested to talk to anyone in leadership, the administrator, DON, but said no-one had responded to his request. CW stated she assisted R5 by calling the facility to file a grievance on 4/12/22. CW stated the incident had occurred possibly Friday 4/8/22 or Saturday 4/9/22 during the evening shift. CW stated she attempted to advocate for R5, but felt it was difficult as the facility did not often reach out to her and she felt there was little change in response to any concerns brought forward.

When interviewed on 4/25/22, 9:33 a.m. R5 stated that being left in BM unattended, and being talked to in a mocking tone of voice, made him feel, "so, so ...I felt uncared for, like you're, like you're not good enough." R5 had difficulty speaking this, turned away and had tears in his eyes.

In review of facility reported incidences on 4/19/22, at 3:45 p.m. the facility failed to report potential abuse and neglect to state agency within two hours.

R9's quarterly Minimum Data Set (MDS) dated 2/10/22, included cognitively intact with diagnoses including cerebral palsy and recurrent major depressive disorder. No behaviors or rejection of cares were noted.

During an observation and interview on 4/18/22, at 3:41 p.m. R9 stated nursing assistant (NA)-A is "such a smartass and does not listen to her

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 ______	C 04/27/2022

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 609	Continued From page 27	F 609		

residents." R9 stated NA-A told her, "don't tell me what to do!" R9 stated NA-A is two faced; stating one minute she is really sweet and the next time she will turn a cheek on you. R9 disclosed NA-A and activities aide (ACT)-B were family members. R9 asked ACT-B to assist her with elevating legs from floor to bed. NA-A entered R9's room on 4/11/22 and yelled at ACT-B for assisting resident's legs into bed, stating "you can't do that, you don't know what you're doing, and you're not doing it right." R9 stated NA-A threw legs into bed and it hurt her legs and hurt her pride. R9 felt NA-A treated her legs roughly. R9 stated she did not report the incident to management, but thought ACT-B would have notified them. R9 stated this made her feel very frustrated. R9 stated NA-A makes her feel like she does not have a brain and makes me feel really bad. R9 observed teary eyed and saddened when speaking to surveyor about the incident. R9 stated she felt NA-A verbally abused her and physically hurt her legs. R9 stated she knew her own body, she has full cognition, and has to tell NA's how to do their jobs as most of them are improperly trained at facility.

When interviewed on 4/19/22, at 8:24 a.m. R9 stated NA-A is "just a thorn in my side." R9 stated she wished NA-A wasn't even at the facility as resident gets very nervous when aide is around her. R9 stated she told facility staff about NA-A's psychosocial mistreatment, verbal abuse, and being rough with her. R9 stated she informed other NA's, activity staff, and the director of nursing (DON) but nothing was ever done about it. R9 stated she felt the DON "didn't do anything at all to be honest." R9 stated she cringed at the sight of seeing NA-A out in the north hallway; let alone, when she comes into my room. R9

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 ______	C 04/27/2022

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 609	Continued From page 28	F 609		

observed shaking and teary eyed again after repeating incident.

When interviewed on 4/19/22, at 8:56 a.m. activities director (ACT)-A stated she was unaware of the situation involving R9, NA-A, and ACT-B as her activities assistant did not mention it to her. ACT-A confirmed ACT-B should not have been completing activities of daily living (ADL's) such as assisting legs into bed for R9. ACT-A stated ACT-B should only be completing activities with residents.

When interviewed on 4/19/22, at 9:25 a.m. director of nursing (DON) stated she was unaware of incident involving R9, NA-A, and ACT-B that included verbal abuse and tossing resident legs into bed. DON stated numerous times facility was immediately suspending NA-A pending internal investigation. DON stated she was going to notify facility management team and start investigations right away. DON stated R9 and NA-A had a concern approximately one year ago, but there is no recent concerns noted. Surveyor notified DON that R9 gets very tearful and cringes at the sight of NA-A. DON confirmed again NA-A would be suspended.

In review of facility reported incidences on 4/19/22, at 3:45 p.m. the facility failed to report potential abuse and neglect to state agency within two hours.

The facility policy titled Abuse Prevention Program dated March 2018 indicated, our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary

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 ______	C 04/27/2022

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 609	Continued From page 29 seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. -Upon receiving an allegation of abuse, committed against a resident, the staff member receiving the allegation must ensure the safety of the resident and immediately notify the supervisor on duty. The supervisor on duty will immediately notify the Administrator or designee. -The Administrator or designee will report to the state alleged abuse no later than 2 hrs. of the allegations. -Results of the investigation will be reported to the state within 5 days of the initial allegation.	F 609		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		6/2/22

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 ______	C 04/27/2022

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 690	Continued From page 30 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure appropriate management and routine care of a condom catheter for 1 of 1 resident (R19) reviewed for catheter care. Findings include: R19's quarterly Minimum Data Set (MDS), dated 2/25/22, included cognitively intact with diagnosis including type 2 diabetes mellitus (DM2), diverticulosis, prostate cancer, cardiac pacemaker, and chronic kidney disease (CKD). R19 required extensive assistance from staff for transfer, dressing, toilet use, and personal hygiene. R19's physician orders included a condom catheter (a urine collection device that fits like a condom over the penis) change every 72 hours as needed for catheter care starting on 12/15/21, rinse out catheter bag that is removed with vinegar two times a day for catheter care starting on 2/24/22, and foley output every shift for	F 690	F 690 R 19 has been free of urinary tract symptoms. Orders have been reviewed and updated to include instructions for cleansing urinary collection systems and storing these to avoid environmental contamination. Residents who change their drainage systems from a urinary collection system to a urinary leg bag have the potential to be impacted by the alleged practice. There are currently no like residents in the facility population. The director of nursing or designee provided education to licensed nurses and certified nursing assistants beginning May 18, 2022, on guidelines for managing urinary catheter collection systems including guidelines for sanitizing and storing drainage bags or system to reduce the risk for environmental contamination. The director of nursing or designee will complete audits weekly to validate guidelines for care and storage of urinary	

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 ______	C 04/27/2022

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 690	Continued From page 31 catheter patency starting on 11/19/21. R19's care plan dated 11/19/21, included use of condom catheter needed due to disease process and history of prostate cancer and incontinence with goal to not have acute complications of urinary catheter use. Staff were directed to change urinary collection bag as needed, report any changes in amount and color or odor of urine, and report to medical doctor (MD) signs of urinary tract infection (UTI) such as blood, cloudy urine, fever, increased restlessness, lethargy, or complaints of pain and burning. R19's medication administration record (MAR) included, R19's condom catheter was changed zero times in December 2021, one time in January 2022, four times in February 2022, six times in March 2022, and three times in April 2022. R19's bladder/incontinence evaluation dated 2/18/22, indicated R19 used a condom catheter but no other information was filled out on the assessment record. R19's hospital discharge summary dated 2/5/22-2/8/22, indicated R19's urine in catheter was cloudy, had leukocytosis (high white blood cell count) and bladder wall thickening concerning for infection so R19 was started on antibiotics 2/6/22 for a urinary tract infection (UTI). When interviewed on 4/19/22, at 10:13 a.m. R19 stated the facility does not have the space to clean his catheter equipment properly as he is in a semi-private room. R19 stated most facility staff do not wash out the leg bag with vinegar and water nightly to properly sanitize. R19 stated he	F 690	catheter collection devices are followed. Audits will be initiated the week of May 23, 2022. Audits will be completed for four weeks and submitted to the facility quality committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 690	Continued From page 32	F 690		

finds his leg bag sitting on the floor and sometimes on the floor of the shared bathroom. R19 stated his equipment needs to be washed and hung up to dry properly. R19 stated he, "passed out" in the bathroom approximately two months ago and the hospital discovered he had a UTI. R19 stated the hospital, "got after the facility for wrong doing."

During an observation and interview on 4/19/22, at 4:30 p.m. licensed practical nurse (LPN)-C stated R19 can assist with putting on condom catheter himself. R19 stated the end piece cover to his catheter tubing is currently missing. R19 stated a nurse hung it up over the bathroom sink earlier today; otherwise, it is normally placed on the floor or in a bath basin all curled up without a place to dry.

During an observation on 4/20/22, at 7:24 a.m. R19 was observed sleeping in bed with leg bag hanging over the bed rail with the catheter tubing tip touching the bath basin on the floor. R19's condom catheter was observed hooked up to resident's homemade overnight gravity bottle. There was white distilled vinegar and syringe in a bath basin on the floor next to the bathroom sink.

During an observation on 4/20/22, at 9:00 a.m. R19's overnight gravity bottle was observed sitting in a bath basin on the floor with the catheter tubing hanging over the bed rails uncapped.

During an observation on 4/20/22, at 12:09 p.m. R19's overnight gravity bottle was observed next to a shared bathroom toilet. The catheter tubing end was observed touching the dirty bathroom floor uncapped.

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 ______	C 04/27/2022

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 690	Continued From page 33	F 690		

During an observation on 4/21/22, at 8:58 a.m. R19's overnight gravity catheter tubing was observed draped over the bed rail uncapped.

During an observation on 4/21/22, at 12:30 p.m. R19's overnight gravity catheter bottle was observed sitting in a bath basin next to the bed with the catheter tubing draping from the bed rail uncapped.

During an observation on 4/21/22, at 2:29 p.m. R19's catheter tubing was observed hanging over the shared bathroom sink in bathroom.

During an observation on 4/22/22, at 8:38 a.m. overnight gravity bottle was observed in a bath basin with catheter tubing hanging over bed rail touching frame of resident's bed.

During an observation and interview on 4/22/22, at 8:59 a.m. R19 observed was wheeling back to room with unbuttoned, soiled pants. R19 explained to nursing assistant (NA)-B he needed a new catheter as the other one fell off. NA-B wheeled R19 back to room, donned gloves, transferred him to bed, pulled curtain divider to roommate, and grabbed residents phone that was ringing out of his left upper shirt pocket. NA-B was observed to not complete hand hygiene upon leaving R19's room. At 9:02 a.m., NA-B was observed back in R19's room without hand hygiene, but donned new gloves and started looking in resident nightstand for new condom catheter. Overnight catheter tubing observed touching the outside of bath basin uncapped. At 9:04 a.m., registered nurse (RN)-A arrived to room to assist R19 but had to leave to gather more supplies central supply room at facility. At

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 ______	C 04/27/2022

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 690	Continued From page 34	F 690		

9:06 a.m. RN-A returned and informed NA-B she would take over from here. NA-B doffed gloves and performed hand hygiene upon exit. RN-A observed assisting R19 place new condom catheter and stated catheter should be changed every three days or more often if needed. RN-A stated all catheter supplies and tubing are to be cleaned daily with vinegar and water solution and hung to dry. RN-A stated she had noted other staff to not complete this task daily for R19 as his leg bag on most days is not clean in the morning when she arrives on shift and she works five dayshifts per week. RN-A stated night staff drapes R19's leg bag over the locked nightstand drawer handle if it is cleaned. RN-A verified catheter tubing should never be placed on floor or bathroom floor. RN-A stated a whole catheter system change would be required if found on floor due to potential contamination concerns which could lead to UTI's. RN-A stated R19 had one UTI since admission to facility.

When interviewed on 4/22/22, at 12:32 p.m. RN-B stated she thought catheter supplies were changed once a month by nightshift staff. RN-B stated she was unaware of cleaning schedule for catheter supplies and tubing as she's, "never done it on dayshift." RN-B stated she did not know what R19's orders for catheter cares were or what they cleansed his equipment with. RN-B stated catheter supplies should never be re-used if found on floors as you, "never know what's on them."

When interviewed on 4/22/22, at 12:55 a.m. RN-C stated catheters are changed out once a month or as needed. RN-C stated catheter equipment is cleaned out daily with a vinegar and water solution and set out to dry before re-use.

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 ______	C 04/27/2022

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 690 Continued From page 35

F 690

RN-C stated catheter equipment and tubing should never be placed on flooring as it would increase a resident's chance for infection.

When interviewed on 4/24/22, at 9:00 a.m. R19 stated his leg bag was not cleaned out with vinegar and water again last night. Overnight gravity bottle and tubing was observed draped over bed rail.

When interviewed on 4/25/22 at 10:32 a.m. RN-A stated R19's overnight catheter equipment is getting cleaned by her; however, the night shift has not been completing leg bag cleaning. RN-A stated she's observed the vinegar solution in R19's bathroom to not decrease between her shifts as she will sometimes mark the level with a black sharpie marker. RN-A stated catheter changes should be charted in electronic medical record (EMR). RN-A stated R19's family would have to bring facility new overnight gravity catheter system and extension tubing as it is homemade. RN-A stated R19's condom catheter is changed approximately every two days as it falls off and it always gets completed on bath day. RN-A stated facility does not use caps on catheter tubing ends when not being used.

When interviewed on 4/25/22, at 11:05 a.m. director of nursing (DON) stated the expectation for R19's condom catheter is to be changed every three days or more often if needed. DON stated expectation for staff nurses to clean catheter equipment with vinegar and water mixture daily keep supplies sanitary which could possibly lead to a potential infection such as a UTI. DON stated R19 and family have been educated and informed about the risks of using his homemade gravity night system; but stated it should not be a

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 ______	C 04/27/2022

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 690	Continued From page 36 concern as long as the system is cleaned out properly every day. DON stated expectation for staff to replace catheter bag and tubing if it was ever accidentally placed on the floor as there would be a potential for cross-contamination leading to infection. When interviewed on 4/25/22, at 3:09 p.m. nurse practitioner (NP)-A expressed concern facility was not keeping R19's catheter equipment cleaned daily. NP-A confirmed R19 utilized a condom catheter prior to admission at home and was able to maintain it without difficulty. NP-A stated she believed in her medical opinion, R19's admission to hospital on 2/6/22 was caused by facility failure to maintain a sanitary catheter system which ultimately lead to R19's UTI. The facility policy titled Catheter Care, Indwelling revised 2/22/21 indicated, ensure, if applicable, if the leg bag urine collection device is cleaned/disinfected and stored per policy and manufacturer's guidance. The "stored per policy" was requested from the facility, but never provided upon request. -Use a dedicated urine collection device with a resident identifier and date. Avoid splashing and prevent contact of the drainage spigot with the nonsterile collecting container when emptying the drainage bag.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		6/2/22

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 ______	C 04/27/2022

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 695	Continued From page 37 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to label, date, and clean respiratory care equipment and protect nebulized mist treatment (NMT) equipment ("set up" - including the breathing mask, medication cup, and tubing) and bipap (a type of ventilator designed to help with breathing support that treats central sleep apnea) equipment from environmental elements for 1 of 1 residents (R24) reviewed for respiratory care. The failure created the potential for outdated respiratory supplies to be used, unsanitary respiratory equipment to be used, and cross contamination of NMT set-ups. Findings include: R24's significant change Minimum Data Set (MDS) dated 4/8/22, included cognitively intact with diagnoses including , congested heart failure (CHF), chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, asthma, pulmonary embolism, and obstructive sleep apnea. R24 required extensive assistance from staff for bed mobility, dressing, toilet use, personal hygiene, and transfers with mechanical lift. R24's Order Summary Report dated 4/24/22, included Ipratropium-Albuterol Solution (medicine that is used to treat air flow blockage and prevent worsening of COPD, asthma or other lung diseases) 0.5-2.5 (3) mg/3ml 1 vial inhale orally	F 695	F 695 R 24s respiratory equipment was replaced on 4/25/2022 and storage bags provided for bedside storage of equipment when not in use. R 24s orders were updated on 4/25/2022 to include replacing equipment weekly, labeling, dating, and storing equipment properly. Residents who use respiratory equipment have the potential to be impacted by this practice. Orders for like residents were reviewed and updated if needed. Supplies were placed in like residents rooms for storage of respiratory equipment. The director of nursing or designee educated licensed nurses and certified nursing assistants on the care and storage of respiratory equipment beginning May 18, 2022. The director of nursing or designee will complete audits weekly for four weeks for compliance with changing, dating, cleaning, and storing respiratory equipment according to professional standards. Audits will begin the week of May 23, 2022. Results of audits will be forwarded to the facility quality committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 695	Continued From page 38	F 695		

four times a day for shortness of breath started 5/25/21 and Saline solution (Soft Lens Products) 1 vial inhale orally via nebulizer two times a day for shortness of breath started 5/25/21. The medication was to be given via NMT. On 12/15/21, four Liters oxygen with nasal cannula ever shift for oxygen ordered by medical doctor (MD). On 2/22/22, to wear bipap with four Liters oxygen piped through at bedtime for sleep apnea.

R24's plan of care dated 6/1/21, included R24 had risk for respiratory impairment related to CHF, COPD, sleep apnea, and asthma. Interventions included administer medications and oxygen per MD orders, report signs of infection or edema, provide assistance with activities of daily living (ADL's) to conserve energy, and evaluate lung sounds and vital signs (VS) as needed and report abnormalities to MD.

During an observation and interview on 4/18/22, at 6:32 p.m. R24 stated she used four Liters oxygen continuously and received NMT's four times a day after each meal and before bedtime. R24 stated she needs to remind staff to keep her equipment cleaned regularly and confirmed NMT equipment was not cleaned after each use. Whole NMT equipment set up, which included the breathing mask, medication cup and tubing, observed not dated and left exposed to the environment. NMT tubing end observed lying on floor between resident bed and nightstand. Condensation observed in the medication cup. Whole bipap equipment set up, which included the breathing mask, humidified distilled water chamber, tubing, and machine observed not dated and left exposed to environment. Condensation observed in the tubing and humidified water chamber. R24's nasal cannula

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 ______	C 04/27/2022

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 695		F 695		

Continued From page 39
oxygen tubing observed running at four Liters; however, tubing is undated and R24 uncertain when it was last changed.

During an observation and interview on 4/19/22, at 3:37 p.m. R24's bipap machine is appeared cleaned, dry, and tubing was coiled up on nightstand. R24's NMT tubing observed lying on floor next to bed with medication chamber and mask sitting on bedside table. Condensation observed in the medication cup. R24 stated staff nurses tell her to hold it in place and put on call light when medication is done dispensing. NMT medication chamber dated with 4/19 now. R24 stated the NMT has not been cleaned out since staff changed the equipment. Nasal cannula tubing remained undated and unchanged.

During an observation on 4/20/22, at 7:07 a.m. condensation observed in R24's bipap humidified water chamber. NMT dated 4/19 observed sitting on nightstand with condensation in chamber. Nasal cannula tubing remained undated and unchanged.

During an observation on 4/20/22, at 12:05 p.m. nursing assistant (NA)-B observed getting R24 out of bed to motorized scooter. The distal portion of NMT tubing observed lying on floor with condensation in medication chamber. Bipap continued to have condensation in water chamber.

During an observation and interview on 4/21/22, at 8:45 a.m. R24's NMT dated 4/19 observed connected to nebulizer machine with full medication chamber of clear liquid but was not running. Registered nurse (RN)-A stated NMT tubing was changed on 4/19 with the medication

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 ______	C 04/27/2022

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 695	Continued From page 40	F 695		

chamber and mask.

During an observation on 4/21/22, at 12:54 p.m. NMT dated 4/19 observed remained untouched on nightstand.

During an observation and interview on 4/22/22, at 11:55 a.m. R24 observed self-administering NMT in room without staff assistance. R24 stated NMT had not been cleansed all week other than changing equipment on 4/19/22.

When interviewed on 4/22/22, at 12:32 p.m. RN-B stated respiratory equipment was changed out on nightshift; however, was uncertain how often this was completed. RN-B stated uncertainty if equipment changes were charted in electronic medical record (EMR), triggered on task list, or just part of facility policy. RN-B confirmed it was never okay to use respiratory equipment that has been found lying on the floor as it could potentially have bacterial growth which could lead to an infection. RN-B confirmed she left R24 unattended while administering NMT in room.

When interviewed on 4/22/22, at 12:55 RN-C stated respiratory equipment was changed out weekly by nightshift. RN-C stated all equipment and tubing should be dated. RN-C confirmed NMT's should be cleaned out after each treatment and set out to dry. RN-C confirmed oxygen tubing lying on the floor is never ok to reuse as there could be the potential for respiratory infection and cross-contamination.

During an observation on 4/22/22, at 1:30 p.m. nasal cannula tubing, NMT tubing, and bipap equipment remained unchanged and undated.

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 ______	C 04/27/2022

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 695	Continued From page 41	F 695		

During an observation on 4/24/22, at 8:40 a.m. NMT's dated 4/19 observed placed on nebulizer machine on nightstand with a full medication chamber of clear fluid. Tubing for nasal cannula, NMT tubing, and bipap equipment remained undated.

During an observation on 4/25/22, at 9:14 a.m. nasal cannula tubing labeled 4/25 and new equipment for NMT's are still enclosed in plastic wrap.

When interviewed on 4/25/22, at 11:05 a.m. director of nursing (DON) stated expectation for all respiratory equipment for staff to date when changed, rinse/cleanse after each use, and left out to dry. DON stated orders should be in EMR on when to change equipment. DON confirmed R24 did not have an order and she would immediately place one. DON expressed expectation if any respiratory equipment was found on the dirty floors; she would expect nursing staff to change it immediately. DON stated her concern would be infection control and the potential for bacterial growth which could lead to further respiratory problems for residents.

The facility policy titled Oxygen Administration dated June 2017 indicated, label humidifier with date and time opened. Change humidifier and tubing per facility policy. At regular intervals, check and clean oxygen equipment, masks, tubing, and cannula.

The facility provided a policy from Northwest Respiratory Services titled positive airway pressure (PAP) EQUIPMENT Care and Cleaning undated indicated:

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 ______	C 04/27/2022

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 695	Continued From page 42 -Daily: Wipe off PAP mask with a warm damp cloth, empty and set out water chamber to dry, drain excess water from tubing and hang dry, refill water chamber nightly; do not fill with chamber in the PAP device. -Weekly: Soak mask, headgear, tubing, and water chamber in warm soapy water for 30 minutes, rinse well and allow to dry. -Monthly: Change intake filter, wipe down machine as needed. -Replace tubing every 3 months, chamber every 6 months.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		6/2/22

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 ______	C 04/27/2022

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 758	Continued From page 43 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a as needed psychotropic medication was evaluated by a physician and addressed every 14 days for 1 of 2 residents (R24) reviewed who had as needed orders. Findings include: R24's significant change Minimum Data Set (MDS) dated 4/8/22, identified R24 had diagnoses of anxiety disorder and schizophrenia. The MDS indicated R24 did not have cognitive impairment, had no signs/symptoms of delirium, did not have hallucinations or delusions, and had	F 758	F 758 R 24 is no longer enrolled in hospice services effective 5/19/2022 and is no longer receiving PRN anti-anxiety medications. Residents who have been prescribed PRN antipsychotic or antianxiety medications have the potential to be impacted by the alleged practice. A list of residents with PRN psychotropic medication orders was completed on 05/16/2022 by the consultant pharmacist and provided to the nursing team as requested. MAR entries were reviewed to	

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 ______	C 04/27/2022

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 758

Continued From page 44

not displayed behaviors. The MDS also indicated R24 was administered antipsychotic, antidepressant, and antianxiety medications.

R24's physician orders included the following
-Lorazepam (antianxiety medication) 2 mg/ml (milligrams/milliliter), give 0.5 mg by mouth every four hours as needed for anxiety. The order start date was 4/5/22, the order did not include a stop date.
-Seroquel (antipsychotic medication) 500 mg by mouth at bedtime related to schizoaffective disorder (start date 9/14/21) .

R24's Psychotropic Medication Use evaluation dated 2/10/22, identified R24 was prescribed antipsychotic, antidepressant, and antidepressant medications for diagnoses of schizoaffective disorder, anxiety disorder, and chronic pain. The evaluation identified R24 had duplicative therapy and did not have delirium. The evaluation also indicated that R24's environmental and psychological stressors could be treatable/reversable. The evaluation did not identify R24's target behaviors, nonpharmacological interventions, nor an analysis of the effectiveness of the psychotropic medications.

R24's behavior care plan dated 1/4/22, included "At risk for behavior symptoms r/t [related to] illness. The only behavior interventions identified was "Cares in pairs". R24's psychotropic medication care plan dated 6/3/21, indicated R24 was at risk for adverse effects related to use of antidepressant medication-pain, schizoaffective. Antianxiety medication. Associated interventions included, evaluate effectiveness and side effects of medication for possible decrease/elimination of

F 758

determine if the resident was using the PRN medication and updates sent to medical provider based on reviews. Care plans were reviewed and updated with target behaviors and non-pharmacological approaches if indicated. Communication was sent to contracted hospice agencies and medical providers regarding the federal regulations for PRN psychotropic use.
The director of nursing or designee provided education to licensed nurses and nursing assistants beginning May 18, 2022, on regulations regarding the PRN use of psychotropic medications, the need to identify target behaviors, and the need to attempt non-pharmacological approaches to assist resident in managing behaviors.
The director of nursing or designee will complete audits of new and existing PRN psychotropic medication orders weekly to ensure stop dates are included on orders for PRN psychotropic medication and medical provider reassessment is completed if the medication is reordered.
The director of nursing or designee will validate documentation of PRN psychotropic medications includes targeted behavior and non-pharmacological approaches weekly for four weeks. Audits will begin the week of May 23, 2022. Results of audits will be forwarded to the facility quality committee for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 758	Continued From page 45	F 758		

psychotropic drugs, and Notify MD of decline in ADL [activities of daily living] or mood/behavior related to dosage change.

R24's care plan lacked identification of target behaviors for Seroquel and Lorazepam. In addition, the care plan did not identify non-pharmacological interventions for Seroquel and Lorazepam.

R24's medication administration record (MAR) was reviewed between 4/5/22 and 4/19/22 in combination with progress notes and Point of Care behavior/mood documentation. The MAR identified R24 was administered Lorazepam on 4/5/22 at 11:25 p.m., on 4/10/22 at 12:51 a.m., on 4/18/22 at 4:55 p.m. and on 4/19/22 at 11:03 p.m. R24's record did not identify anxiety symptoms/behaviors R24 had demonstrated, nor non-pharmacological intervention attempted prior to the administration of Lorazepam.

R24's behavior documentation between 3/22/2022 and 4/19/22. The documentation identified R24 had seven occurrences of rejection of care, mainly in the morning. The dates/times are as follows:
-3/22/22 at 10:47 a.m.
-4/1/22 at 8:47 a.m.
-4/3/22 at 1:59 p.m.
-4/5/22 at 9:48 a.m.
-4/7/22 at 10:19 a.m.
-4/11/22 at 9:17 a.m.
-4/12/22 at 9:00 a.m.
The documentation does not identify the reason for R24's rejections.

R24's progress notes reviewed between 3/22/2022 and 4/19/22, included behavior notes

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 ______	C 04/27/2022

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 758	Continued From page 46 that indicated R24 had depressive symptoms on 3/28/22, 3/29/22, and 3/30/22. The record indicated the depressive symptoms were related to pain, R24 was checked on more frequently during those days, and a referral was made to outside social services for additional support. During an observation on 4/20/22, at 9:00 a.m. R24 observed calm, not restless, even tone of voice, no observed hallucinations or delusions, and her speech patterns were slow. When interviewed on 4/25/22, at 10:39 a.m. registered nurse (RN)-A stated uncertainty if staff utilized non-pharmacological interventions for R24's anxiety and mood. RN-A stated she was unaware if facility charted non-pharmacological interventions in their electronic medical record (EMR). RN-A indicated the EMR did not identify if non-pharmacological interventions were attempted or offered and stated refusals should be documented as well. When interviewed on 4/25/22, at 4:12 p.m. director of nursing (DON) stated expectation for non-pharmacological interventions should be attempted prior to giving pharmacological medications. DON expected staff to document in the EMR in a progress note. DON stated prn anti-anxiety medications are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. DON stated she knew R24's order was past 14 days as she handed the information to the practitioner on 4/21/22.	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		6/2/22

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 ______	C 04/27/2022

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 804	Continued From page 47 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide meals that were palatable in taste, texture, appearance and at an appetizing temperature for 11 residents (R18, R19, R26, R13, R17, R9, R24, R5, R27) of the facility population of 28 observed for dining during the survey. Findings include: On 4/18/22, at 5:21 p.m. the evening meal trays were observed placed on an upright cart with doors to the front and back, but no heating element to maintain temperature. All facility trays had been plated before being brought out in the cart. Plates were covered with a domed cover. When staff began to pass the meal tray, both doors to the cart were opened and remained open until all trays were delivered. No condiments were observed on the trays. Beverages had come to the dining area on an open cart and had been served to residents prior to the trays arriving. A small basket of salt and pepper were observed on a small table away from the tray cart, and none were observed being placed on any tray being served. R18 received a hamburger as the alternative to the main meal of fried fish, and	F 804	F 804 R 27 no longer resides at facility. R 18, R19, R26, R13, R17, R9, R24, and R5 were interviewed regarding food service since survey exit beginning May 23, 2022, to determine current level of satisfaction and share plans for changes in meal delivery services. Residents who receive meals from facility dietary department have the potential to be impacted by the alleged practice. Dietary tray service delivery changes were implemented on May 23, 2022, to increase the potential for meals being delivered at appropriate temperatures. Condiments will be included on trays to improve overall customer satisfaction. Ice machine was repaired, and ice coolers are utilized to pass ice water. Cold drinks are delivered on ice to maintain palatability. The director of nursing or designee provided education to nursing staff on meal delivery expectations and customer services expectations for meals beginning May 18, 2022. The food service manager or designee provided education to dietary	

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 ______	C 04/27/2022

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 804

Continued From page 48

yelled at staff that she could not eat it, and asked staff if they would eat it. The burger was ground meat on a bun and there were no condiments. A licensed practical nurse (LPN)-A was unable to locate any condiments so went to the kitchen and came back with a handful of ketchup packets and also tarter sauce as this had not been provided for the fish meals.

When interviewed on 4/19/22, at 10:05 a.m. R19 said, "The food isn't very good. The food is not hot by the time I get them."

When interviewed on 4/18/22, at 2:07 p.m. R26 said, "I have ham up to three times per week. If it is not for breakfast it is for supper. The menu just comes. You could get a grilled cheese or hamburger but that's the same thing too, you get tired of the alternative. There are very few fresh fruits and vegetables."

When interviewed on 4/18/22, at 2:11 p.m. R13 said, "The food is not that great, every once in a while we get something good. Sometimes they cook it too much; the food gets tough to chew, the meats. Sometimes it can be a little charred and burnt on the edges."

When interviewed on 4/18/22, at 2:48 p.m. R17 stated the food was, "horrible. The eggs will come cold, like cold snot, the food is lukewarm-y."

When interviewed on 4/18/22, at 4:02 p.m. R9 said, "Their food is not the greatest. The food isn't always hot. The meat is sometimes chewy. We get too much ham, now I'm beginning to hate it as we get it too often."

When interviewed on 4/18/22, at 6:19 p.m. R24

F 804

staff on meal delivery changes and customer services expectations for meals beginning May 23, 2022. Staff training on infection control practices in handling and delivering foods was completed during the survey in response to infection control citation.
The interdisciplinary team members will complete audits three times weekly for four weeks regarding customer satisfaction of quality of meals and meal service. Audits will begin the week of May 23, 2022. Results of audits will be analyzed by the interdisciplinary team weekly to determine if changes implemented to meal service have positively impacted customer satisfaction with meal quality and meal delivery.
Analysis of audits will be forwarded to the facility quality committee for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 804	Continued From page 49	F 804		

said, "the hot food isn't always hot and the cold food isn't always cold; most of the time the meals are cold."

When interviewed on 4/19/22, at 9:46 a.m. R5 said, "the food is not good, some of the food is dry or burned."

When interviewed on 4/19/22, at 11:19 a.m. R27 said he didn't get items he requested and complained the food was often cold.

During an observation on 4/19/22, at 11:56 a.m. the beverage cart was observed sitting to the side of the dining area with no ice under or around the milk or juice containers to keep them cold. The outside of the beverages were slightly cool, but not cold to the touch.

During an observation on 4/21/22, at 9:02 a.m. R18 was seated in the dining room and loudly calling a family member (FM)-A to look at her food. R18 complained that her omelet was burned, and flipped it over for FM-A to see. FM-A then asked another resident seated at the table (R20) to turn his eggs over, and they were observed to be burned as well.

During an observation on 4/21/22, at 12:20 p.m. the meal trays were loaded on the cart and transported out to the dining area to be passed to residents in the dining room and on the units. A taste test tray had been requested to be served last, and when all trays were passed, at 12:37 p.m. the temperatures of the plated food were as follows: meatloaf 102.2 degrees, au gratin potatoes at 107 degrees and peas were 105 degrees. The meatloaf was tender and with good flavor, but felt barely warm in the mouth. The

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 ______	C 04/27/2022

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 804		F 804		

Continued From page 50
potatoes were dry around the edges and lacked significant seasoning, and felt only slightly warm. The peas were not seasoned but felt warmer than the other foods. A registered dietician (RD) also tasted the food and indicated that it did not feel warm, but thought the flavor was pleasant. RD stated the food should be appropriately warm when served to the residents.

When interviewed on, 4/21/22, at 2:04 p.m. FM-A stated R18 had been really upset about her breakfast being burned. FM-A said R18 does not often complain of the food, but when she does, it is to say the food is cold.

When interviewed on 4/25/22, at 12:46 p.m. the RD stated any cook might accidentally burn food, but it should not be served if it was burned. If omelets were heated in a large pan and not turned over before being served it would be possible to accidentally serve a burnt portion, but RD stated an expectation for food to be examined for being properly cooked before being served. RD stated food that was not properly prepared, that might be burned or was otherwise unpalatable for any reason should not be served and steps taken to remedy the situation.

During an observation on, 4/25/22, at 9:33 a.m. R5 had received bacon and fried eggs for breakfast. The eggs were burned all over to the point that they were hard and brown. R5 said he had called for something else as he felt the eggs were overdone and the bacon was underdone, but had not yet received anything different and thought he had been waiting for about half an hour.

When interviewed on 4/25/22, 9:40 a.m. R17

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 ______	C 04/27/2022

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 804	Continued From page 51 stated she did not get her breakfast. She had a tray with oatmeal in front of her. Later in the conversation R17 made it clear that she had asked staff to get her something different as the food she had was not what she wanted, and the oatmeal was cold and a solid lump. The oatmeal was observed to be in a mound, shaped like a scoop. R17 did not have any milk, sugar or other to add to her cereal. R17 said she had been waiting for an extended time for her requested alternative to arrive. A facility policy titled Food: Quality and Palatability dated May 2014 indicated that food was to be prepared by methods that conserve "nutritive value, flavor and appearance. Food is palatable attractive and served at the proper temperatures."	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		6/2/22

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 ______	C 04/27/2022

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 52 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure refrigerator items were not stored beyond their expiration dates for 2 of 2 kitchen refrigerators and 2 of 2 kitchen freezers, and failed to ensure refrigerator items were dated, labeled, and stored beyond their expiration dates for 1 of 1 dinette kitchen refrigerators. These failures had the potential to affect all 28 residents in the facility. Findings include: During observation on 4/18/22, at 11:50 a.m. Temperature logs for the cooler and freezer had multiple blank entries and identified temperatures that were above safe zones (41 degrees Fahrenheit (F) or lower for cooler and 0 degrees F for freezer). The facility lacked evidence of evaluation and/or interventions when temperatures were above safe zone temperatures. On 2/13/22, freezer log indicated in the morning the freezer door was found to be ajar. The temperature recorded on the log was 30 degrees. On 1/24/22, the cooler temperature was 55 degrees in the morning. During an initial brief kitchen tour on 4/18/22, at 11:52 a.m. with the dietary manager (CDM) the following items were noted to be undated, unlabeled, and expired in kitchen refrigerators: -opened and undated carrots, spinach. -opened bag of coleslaw with use by date of 4/14/22. -undated and unlabeled sliced tomato and cucumber in zip-lock baggies. -opened bag of bag of parmesan cheese dated	F 812	F 812 No residents were directly identified. Facility staff discarded outdated or unlabeled open food items from food storage areas when they were made of aware of the concerns during survey. Forms for recording freezer, refrigerator, and dishwasher temperatures per policy were posted in kitchen upon survey exit. Cleaning was completed upon survey exit and cleaning schedule posted. Tray line checklist was posted in kitchen to be completed per facility policy. The ice machine is repaired Residents who receive food from the facility kitchen have the potential to be impacted by the alleged practice. Temperature logs, tray line checklists, and cleaning protocols were posted in kitchen and are monitored daily/weekly/ or monthly as appropriate for completion of tasks. Hand hygiene competencies were completed with staff during survey and audits are ongoing. A full review of storage areas was completed by the food service manager and dietitian on May 3, 2022, to ensure all outdated or opened food had been discarded The food service manager or designee provided education beginning May 3, 2022, to dietary staff on requirements for food storage, timelines for food use, and infection control for dietary staff. The food service manager or designee and the director of nursing or designee presented information to the dietary staff and nursing	

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 ______	C 04/27/2022

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 53 3/24/22; good for two weeks per certified dietary manager (CDM). -opened and undated bag of shredded mozzarella cheese; three quarters used. -opened and undated bag of finely shredded cheddar cheese. -opened, undated, and unlabeled cream of wheat and peaches pureed for an unknown resident per CDM. -opened container of cottage cheese on 3/31/22; best if used by date of 4/13/22; good for seven days per CDM. -opened chopped garlic in oil dated 2/24/22; only good for two weeks per CDM. -opened sticky and unlabeled bottle with white liquid substance. CDM confirmed this belongs to dietary aide (DA)-A and white substance is staff's personal coffee creamer. CDM confirmed staff food does not belong in kitchen refrigerators and staff have a breakroom where they can store personal items. -opened and undated Sweet Baby Ray's barbeque sauce. -opened French's Worcestershire sauce dated 12/21; best if used by 6/26/21. -opened soy sauce dated 12/8; best if used by 11/15/21. -opened soy sauce dated 2/6; delivered to facility on 3/11/21; best if used by 11/15/21. -opened and undated thickened dairy drink. -opened and undated liquid whole eggs. -opened and undated Hershey chocolate syrup; best if used by 5/21. -unopened and undated lettuce that was wilted, brown, mushy, and liquefied. -undated and unlabeled onion that was turning brown and mushy. -ham that was undated wrapped in Saran wrap was unknown when it was defrosted. One sliced	F 812	staff on food storage and sanitary environment for food services beginning May 18, 2022. The food service manager or designee completes audits five times weekly in the kitchen service area to monitor compliance with cleanliness, hand hygiene, and food storage policies. These audits were initiated May 3, 2022 and will continue through May 31, 2022. Results of audits will be analyzed weekly, and analysis forwarded to facility quality committee for review and recommendations. The director of nursing or designee will complete audits during meal tray delivery to ensure staff are compliant with customer service expectations and infection control measures in the delivery of meals.	

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 ______	C 04/27/2022

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 54	F 812		

ham was touching the bottom of the cooler. CDM verified with cook (C)-C that ham was sliced on 4/13/22; however, C-C uncertain on date it was defrosted from freezer. C-C stated she would have to look back on previous week's menus to verify exact date it was sliced and defrosted. C-C confirmed food should be labeled and dated upon opening items in kitchen.

During an observation on 4/18/22, at 12:15 p.m. the following items were noted to be undated, unlabeled, and expired in kitchen freezers:
-multiple open bags of cookie dough not dated had a thick yellowish layer of ice crystals.
-opened undated bags of fish, breaded fish, sausage patties, beef patties, and white turkey.
-opened undated bag of cinnamon rolls.
-opened undated bag of dinner rolls.
-opened undated bag of peas.

During an observation on 4/18/22, at 12:30 p.m. the following items were noted to be undated and expired in dry storage:
-opened and undated vegetable oil .
-dented diced tomatoes. CDM pulled them off of storage rack and stated, "those cannot be used and will have to be tossed out." CDM stated she does all the facility ordering from Sysco, dates all foods with received date, and uses the "first in, first out" method.
-opened and undated bread crumbs.
-opened, undated, and expired baking soda; expired on 1/28/22.
-opened and undated parsley, paprika, garlic salt, ground nutmeg, ground cloves, and oregano.
-opened and undated cinnamon; expired on 11/21/21.
-opened and undated bay leaves; manufacturers date 7/20/20.

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 ______	C 04/27/2022

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		F 812		

Continued From page 55
-opened and undated fajita seasoning; manufactures date 2/27/20.
-opened and undated whole sweet basil; manufactures date 6/30/20.
-opened and undated ground thyme; manufactures date 12/24/20.
-opened and undated lemon pepper; received on 7/31/20.
-opened and undated ground rosemary; received 11/24/20.
-opened and undated celery salt; received 7/9/20.
-opened and undated ground ginger; CDM uncertain on date received as label has worn off.
-opened and undated tarragon leaves; received 9/19/19.
-opened and undated allspice; manufactures date 11/18/18.
-opened and undated powdered sugar.
-opened and undated vanilla.

When interviewed on 4/18/22, at 12:48 p.m. CDM stated her expectation for dietary staff was to label and date foods upon opening and to dispose of expired foods. CDM expressed concern could potentially lead to food borne illnesses and unsanitary temperatures. CDM stated refrigerator and freezer temperatures should be checked and verified twice a day in the mornings and evenings. CDM confirmed these temperatures were not being completed in kitchen. CDM stated dishwasher temperatures should be completed three times a day; however, confirmed these were not getting completed either. CDM had to look at dishwasher log sheet to confirm how many times a day temperatures should be checked. CDM stated she would need to reeducate dietary staff right away.

During an observation of the kitchen on 4/18/22,

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 ______	C 04/27/2022

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 56	F 812		

at 1:00 p.m. the kitchen was found to have dirty cooking equipment; the microwave was soiled with dry food particles, the three compartment sink had dishes soaking from breakfast and dry food debris was scattered throughout all three areas, the grill had a very thick layer of black grease, the floor was soiled with dry potato peels, and floors were sticky, counter tops were also not clean in appearance. CDM confirmed grill grease should be cleaned daily and, "it had not been done in a very long time."

During an observation on 4/18/22, at 1:15 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette refrigerator:
-opened and undated tomato juice; best use by 5/4/20.
-opened and undated Member's Mark cheesecake.
-undated and unlabeled take out meal with can of Sprite in white grocery bag.
-undated and unlabeled broccoli and unknown meat with plastic white fork in Glad-wear container; C-C stated a nurse with blonde hair was eating this on 4/18/22 in the morning.
-opened and unlabeled bowl of sausage dated 4/18; the aluminum foil cover was torn open with food exposed.
-Chobani Greek strawberry banana yogurt; expired on 12/16/21.
-opened, undated, and unlabeled crushed peppers.
-undated and unlabeled mushy and brownish discolored apple slices.
-undated and opened green top jar from R20; C-C uncertain what product inside jar included.
-undated, unlabeled, and opened jar of beans and chicken.
-opened and undated sweet relish labeled

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 ______	C 04/27/2022

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 57	F 812		

"ARTS".
-opened and undated Sweet Baby Ray's barbeque sauce labeled "ARTS".
-opened and undated Hershey's chocolate syrup labeled "ARTS".
-opened Sara Lea classic white bread found in countertop drawer without twist tie; dated 2/23/22; bread was hardened but not moldy.
-opened and unlabeled Great Harvest Ambrosia sliced bread found on top of refrigerator.

When interviewed on 4/18/22, at 1:19 p.m. C-C stated uncertainty if food in dinette refrigerator and freezer was for staff or residents. C-C confirmed food in this refrigerator was not for staff use of personal food items brought into facility. C-C confirmed two packages of room temperature sliced Hormel pepperoni packages were left on countertop area by activities director (ACT). C-C confirmed undated and room temperature leftover steak and chicken found on countertop in Outback Steakhouse brown paper bag belonged to R19. C-C confirmed knowledge of posted sign on outside of refrigerator door that stated, "please mark sure all items are labeled and dated - anything not labeled and dated and/or is 7 days old or older will be thrown away. Unless otherwise specified. Any questions or concerns please see Jamie, dietary manager." An unidentified staff member who was giving a facility tour to a family member walked by and stated "this refrigerator is for resident food only."

When interviewed on 4/18/22, at 1:21 p.m. registered nurse (RN)-B confirmed dinette refrigerator and freezer were for resident food only. RN-B guessed leftover broccoli and meat with plastic fork was possibly a residents but was uncertain. RN-B stated anything labeled "ACTS"

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 ______	C 04/27/2022

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 58	F 812		

was used during resident activities and the activities director was in charge of labeling and dating these items. RN-B tossed leftover meal into garbage as she was not able to identify who it belonged to. RN-B uncertain who cheesecake belonged to or how long it had been opened, but she placed it back in refrigerator.

During an observation on 4/19/22, at 8:40 a.m. the following items were noted to be undated and opened above the kitchen stove:
-opened ground cumin; received 9/24/20.
-opened and undated poultry seasoning, whole celery seed, ground sage, ground ginger, rosemary leaves, and beef base.

When interviewed on 4/19/22, at 9:01 a.m. activities director (ACT) confirmed dietary is supposed to be checking temperatures on dinette refrigerator and freezer and making sure everything is dated and labeled. ACT stated nursing or activities staff will assist dietary if they were the ones who obtained and opened the food items first. ACT confirmed all food items should be dated/labeled and only kept for 72 hours after receiving. ACT stated activities foods are to be labeled and dated.

During an observation on 4/19/22, at 11:15 a.m. the refrigerator in the kitchen had 4 individual package of ham wrapped in saran wrap dated 4/12/22. One package of ham was not completely wrapped, leaving the ham exposed and touching the bottom of the refrigerator. The bottom shelf of the refrigerator also had a metal pan with defrosted ground beef that was undated.

A menu was observed hanging on the side of the refrigerator for 4/19/22. Menu included chicken

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 ______	C 04/27/2022

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 59	F 812		

soft shell taco, green chili rice, and Mexican corn.

During an observation on 4/19/22, at 11:25 a.m. C-C was taking temperatures of food that was coming out of the oven and placing the metal pans on the steam table. An unused area of the steam table was covered with a metal lid in order to keep the water hot; the lid was warm to the touch. On top of the lid was metal pan of chopped lettuce and a separate pan with chopped tomatoes and onions (items noted there at 11:15 a.m.); there was no barrier or a pan of ice to keep the lettuce cool. C-C was not observed to take temperatures of the "cold" items that were on the steam table lid.

During an observation on 4/19/22, at 11:39 a.m. an unidentified nursing assistant (NA) entered the kitchen from the small dinning room door without a hairnet, opened the refrigerator, removed unknown item, and then exited through the same door.

During an interview on 4/19/22, at 11:43 a.m. C-C stated she had not taken temperatures of the "cold" food items, cold food items temperatures, stated "we don't check temps of cold foods". C-C stated they [kitchen staff] did not check cold items because it was cold when they pulled them out of the refrigerator. When C-C was asked how to you make sure those items stay cold, C-C responded by stating because the food was cold. C-C was not able to articulate how cold food items maintained a safe temperature once items were removed from the refrigerator.

During an observation on 4/19/22, at 11:51 a.m. C-C set five plates on the make table and placed menu items on the plates which included the

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 ______	C 04/27/2022

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 60	F 812		

toppers (lettuce/tomato/cheese) that had been sitting on the steam table cover. At 11:53 a.m. C-C with gloved hands, removed shredded cheese from refrigerator, put into a metal pan, placed the pan on the steam table cover next to the lettuce, and with the same gloves on put lettuce and cheese onto the tacos. At 11:58 a.m. C-C with the same gloves on touched the outside of the tray cart, turned the cart around, and without performing hand hygiene picked up clean plates. When C-C picked up 5 more plates during which time her thumb was touching the inside of the plate. With the same gloves on, C-C then placed taco shells onto those plates, used a scoop for the chicken however, when she put chicken on the first plate some of the chicken pieces rolled outside the taco shell, C-C picked up the chicken with her gloved hand and placed it back into the shell.

During an observation on 4/19/22, at 11:56 a.m. beverage cart in the hallway was observed with no ice under the milk or juices. A nursing assistant (NA)-F was observed grabbing ice out of a pitcher with ungloved un-sanitized hands. From 4/18/22 to 4/21/22 resident freezer in the dining room had an open bag of ice with a cup that was used by multiple staff with ungloved un-sanitized hands.

During an observation on 4/19/22, at 12:00 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette freezer:
-opened and undated bag of ice with a facility beverage cup located on bottom shelf to grab ice with.
-undated and unlabeled Devour sweet and tangy pulled pork.
-undated beef soup for R20.

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 ______	C 04/27/2022

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 61	F 812		

-undated, unlabeled, opened box of ice cream crunch bars and ice cream sandwiches.
-unlabeled and opened container of rocky road ice cream dated 2/16.
-undated and labeled "CAT" Cilantro and Lime burrito.

During an observation and interview on 4/19/22, at 12:02 p.m. dietary assistance (DA)-A was asked by surveyor to take temperatures of the "cold" items that continued to be on top of the steam table lid and had not been temperature checked since removal from the refrigerator. DA-A stated lettuce was 75.0 degrees, tomatoes was 73 degrees, and cheese was 59 degrees. Despite the warm temperatures for these food items, they continued to be on top of the steam table lid until all meals were plated and delivered to the residents at approximately 12:40 p.m.

During an observation on 4/19/22, at 12:05 p.m. "ACT" condiments found in refrigerator the day prior were no longer found. An unidentified female nurse grabbed ice cubes out of dinette freezer with un-sanitized bare hands; poured Shasta soda can for R11 into a covered sippy cup, touched wheelchair arms to adjust resident, then touched resident cup, then went back to refrigerator and then completed hand hygiene using wall mounted hand sanitizer.

During an observation on 4/19/22, at 12:10 p.m. the following items were noted to be undated, unlabeled, and expired underneath popcorn cart located in dinette area:
-opened and undated ranch popcorn seasoning.
-opened and undated nacho cheddar popcorn seasoning.
-opened and undated whole yellow kernel

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 ______	C 04/27/2022

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 62	F 812		

popcorn.
-opened, unlabeled, undated, and uncapped popcorn oil with artificial butter flavor; best if used by 11/21.
-opened, unlabeled, undated popcorn oil with artificial butter flavor; best if used by 3/21.
-opened and undated pure vegetable oil.
-opened and undated Nestle hot chocolate powder.
-opened and undated Great Value honey graham crackers; best if used by 10/2/20.
-opened bottle of Dawn platinum powerwash dish spray.
-opened and unlabeled bottle of clear liquid cleaner.
-opened bottle of Oxivir Tb spray cleaner.

During an observation on 4/19/22, at 3:56 p.m. a footlong Subway sandwich and opened Body Armor beverage located inside resident dinette refrigerator.

During an observation and interview of the kitchen on 4/20/22, at 8:36 a.m. the floor remained unchanged and sticky. Grease was still observed on the grill. Right side of grill was dated 2/10. Left side of grill was not dated and more soiled with half inch of grease. C-C stated grill aluminum foils should get changed once a month. C-C stated previous CDM used to complete this task as cooks and dietary aides do not have enough time in their shift to complete. C-C stated current CDM does not help out in the kitchen at all. C-C stated she just sits and watches us struggle to survive in here. C-C confirmed the dishwasher and herself are the only staff in kitchen on most days of the week and it is not enough help. C-C stated current CDM does not work full-time hours and is only at facility between

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 ______	C 04/27/2022

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 63	F 812		

10 or 11am until 4pm at the very latest.

During an observation on 4/20/22, at 8:42 a.m. NA-B walked into kitchen without a hairnet on and did not perform hand hygiene, grabbed an unidentified item from steam table, and walked out of kitchen with item.

During an observation on 4/20/22, at 3:06 p.m. a saran wrapped plate with tomato, lettuce, and pickle for R11 was found in the resident dinette refrigerator; however, it was undated. A three piece chicken tenders package from Kwik Trip and Body Armor was placed on the counter top next to refrigerator. At 3:08 p.m., a licensed practical nurse (LPN)-D grabbed ice from resident freezer with un-sanitized gloved hands to refill ice water pitcher from medication cart.

During an observation on 4/21/22, at 9:34 a.m. a facility plastic beverage glass was observed sitting inside opened ice cube bag inside resident dinette freezer.

During an observation and interview on 4/21/22, at 9:36 a.m. CDM confirmed grill grease trays have not been cleaned yet. CDM stated her expectation for these to be cleaned once a week or more often if needed. CDM stated the cooks are to change these and she asked C-C to complete on 4/18/22 afternoon via verbal discussion. A cleaning schedule was observed taped to kitchen refrigerator door with numerous blanks last dated in February 2022. CDM confirmed she was the manager in charge in the kitchen to ensure cleaning schedule gets completed on time. CDM confirmed dietary staff

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 ______	C 04/27/2022

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 64 check temperatures of resident dinette refrigerator/freezer, ensure everything is labeled and dated, and check once a week to ensure foods have not expired. CDM stated this is her task to complete and it has not been getting completed routinely. A March 2022 temperature log was taped to the outside of dinette freezer. CDM confirmed she did not post a new one and it was not getting completed twice a day. CDM expressed concern potentially leading to food spoilage, thawed frozen foods, improper food temperatures which could lead to food borne illnesses for residents. CDM confirmed the following items found in the dinette refrigerator/freezer: -kitchen sausage labeled 4/18; CDM stated this should be in the kitchen and not in the resident refrigerator. -2 liter bottle of Mt. Dew dated 2/10; CDM uncertain who this belongs to. -2 liter bottle of Pepsi dated 3/15 for R2; CDM stated this should be thrown out. -opened tart cherry juice dated 2/16 for R24. -opened, undated, unlabeled bottle of ensure; CDM confirmed seal was broken and which resident it was used for. -opened, undated, unlabeled crunch ice cream bars. -opened, undated, unlabeled ice cream sandwiches; 2 boxes. -opened, undated, unlabeled popsicles; CDM confirmed these were freezer burnt and threw them out. -undated, unlabeled, frozen pulled pork and soup -undated but labeled "CAT" burrito; CDM stated she's unable to identify "CAT" and uncertain if it's a resident's or employee's food. -opened Sara Lea Bread in drawer below countertop; CDM stated, "this is very expired,	F 812		

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 ______	C 04/27/2022

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 65	F 812		

hardened, and can't be served to anyone."

When interviewed on 4/21/22, at 10:05 a.m. CDM stated the kitchen ice machine is unable to keep up with facility needs and the ice machine located in the "coffee room" is not functional currently so nursing staff use the ice placed in the dinette freezer. CDM confirmed all ice should be kept in a sealed container with an appropriate ice scoop that is not left in the bag. CDM confirmed ice was not labeled, dated, closed, or unsure how old it was. CDM threw the bag out immediately. CDM confirmed staff should use hand hygiene, clean gloves, a clean scoop or glass, and not place the scoop inside of bag between using. CDM confirmed ice should be used in their beverage cart container which holds milk and juices to ensure they are kept at appropriate temperatures.

During an observation and interview on 4/21/22, at 10:19 a.m. ACT stated the popcorn machine in dinette kitchen is seldom used and confirmed activities uses it once a month. ACT stated she used the popcorn machine "just the other day," however, it remains soiled and unsanitary today. ACT stated she uses the expiration dates of food items located in popcorn cabinet. ACT confirmed the popcorns expiration date she used "just the other day" had worn off and was unable to identify date. ACT stated she does not think popcorn seasonings need date opened labeled on them, but stated they were considered opened. ACT confirmed vegetable oils, hot chocolate cocoa powder, and graham crackers were opened, undated, and expired. ACT opened unidentified spray bottle cleaner, sniffed it, and stated it was vinegar and water and "I guess it should state what's inside the bottle." ACT stated she was in charge of checking food items in popcorn cart;

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 ______	C 04/27/2022

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 66	F 812		

however, confirmed she only checks items she used and never checked the entire popcorn cabinet. ACT expressed concern of other facility staff using outdated and expired foods. ACT confirmed cleaning supplies with chemicals should not be with resident food items.

When interviewed on 4/21/22, at 10:54 a.m. RN-A stated ice machine in "coffee room" has been broken for a very long time and the one in the kitchen is unable to keep up with demand.

During an observation on 4/21/22, at 11:37 a.m. environmental services manager (EVS)-A observed entering kitchen without hairnet and unwashed hands prior to grabbing an unidentified item off of steam table.

During an observation on 4/21/22, at 11:59 a.m. director of nursing (DON) entered kitchen door, then backed out, and then rummaged through where the hairnets should be kept. DON asked surveyor where she retrieved hairnet from and surveyor said the survey team brings their own. DON then asked CDM where the hairnets are kept and found one to don on her head. A personal staff lunch bag observed sitting on counter in kitchen underneath the bananas located next to steam table. DA-A observed putting away the weekly shipment of foods from Sysco and was not dating items with received date. Food temperatures were not tempted for dinner on 4/20/21. Grill tray observed very heavily soiled with great yet.

During an observation on 4/21/22, at 12:20 p.m. beverage cart was observed without ice underneath milks and juices.

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 ______	C 04/27/2022

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 67	F 812		

When interviewed on 4/21/22, at 12:56 p.m. registered dietician (RD) stated kitchen has been part of facility quality assurance and performance improvement (QAPI) and part of their plan of correction since the last state survey. RD confirms CDM is supposed to be working full-time at 40 hours per week. RD confirms CDM is salaried and does not have to report hours worked.

During an observation and interview on 4/21/22, at 4:20 p.m. NA-E observed entering kitchen without a hairnet or completing hand hygiene. NA-E stated she was unaware as "nobody ever told me I'm not supposed to walk into kitchen without a hairnet." DON overheard conversation between NA-E and surveyor and quickly wanted to interrupt to do education. DON stated she was going to immediately put up a sign on the kitchen door telling all staff to not enter kitchen without a hairnet. DON observed starring at kitchen door when she realized a sign was already posted on their main door. A sign observed stated, "Stop! Please put on a hairnet before Entering the Kitchen!!!" Hairnets were not observed on the outside of the kitchen but inside the doorway to the kitchen.

When interviewed on 4/21/21, at 4:26 p.m. CDM confirmed she has noticed nursing staff enter kitchen without hairnets. CDM stated she has not told any staff this week. CDM expressed concern could be loose hair getting into resident foods on dishware.

When interviewed on 4/21/21, at 4:28 p.m. RD confirmed kitchen was cleaned on 3/28/22, by another dietary manager from a sister facility. RD was uncertain why CDM did not know this

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 _______	C 04/27/2022

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 68	F 812		

information and why there are two different forms (one in the kitchen and one in the CDM office downstairs in the basement). RD confirmed the kitchen was unsanitary when she arrived this week. RD expected her CDM to ensure facility staff wore hairnets in kitchen at all times and performed hand hygiene. RD expressed concern for the opportunity for hair to get in food and for staff to easily touch their hair and faces which could potentially lead to cross contamination. RD stated expectation for dietary staff to check cold food temperatures before severing as her concern would be potential food poisoning and foods being in the danger zone. RD stated, "I would expect my CDM to know all of this."

When interviewed on 4/22/22, at 1:10 p.m. RD stated she felt fortunate state survey walked into facility this week. RD stated, "I can't find all of this out as my staff change how they act when I'm present in the facility." RD confirmed the temperatures and dating foods have been an issue for this facility for a very long time. RD expressed she did not realize how unknowledgeable her CDM really was. RD confirmed CDM had previously been verbally coached on being present in the kitchen and assisting staff with dietary duties and communicating with her team. RD stated CDM "blatantly lies to your face." RD confirmed facility was without dietary staff on 4/17/22 for breakfast as CDM did not confirm a back-up plan with a sister facility. RD stated CDM "dropped the ball." RD confirmed another instance when facility was without dietary staff as a new employee "no called, no showed" and residents were served McDonald's by activities director. RD confirmed she was in contact with North Shore corporate training to obtain Spanish educational materials

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 ______	C 04/27/2022

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 69	F 812		

for current staff as half of dietary speaks and reads Spanish. RD confirmed dietary staff takes quizzes on education and signs off on materials when completed. RD brought surveyor to basement where another freezer and dry storage was located. CDM failed to show surveyor the additional freezer and dry storage located in the basement. Freezer lacked temperature checks since 3/18/22.

During an observation on 4/24/22, at 8:09 a.m. a sign is posted on refrigerator door stating, "Please make sure all items are labeled and dated!!!! Anything not labeled and dated and/or is 7 days old or older will be thrown away, unless otherwise specified. Any questions or concerns please see Jamie, dietary manager." Freezer temperatures were not completed in evening on 4/22/22. No temperatures were obtained for refrigerator/freezers until C-D noticed surveyor noticed lack of tempting. C-C and C-D confirmed CDM never assists dietary staff in kitchen and usually is located in downstairs basement office when she is at facility. C-C confirmed CDM did not use a translator or use Spanish educational pamphlets with C-C or DA-A who primarily read and speak Spanish.

During an observation on 4/24/22, at 8:20 a.m. undated and unlabeled Cream Dream donuts were observed sitting on top dinette refrigerator with only one donut leftover. C-D observed tempting resident dinette refrigerator and freezer on March 2022 temperature log for 4/24/22 morning.
The facility policy titled Food: Preparation revised 9/2017 indicated, all foods are prepared in accordance with the FDA Food Code.
-All staff will practice proper hand washing

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 ______	C 04/27/2022

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 70 techniques and glove use. -Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially physical, biological, and chemical contamination. -The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F, or per state regulation. -All foods will be held at appropriate temperatures, greater than 135 degrees F (or as state regulation requires) for hot holding, and less than 41 degrees F for cold food holding. -All TCS foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a "prepared date: (Day 1) and a "use by date" (Day 7). The facility policy titled Receiving revised 9/2017 indicated, all canned goods will be appropriately inspected for dents, rust or bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal, as appropriate. -All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. The facility policy titled Food Storage: Cold Foods revised 4/2018 indicated, all perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service. -Freezer temperatures will be maintained at a temperature of 0 degrees F or below. -A written record of daily temperatures will be recorded. -All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.	F 812		

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 ______	C 04/27/2022

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 71	F 812		

The facility policy titled Storage: Chemicals revised 9/2017 indicated, all chemicals will be in a separate/secured area.
-All chemicals will be retained in their original containers. If chemicals are not in original container, the holding container will be clearly labeled with the name corresponding with the Safety Data Sheet (SDS).
The facility policy titled Ice revised on 9/2017 indicated, ice will be prepared and distributed in a safe and sanitary manner.
-Ice scoops will be cleaned and stored in a separate container that limits exposure to dust and moisture retention.
-Staff will adhere to proper utensil usage or clean gloved hands for handling.
-In the event of a mechanical malfunction, ice will be purchased from an approved vendor and stored in a manner that maintains proper temperature and prevents cross contamination.

The facility policy titled Staff Attire revised 9/2017 indicated, all staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained.

The facility policy titled Equipment revised 9/2017 indicated, all foodservice equipment will be clean, sanitary, and in proper working order.
-All good contact equipment will be cleaned and sanitized after every use.
-All non-food contact equipment will be clean and free of debris.

The facility policy titled Environment revised 9/2017 indicated, all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.
-The Dining Services Director will ensure that a

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 ______	C 04/27/2022

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 72 routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. -All food contact surfaces will be cleaned and sanitized after each use. The facility policy titled Food: Safe Handling for Foods from Visitors revised 7/2019 indicated, when food items are intended for later consumption, the responsible facility staff member will: -Ensure that the food is stored separate or easily distinguishable from the facility food. -Ensure that foods are in a sealed container to prevent cross contamination. -Label foods with the resident name and the current date. -Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and have temperature monitored daily for refrigeration less than or equal to 41 degrees F and freezer less or equal to 0 degrees F. Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for greater than or equal to 7 days. (Storage of frozen foods and shelf stable items may be retained for 30 days.) Cleaned weekly.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with	F 849		6/2/22

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 ______	C 04/27/2022

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 849	Continued From page 73 a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility	F 849		

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 ______	C 04/27/2022

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 849	Continued From page 74 for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property	F 849		

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 ______	C 04/27/2022

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 849	Continued From page 75	F 849		

by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the

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 ______	C **04/27/2022**

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 849	Continued From page 76 hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to coordinate services between the facility and the hospice agency by obtaining the hospice plan of care or the hospice schedule for providing services to ensure coordination of care for 1 of 1 resident (R24) reviewed for hospice.	F 849	F 849 R 24 has discontinued services with hospice effective 5/19/2022. Residents who are receiving hospice services have the potential to be impacted by the alleged practice. Care plans were reviewed and updated if indicated for residents currently enrolled in hospice	

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 ______	C 04/27/2022

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 849	Continued From page 77 Findings include: R24's significant change Minimum Data Set (MDS) dated 4/8/22, included cognitively intact with diagnoses including schizoaffective disorder, anxiety disorder, congested heart failure (CHF), chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, asthma, pulmonary embolism, obstructive sleep apnea, and chronic pain syndrome. R24 required extensive assistance from staff for bed mobility, dressing, toilet use, personal hygiene, and transfers with mechanical lift. R24's Order Summary Report dated 4/25/22, indicated R24 admitted to hospice services on 4/5/22. R24's hard medical chart only contained original hospice signed consent form on 4/1/22 and handwritten doctor's orders on 4/6/22. R24's care plan dated 4/1/22, identified terminal illness utilizing hospice services. There were no individualized interventions to direct staff on how to care for R24's terminal condition. The facility had not obtained the hospice plan of care or hospice schedule of visits for continuity of care. During an observation and interview on 4/18/22, at 5:35 p.m. R24 stated the hospice nurse was scheduled for a visit today, but did not show up or notify her of rescheduling. R24's room lacked any hospice schedule or notice. When interviewed on 4/20/22, at 2:50 p.m. licensed practical nurse (LPN)-D stated she had no idea if R24 had a hospice three ringed binder, plan of care, or schedule. LPN-D stated, "I'm just	F 849	services. The director of nursing or designee provided education to the interdisciplinary team on the need to include care and services being provided by hospice on 05/18/2022 and presented education to the licensed nurses and nursing assistants on hospice services beginning 05/18/22. The Director of Nursing or designee will complete audits of hospice care plans and facility care plans weekly for four weeks to validate the documents contain consistent information. Audits will be initiated the week of May 23, 2022. Results of audits will be submitted to the facility quality committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 849		F 849		

Continued From page 78
a pool agency nurse so I don't need to know that."

When interviewed on 4/20/22, at 2:54 p.m. LPN-A stated R24 did not have a hospice three ringed binder (which is normally kept at the nurses station and contains hospice care plan, schedule and any pertinent information the facility may need such as emergency contact for hospice) and the only hospice information was located in the hard medical chart. LPN-A stated R24 started on hospice the beginning of April 2022 for pain control. LPN-A stated a nurse comes, licensed social worker, and nursing assistants come during the day but was unable to articulate what they did for R24 other than pain control.

When interviewed on 4/20/22, at 3:00 p.m. LPN-C stated she was unsure if R24 had a hospice binder. LPN-C stated hospice nurses come one to two times a week, music therapy was involved, and hospice only let staff know when they were here on site. LPN-C stated, "I would hope they have a nursing assistant come."

When interviewed on 4/21/22, at 10:59 a.m. registered nurse (RN)-A stated R24 has hospice for pain management. RN-A stated a hospice aide comes to facility, but R24 sometimes refuses cares. RN-A was unable to articulate what hospice aide completed for R24 or when they were supposed to come.

During an observation and interview on 4/21/22, at 2:37 a.m. LPN-A stated she spoke to R24's hospice nurse last evening and confirmed the facility was supposed to have a three-ringed hospice binder. Binder observed located in correct spot in nurses station on book shelf. Hospice binder lacked information regarding R24

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 ______	C 04/27/2022

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 849	Continued From page 79	F 849		

such as: this is a hospice patient (not filled out with resident name, hospice diagnosis, funeral home, or code status), your hospice team is blank, POLST is blank, no hospice plan of care, no aide plan of care, admission doctor's orders not filled out, no doctor's orders, no medications, no interdisciplinary group report, no aide notes, no social worker (SW) notes, no chaplain visit notes, no therapy notes, and no continuous care additional nursing notes. Hospice visit calendar was first completed on 4/20/22 by hospice nurse identifying she visited and will be back on 4/22/22. The only nurses notes found were from 4/20/22.

When interviewed on 4/22/22, at 8:45 a.m. nursing assistant (NA)-B stated hospice will spend time with R24. When asked what hospice does for R24, NA-B stated, "I don't know; you will have to ask them yourself." NA-B could not specify when hospice comes other than stated a hospice aide comes once or twice a week to shower R24.

When interviewed on 4/22/22, at 1:30 p.m. hospice RN-F stated they are focusing on pain control and anxiety for R24. RN-F stated the hospice SW came out on 4/21/22 to address her motorized scooter. RN-F stated hospice increased nursing visits to twice a week, an aide to three times a week, bathing once a week, and music therapy. RN-F stated R24 really just wants someone to be with her to speak to, read to her, and someone to do her hair and keep it untangled. RN-F stated she was unable to find the hospice three-ringed binder on 4/20/22, but initiated one on 4/22/22 after a facility nurse informed her R24 did not have one. RN-F stated she speaks to the floor nurse and director of

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 ______	C 04/27/2022

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 849	Continued From page 80	F 849		

nursing (DON) after each visit and uses the hospice binder to look at past notes for communication.

When interviewed on 4/25/22, at 11:05 a.m. DON stated that hospice emails social worker (SW) and herself. DON expressed frustration with nurses for not knowing the orders and hospice plan of care for R24. DON stated expectation of the hospice binder would at least include phone numbers to call in case of an emergency, hospice plan of care, to provide the facility with a calendar and schedule for each month of the hospice staff that planned on coming to the facility to provide care to R24, and a communication log in the binder so facility staff on all shifts knew the plan.

The facility policy titled Hospice Benefit Care Requirements dated 6/1/17 indicated, the hospice and the facility will communicate with each other when any changes are indicated to the plan of care.
-The hospice and the facility should be aware of the other's responsibilities in implementing the plan of care.
-When a facility resident has also elected the Medicare hospice benefit, the hospice and the nursing home must communicate, establish and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation in the facility.
-The facility and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The hospice retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related condition.

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 ______	C 04/27/2022

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 880 SS=K	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, 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 §483.70(e) 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:	F 880		6/2/22

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 ______	C 04/27/2022

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 880	Continued From page 82 (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 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 document review the facility failed to ensure infection control procedures were implemented to reduce the risk and spread of an unknown gastrointestinal (GI) illness in the facility resulting in 10 of 28 residents (R82, R27, R1, R20, R18, R19, R26, R15, R13, and R9) developing GI symptoms and the facility lacked any investigation of causal factors and or testing for pathogen. In addition, the facility failed to implement timely isolation of symptomatic residents, and failed to perform hand hygiene	F 880	Attachments added F 880 R 82 and R27 recovered from GI illnesses and have been discharged to home since survey exit. R1, R9, R13, R15, R18, R19, R20, R21, and R26 were placed on transmission-based precautions and remained on precautions until prescribed treatment was completed if indicated and when symptoms had resolved. Identified residents have since recovered.	

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 ______	C 04/27/2022

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 880	Continued From page 83 following care of symptomatic residents, placing this vulnerable population of residents and health care workers at risk of serious illness. Further, the facility failed to use sanitary practices when passing ice water to residents, using bare hands and a cup inside with the ice to scoop, this had the potential to affect all 28 residents currently residing in the facility. The immediate jeopardy (IJ) began on 4/12/22 when the facility failed to ensure infection control procedures were implemented related to signs and symptoms of GI illness to reduce the risk of spread of unknown GI illness and was identified on 4/22/22. The administrator and director of nursing (DON) were notified of the IJ on 4/22/22, at 1:31 p.m. The IJ was removed on 4/27/22 at 1:07 p.m. when the facility ensured all residents with symptoms of GI illness were placed on transmission-based precautions with signage in place. All residents were screened for signs of GI illness, the physician was notified, policies and procedures were reviewed, all staff were educated, high touch areas were disinfected, tracking was started for employee call in's, and audits of handwashing were started. However, the non-compliance remained at the lower scope and severity of an F -widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: When interviewed on 4/20/22, at 2;39 p.m. the director of nursing stated they had some GI illness in the facility but it was resolved at this point. The DON stated they treated it as an outbreak and notified Olmstead County Public	F 880	Residents who reside in the facility have the potential to be impacted by the alleged practices. Residents were monitored for symptoms of GI illness once the outbreak was identified. Residents who developed symptoms of GI illness were reviewed by the interdisciplinary team transmission-based precautions/cohorting and isolation, environmental and shared equipment management, hand hygiene, PPE use, and tracking and trending of infections The facility has retained the consultation services of the corporate Director of Education, an RN who has infection preventionist certification. The consultant will work with the facility on infection control practices including transmission-based precautions/cohorting and isolation, environmental and shared equipment management, hand hygiene, PPE use, and tracking and trending of infections. The consultant will assist the leadership team in completing root cause analysis for the deficiencies cited. Results of RCA will be shared with the Quality Assurance committee for review and recommendations. The consultant RN, Infection Preventionist, will provide education to the Director of Nursing and interdisciplinary team on infection control practices including transmission-based precautions/cohorting and isolation, environmental and shared equipment management, hand hygiene, PPE use, and tracking and trending of infections the week of May 23, 2022. The Director of Nursing or designated certified Infection Preventionist will provide education to	

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 ______	C 04/27/2022

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 880	Continued From page 84 Health and notified the nurse practitioner and the medical director. One test had been ordered for R9, but canceled because R9 went to the hospital and they determined her symptoms were from constipation. Another specimen was ordered, but pending. Some staff had been ill with GI symptoms, but did not come back to work until all symptoms were gone. The DON had not tracked which staff had been ill. They were questioning if they had a norovirus (gastro-intestinal illness that is highly contagious), but did not have confirmation of that. The DON stated they put anyone who had one to two loose stools on precautions and anyone who had an emesis immediately. Staff were to wear gowns and gloves in any symptomatic resident room. Also, they placed the residents on, "enhanced barrier protection," which meant staff were also supposed to use soap and water for washing hands after any cares rather than hand sanitizer. R82's admission Minimum Data Set (MDS) dated 4/13/22, identified moderate cognitive impairment, with diagnosis of heart failure and dementia. R82 required extensive assistance with toileting and was frequently incontinent of stool. R82's care plan dated 4/15/22, identified a gastro-intestinal illness related to an outbreak of Clostridium Difficile Colitis, (an inflammation of the colon caused by the bacteria Cloststridium difficile, often resulting from disruption of normal healthy bacteria in the colon, often from antibiotics. C. Diff can also be transmitted from person to person by spores and spores are not killed by hand sanitizer, they can be washed off with judicious hand washing with soap and water). Staff were directed to, "Maintain droplet precaution as indicated for cdiff," and monitor for	F 880	interdepartmental staff members who enter resident rooms on transmission-based precautions/cohorting and isolation, environmental and shared equipment management, hand hygiene, and PPE use the week of May 23, 2022. Competency audits will be repeated during this training and a posttest completed to validate staff understanding of topics covered. Education and competencies were presented to these staff members during the extended survey as well and completed by April 27, 2022. The Director of Nursing or a certified Infection Preventionist or assigned licensed nurse will complete hand hygiene and PPE compliance each shift for seven days beginning May 20, 2022, and then three times weekly until full compliance is reached. The Director of Nursing or designee will complete audits of cleaning of environment and of shared equipment four times a week on each shift beginning May 20, 2022, and then three times weekly on various shifts until full compliance is reached. Audits of infections will be completed as per routine during morning clinical meetings Monday-Friday. Audits of compliance with surveillance measures will be completed twice weekly by a certified infection preventionist or the Director of Nursing until compliance is reached. Results of audits will be submitted to the facility Quality Assurance Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 04/27/2022

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 880	Continued From page 85	F 880		

signs of dehydration. The care plan did not direct staff on contact precautions or direct them to use soap and water for hand washing rather than hand sanitizer and did not give any direction on cleaning room or dedicating equipment to prevent the spread of infection.

R82's medication administration record dated 4/15/22, identified "enhanced barrier precautions for cdiff."

R82's bowel record showed she had frequent loose stools, up to several times per day since admission on 4/6/22.

The facility GI illness tracking log identified R82, but did not identify the start date of loose stool, it indicated, "Ongoing," only. The map of GI illness had R82 listed as being, "C. Diff."

During observation on 4/19/22, at 4:10 p.m. R82's door was closed and there was a sign on the door indicating, "enhanced barrier precautions," and instructed to staff to clean hands and there was picture of a bottle of hand sanitizer on it, use of gloves and gown. A bottle of hand sanitizer was on top of the cart and some disinfectant wipes.

During observation on 4/20/22, at 8:20 a.m. NA-B entered R82's room with a meal tray. NA-B did not put on gown or gloves. NA-B set the meal tray on R82's over-bed table and with bare hands moved the table towards R82 and arranged items on the tray table. NA-B then took the plate cover off and left the room without performing any hand hygiene. NA-B placed the plate cover on the tray cart, then proceeded to move the cart down the hall with her bare hands. When interviewed at this time, NA-B stated R82, "might have C. Diff."

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 ______	C 04/27/2022

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 880	Continued From page 86	F 880		

NA-B stated she had been told to wear a gown and gloves if she was working with, "body fluids," and did not wash her hands due to being in a hurry. NA-B stated she should have used hand sanitizer and was unaware C. Diff spores are not removed by using hand sanitizer and hand washing with soap and water should be used instead.

When interviewed on 4/20/22, at 9:38 a.m. the environmental services supervisor (EVS)-A stated hand sanitizer should be used before going into a resident room and after leaving the room. In the case of C. dif, EVS-A stated she was not aware of any difference, stating, "we typically use hand sanitizer, it is quicker." EVS-A stated infection control education had been provided at the facility, but did not recall receiving anything specific related to washing hands with soap and water in the case of C. dif. or Rotavirus.

When interviewed on 4/20/22, a 9:46 a.m. licensed practical nurse (LPN)-A stated, for residents such as R82 who had C. Diff, the resident should have separate dedicated equipment, staff should use gown and gloves and hands should be washed with soap and water instead of hand sanitizer. LPN-A stated staff should be using hand washing with soap and water for any residents with vomiting or diarrhea symptoms. LPN-A was not sure why the TBP sign indicated hand sanitizer was to be used for R82.

During observation on 4/21/22, at 10:50 a.m. occupational therapist (OT)-A was observed assisting R82 to the bathroom, R82 had an incontinent loose stool and OT-A wearing gown and gloves assisted R82 with cleaning up, when completed OT-A placed the soiled items in a bag.

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 ______	C 04/27/2022

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 880	Continued From page 87	F 880		

OT-A removed her gloves and gown and left the room with a tablet, OT-A set the tablet down and used hand sanitizer. When interviewed, OT-A stated R82 had an infection, but was unsure what type of infection. OT-A did not know R82 had C. Diff and hand washing should be used instead of hand sanitizer. OT-A had not sanitized her tablet after it had been in R82's room and touched by OT-A with contaminated hands. It was noted at this time, R82 shared a bathroom with R15 in an adjacent room.

When interviewed on 4/21/22, 10:59 a.m. a registered nurse (RN)-C stated staff would know what type of transmission based precautions (TBP) a resident required if infectious by the sign posted on their door. RN-C also said that staff should use soap and water hand washing instead of alcohol based sanitizer when working with a person with C. dif, but was unsure it that information was posted on the door, or how staff knew that. After checking R82's door, and not finding such information, RN-C stated he was going to post a sign immediately.

When interviewed on 4/21/22, 11:30 a.m. the director of nursing stated there had been some gastro-intestinal (GI) infections in the facility over the past week, but normally they did not consider it to be an outbreak until they had three or more cases of diarrhea in residents. DON said the physicians and nurse practitioners (NP) had been notified, but said they, "didn't think anything of it," but DON stated in her past experience they would have been hyper-vigilant. Three residents had received orders for testing, but DON said they had been unable to gather a sample for one resident, and the orders for another had been canceled. The test for R82 had indicated R82

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 ______	C 04/27/2022

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 880	Continued From page 88 was positive for C. Dif. DON said in the case of a GI outbreak, residents with symptoms would be monitored, signs regarding TBP would be posted, and personal protective equipment (PPE) supplies would be placed outside the room. DON said she was unsure if there was a sign posted about using soap and water instead of hand sanitizer in the case of C. Dif. DON said she had not posted a sign, but had started educating staff between 9:30 a.m. and 10:00 a.m. and she would go post the sign right away. DON said she was going to start PPE and handwashing audits. DON said R15 and R26 had developed symptoms of GI illness, and she had placed them in "enhanced barrier precautions and droplet precautions" and was going to talk with the medial providers and "strongly encourage" testing to be done on them, and any residents who developed GI symptoms. DON said R15's FM should not use the bathroom shared with R82, but was unsure if there was a sign on the door or in the bathroom. R27's admission MDS dated 3/28/22, identified cognitively intact and had heart disease and diabetes. R27 required limited assistance with toileting and was continent of bowel. R27 was not shown on the facility GI illness tracking log. R27's medical record identified R27 had loose watery stools and emesis on 4/12/22, and had been placed on TBP, which were removed on 4/14/22. When interviewed on 4/22/22, at 9:00 a.m. R27 stated he had gotten ill about 10 days ago and has had loose stools off and on since then.	F 880		

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 ______	C 04/27/2022

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 880	Continued From page 89	F 880		

When interviewed on 4/22/22, at 10:19 a.m. the DON stated a stool collection order was not obtained for R27 as they only had vomiting and no diarrhea. The DON was not aware R27 reported he had loose stools along with the vomiting on 4/12/22.

During an observation and interview on 4/22/22, at 10:31 a.m. RN-C was observed leaving R27's room and proceeded going from room to room on south hall completing vital signs on each resident. RN-C observed using hand sanitizer outside each resident room instead of hand washing. RN-C was observed not sanitizing thermometer and pulse oximeter equipment between resident use. RN-C stated he should have disinfected the equipment between each resident and used soap and water for hand washing.

R1's annual MDS dated 4/1/22, identified cognitively intact with diagnosis of heart disease. R1 required extensive assistance to toilet and was frequently incontinent of stool.

R1's bowel record identified loose stools as early as 4/9/22, with multiple daily loose stools starting on 4/12/22.

R1's care plan dated 4/22/22, identified a gastro-intestinal illness related to C. diff and Rotavirus, staff were to educate on signs and symptoms of GI outbreak, frequent handwashing and encourage to stay in room along with contact precautions, and to monitor for signs of dehydration. The care plan also directed to use soap and water for hand washing.

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 ______	C 04/27/2022

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 880	Continued From page 90	F 880		

R1 was identified on the facility map of GI infections as being in one room but moved due to GI illness symptoms to another room where she did not have a room mate and a stool specimen was sent on 4/23/22. The line listing of GI illness identified R1 as starting symptoms on 4/20/222, with the word, "again." A stool specimen had been sent and was back, with no information on pathogen.

R1's Clinical Communication from Mayo Clinic lab identified they had received a stool specimen on 4/23/22, and the stool contained Rotavirus and C. Diff and directed facility to place R1 on isolation and provide proper infection control processes and a report was sent to community heath. Vancomycin (antibiotic used to treat C. Diff) was ordered.

R1's progress note dated 4/23/22, at 10:42 p.m. included, "Call received from [physician] from clinic with lab results for resident. Stool was tested and resulted with positive results for Rotavirus and C-diff. Pharmacy notified, as [physician] gave telephone order for Vancomycin 125 mg to start within 24 hrs. Pharmacy will be sending enough med through back up pharmacy to be started tomorrow morning."

When interviewed on 4/24/22, 8:17 a.m. RN-C stated R1 had developed GI symptoms the previous evening, and had to be moved to a private room. Testing had been completed immediately and returned results indicated R1 had Rotavirus and C. Diff. RN-C stated staff were to isolate the resident, wear PPE of gown, gloves and mask and wash hands with soap and water.

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 ______	C 04/27/2022

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 880	Continued From page 91	F 880		

R20's quarterly MDS dated 3/2/22, identified cognitively intact and diagnoses including irritable bowel syndrome with diarrhea and a stroke. R20 required extensive assistance with toileting, but was always continent of bowel.

R20's bowel and bladder elimination log for April 2022 identified loose stools starting on 4/14/22, had two loose incontinent stools on 4/15/22 and again on 4/21/22. R20's progress notes identified the DON had been notified of loose stools and R20 was placed on transmission-based precautions (TBP).

R20 was identified on the facility GI illness tracking log as starting symptoms on 4/21/22. The map of GI illness's identified R20 as having Rotavirus and GI symptoms.

R20's Clinical Communication from Mayo Clinic identified a stool sample had been obtained by the lab on 4/22/22, and on 4/25/22 the specimen identified Rotavirus (a very contagious virus that causes diarrhea, vomiting, fever and/or abdominal pain and can lead to dehydration or even death). The communication identified public health would need to be notified of this contagious virus. A nurse practitioner note dated 4/22/22, also identified R20's stool sample was positive for Rotavirus.

During observation on 4/22/22, at 9:50 a.m. nursing assistant (NA)-B was in R20's room and arranged items on the bedside stand, removed gloves and left the room without washing hands. NA-A touched R20's door handle, then went to a mechanical lift in the hallway and brought it to the communal bath hallway. NA-A then went into R3's

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 ______	C 04/27/2022

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 880	Continued From page 92	F 880		

room and went into the bathroom where she washed her hands. NA-A did not disinfect the door handle or the lift after touching with contaminated hands.

During observation on 4/22/22, at 9:58 a.m. medical doctor (MD)-C was observed to have assisted R20 with toenails, when MD-C exited the room he used hand sanitizer outside of the room. According to the Center for Disease Control (CDC) updated 2021, hand washing with soap and water is most effective for removing Rotavirus from hands versus hand sanitizer. MD-C used his personal laptop, touched a backpack then used personal cell phone from shirt pocket and proceeded to R30's room. MD-C donned gloves without washing hands with soap and water and assisted R30 with toenails. When interviewed on 4/22/22, at 12:11 p.m. MD-C stated staff had instructed him to don/doff gloves at door, but did not specify the type of illness the residents who were on TBP had. If he had known, he would have used soap and water versus hand sanitizer.

During observation on 4/24/22, at 9:25 a.m. R18 attempted to bring a bottle of sparkling water to R20 whose room is directly across the hall. The regional nurse consultant (RNC)-B instructed R18 she could not take items from one room to another without using a bleach wipe on it.

During observation on 4/25/22, at 8:27 a.m. the health unit coordinator (HUC) knocked on R20's door, donned personal protective equipment (PPE) and entered the room with a meal tray. The HUC set the tray on the bedside table, moved R20's urinal off the bedside table, removed gloves and stepped outside the room, where she

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 ______	C 04/27/2022

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 880	Continued From page 93	F 880		

punched a code into the utility room door and used the door handle to open the door. The HUC then washed her hands, but did not disinfect the code buttons or the door handle that she had touched with potentially contaminated hands.

The facility provided room tracking log identified R20 as having GI symptoms, and the GI illness tracking log identified R20 as beginning symptoms on 4/21/22, even though loose stools were noted prior to that date.

R18's significant change MDS dated 2/24/22, identified cognitively intact with diagnosis of multiple sclerosis. R18 required extensive assistance with toileting and was frequently incontinent of stool.

R18's bowel record identified loose watery stools on 4/14/22. R18's medical record identified she had been placed on TBP on 4/16/22, but was removed on 4/18/22.

A progress note identified a note was sent to R18's physician on 4/22/22 indicating she had loose stools again, so isolation precautions were started again.

R18 was identified on the facility GI illness log as starting symptoms on 4/22/22.

During an observation on 4/24/22, at 8:08 a.m. a new isolation cart was located outside R18's room.

During an observation on 4/24/22, at 8:47 a.m. R18 was observed coming outside of her isolation room and into hallway. LPN-A glanced over 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 _____	C 04/27/2022

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 880	Continued From page 94	F 880		

asked R18, "What's up?" and did not provide redirection to R18 to go back into her room. Family member (FM)-A was observed leaving another resident room on north hallway and redirected R18 to go back into her room. FM-A donned PPE and assisted R18 back to room.

During an observation on 4/24/22, at 8:54 a.m. R18 was observed back in hallway requesting help to get to the bathroom. LPN-A observed at medication cart; while FM-A ran down the hallway to assist. FM-A requested help from DON; however, DON told FM-A to, "hold on." R18 stated she couldn't wait.

R19's quarterly MDS dated 2/25/22, identified cognitively intact with diagnosis of diabetes and prostate cancer. R19 required extensive assistance for toileting and was always continent of bowel.

When interviewed on 4/19/22, at 11:35 a.m. R19 stated he had become ill with severed diarrhea starting 4/16/22. R19 stated staff were aware of his diarrhea and had placed incontinent pads on his bedding as he was unable to control the loose stools. R19 stated he had started to feel better on 4/18/22 in the evening, but was still unable to eat much dinner. R19 stated he had never been placed on any time of precautions and he went out to eat Easter lunch on 4/19/22, but was unable to eat as he still felt ill.

R19's bowel elimination record for April 2022, identified regularly formed stools until 4/16/22, then had incontinent watery/diarrhea bowel movements after 4/16/22.

R19's progress notes did not show any

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 ______	C 04/27/2022

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 880	Continued From page 95	F 880		

identification of the diarrhea, nor did R19's medical record show any evidence the physician had been notified of the illness or any monitoring of R19's illness.

When interviewed on 4/22/22, at 10:19 a.m. the DON stated . DON confirmed she was aware R19 had diarrhea on 4/16/22 as she worked an overnight shift. DON failed to inform medical provider of gastrointestinal symptoms. DON confirmed R19 was never placed on isolation precautions and his symptoms still existed on 4/18/22. No stool sample had been sent to the lab.

A facility provided map of GI illness symptoms, undated, identified several residents who had GI illness, but R19 was not identified as having any GI illness. A line listing of residents who had been ill with a GI illness dated 4/24/22, also did not identify R19.

R26's quarterly MDS dated 3/26/22, identified cognitively intact with diagnosis of heart failure. R26 required extensive assistance with toileting and was frequently incontinent of bowel.

R26 was identified on the facility GI illness tracking log as beginning GI symptoms on 4/21/22. The map of illness showed she had GI symptoms.

R26 has 2 loose stools on 4/19/22, 4/20 had one loose, one formed, 4/21 had 7 loose stools, was put on isolation the 21st.

During an observation on 4/21/22, 10:29 a.m. R26 had a sign on her door indicating the need

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 ______	C 04/27/2022

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 880	Continued From page 96	F 880		

for "droplet precautions," but the door was wide open and R26 was sleeping without cough or obvious symptoms of respiratory disease noted.

R26's bowel record showed R26 had loose stools on a regular basis, but had an increase in frequency on 4/21/22.

R26's clinical communication from Mayo clinic identified R15's stool sample had been obtained on 4/22/22, and was identified to be Rotavirus and community health was to be advised.

R15's admission MDS dated 2/24/22, identified cognitively intact, required extensive assistance with toileting, and was frequently incontinent of bowel and had a diagnosis of ulcerative colitis, Chrohn's disease or an inflammatory bowel disease.

R15's bowel record showed she had started having loose stools on 4/16/22. R15's physician orders dated 4/24/22, identified staff were to collect a stool specimen for diarrhea over 7 days.

The facility GI illness tracking log identified a start date of symptoms as 4/20/22. The map of infections identified her as having a GI illness.

During an observation on 4/21/22, at 10:49 a.m. it was noted R15 shared a bathroom with R82 who had been placed on precautions for GI illness. Family member (FM)-C was visiting R15, but was not wearing a gown, gloves or mask. He was overheard on the phone to not visit as R15 had a case of, "stomach flu." FM-C went into the shared to the bathroom. FM-C came out of the bathroom. At 10:57 a.m. FM-C said he was aware of R15's

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 ______	C 04/27/2022

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 880	Continued From page 97	F 880		

illness and also R82's illness. FM-C said persons should not enter without wearing a gown and gloves. FM-C stated it was too far to walk all the way down the hall to dump things such as unconsumed beverages, so he had gone in the bathroom to dispose of them. He said he had been told he should not use the bathroom. He stated there was no posted information in the bathroom regarding use of the toilet or handwashing.

R15's progress note dated 4/22/22, at 8:45 a.m. identified R15 had developed, "GI symptoms that have been going around the facility."

R13's quarterly MDS dated 4/21/22, identified cognitively intact with diagnosis of a stroke. R13 required extensive assistance to toilet and was frequently incontinent of stool.

R13 was identified on the GI illness tracking log that he had developed symptoms and was placed on isolation on 4/21/22.

R9's quarterly MDS dated 2/10/22, included cognitively intact with diagnoses including cerebral palsy. R9 required extensive assistance with toileting and was always continent of bowel.

A progress note dated 4/12/22, at 1:29 p.m. indicated R9 had four episodes of emesis which started at 7:15 a.m. Registered nurse (RN)-A documented R9 suddenly awoke this morning and threw up without no warning. R9 had one small, hard bowel movement but has refused enema at this time. RN-A documented there were reports of other residents with symptoms on emesis at the skilled nursing facility.

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 ______	C 04/27/2022

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 880	Continued From page 98	F 880		

A progress note dated 4/13/22, at 10:08 a.m. indicated R9 requested to go to emergency room for evaluation as she was not feeling well. R9 stated she felt weak and had abdominal discomfort. R9 refused enema at this time. At 4:50 p.m., R9 returned to facility.

An emergency department note dated 4/13/22, at 1:47 p.m. indicated R9 was likely to have constipation; however, abdominal pain and vomiting resolved without further intervention. A fleets enema offered to R9, but she declined since her abdominal pain resolved.

A progress note dated 4/16/22, at 10:21 a.m. indicated R9 had two emesis and two loose stools which was reported to director of nursing (DON). At 10:09 p.m., R9 had three emesis and diarrhea. On 4/17/22, at 6:30 p.m. licensed practical nurse (LPN)-A indicated R9 had no emesis or loose stools on this shift and the issues were resolved.

When interviewed on 4/18/22, at 4:02 p.m. R9 stated she became violently ill on 4/12/22 with gastrointestinal signs and symptoms of vomiting and diarrhea. R9 stated she was so ill that "it was coming out both ends at the same time." R9 stated she requested to be transferred to the local emergency department on 4/13/22. R9 stated other resident's down the south hallway with similar gastrointestinal symptoms. R9 stated she was sick all week with nausea, vomiting, and diarrhea and could barely eat as her stomach did not feel well. R9 stated the facility placed her on isolation precautions; however, the isolation cart which was located outside R9's room was not utilized on 4/18/22 and no door signs were

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 ______	C 04/27/2022

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 880	Continued From page 99 posted. When interviewed on 4/22/22, at 10:19 a.m. the DON stated the nurse practitioner (NP)-A had canceled a stool specimen for R9 as she had issues with constipation not diarrhea and was maybe not part of the GI illness outbreak. When interviewed on 4/21/22, at 12:27 p.m. the facility social worker (SW) stated she had not received any new infection control training today. When interviewed on 4/21/22, at 12:31 p.m. RN-E stated she had not received any recent infection control training. When interviewed on 4/22/22, at 11:18 a.m. the DON stated it was important for staff to be using a bleach based cleaning solution for surfaces, but had not switched out their standard disinfectant with bleach. The DON stated they would do that right away. When interviewed on 4/22/22, at 10:19 a.m. the DON stated no stool samples had been obtained yet, they had received orders, and sent specimens in the wrong type of specimen cup so they had been rejected by the lab on 4/21/22. When interviewed on 4/24/22, 8:39 a.m. DON stated one staff person had developed GI symptoms 4/22/22 and was sent home, and another had called in sick overnight; R1 was moved due to symptoms and confirmed GI infections The facilities GI illness outbreak log identified a dietary aide had come down with GI symptoms on 4/22/22 and a nurse had on 4/24/22.	F 880		

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 ______	C 04/27/2022

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 880		F 880		

Continued From page 100

When interviewed on 4/24/22, 8:39 a.m. DON stated one staff person had developed GI symptoms 4/22/22 and was sent home, and another had called in sick overnight; R1 was moved due to symptoms and confirmed GI infections. DON also said R18 had started to develop some GI symptoms on 4/22/22 in the afternoon. DON said she had done some staff audits on PPE use and handwashing for the facility IJ removal plan that morning when arriving at the facility. DON stated a regional nurse consultant (RNC)-B had come in to help, and they had been going through their infection control policies in the last two days.

When interviewed on 4/24/22, 8:59 a.m. RNC-B stated she was not sure if the correct cleaning products were out on the isolation carts for staff to use, but then brought in a container of "Oxivir TB" wipes containing peroxide, and said they did have the correct cleaning solution. Shortly after this, an observation revealed there were no bleach, peroxide or Oxivir TB wipes on any isolation carts or with the shared equipment in the facility such as mechanical lifts.

During an observation on 4/25/22, at 8:14 a.m. NA-F walked across the north hallway carrying unbagged laundry against her clothing to the dirty clothes bin. NA-F then washed hands located near the laundry receptacle. NA-F did not change her potentially contaminated clothing. When interviewed at 8:17 a.m. NA-F stated she should have bagged the laundry and not carried it against her clothing.

During an observation on 4/25/22, at 8:27 a.m. HUC knocked on R20's door, donned appropriate

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 ______	C 04/27/2022

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 880	Continued From page 101	F 880		

PPE, entered the room with R20's breakfast tray, set the breakfast tray down the bed side table, moved R20's urinal off the bedside table, removed gloves, stepped outside the threshold of R20's room, removed her gloves, walked to the utility room door, punched the code in, used the door handle to open the door, entered and washed her hands with soap and water, exited the room and walked away. HUC did not disinfect the door handle.

During an interview on 4/25/22, at 8:39 a.m. RNC-C indicated she had seen the HUC contaminate the door code and handle, and indicated more infection control audits of the staff needed to be completed.

When interviewed on 4/25/22, at 9:29 a.m. registered dietician (RD) indicated even though she had educated nursing staff to not return trash from isolated resident trays back to the kitchen, the practice continued. RD indicated in order to mitigate this she had made signs so that this practice was stopped.

When interviewed on 4/24/22, at 10:01 a.m. RNC-B and the administrator stated they had updated all resident care plans and had ordered disinfectant that works on Rotavirus and C. Diff. They had placed spray bottles of bleach solution for staff to use on each wing. Lab results for R20 and R26 had come back and were positive for Rotavirus.

When interviewed on 4/25/22, at 11:28 a.m. RD stated even with all the signs on the resident doors who are on isolation and again talking to nursing staff, nursing brought back 5 trays from

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 ______	C 04/27/2022

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 880		F 880		

Continued From page 102
isolation rooms with garbage back to the kitchen. One was tray was even set on a kitchen countertop.

During an observation on 4/25/22, at 11:49 a.m. R21 wheeled down to use the communal bathroom in the hallway and then returned to her room. R21's roommate remained on TBP for GI illness. The toilet bowel in the bathroom was observed to have brown spots all over the toilet bowel. At 11:57 a.m. NA-B walked down the hallway with gloves on carrying a used mattress protector up against her chest. NA-B then walked to a mechanical lift located down the hallway and used the appropriate disinfectant to wipe it off, then washed her hands with soap and water. NA-B did not change her contaminated clothing. At 11:59 a.m. NA-B assisted R9 onto mechanical lift and put her on the toilet in the communal bathroom, even though the brown spots on the toilet seat had not been cleaned off.

During an interview on 4/25/22, at 12:04 a.m. NA-B confirmed she put R9 onto the toilet in the communal bathroom and stated R10 who was on TBP and was R21's roommate. NA-B stated R21 had a formed bowel movement, stated she had wiped down the toilet seat however did not clean the toilet bowel prior. NA-B indicated the toilet bowls were not cleaned between residents, the toilet had overflowed over the weekend, the brown spots on the bowl had been there the whole weekend, and housekeeping had not cleaned it after it overflowed. NA-B stated she knew that brown stuff has been there since Saturday, "that's when I noticed it"

During an interview on 4/25/22, at 12:13 p.m. HSK stated she had been the housekeeper on

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 ______	C 04/27/2022

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 880	Continued From page 103	F 880		

Saturday. HSK indicated she had been told to clean only the resident room bathrooms and did not clean the communal bathrooms and/or toilets on Saturday.

During an observation and interview on 4/25/22, at 12:21 p.m. EVS-A completed cleaning the toilet in the communal bathroom, brown spots were not longer observed in the toilet bowl. EVS-A verified the condition of the toilet bowl prior to cleaning. EVS-A stated that was the first time she had cleaned the bathroom/toilet today. Indicated she had not cleaned it prior because the bathroom had been busy. EVS stated the toilet bowls were not disinfected after each resident and were cleaned after breakfast, after lunch, and before leaving at the end of the day. EVS-A stated she had worked on Sunday and did not notice the dirty toilet bowl.

During an interview on 4/25/22 at 12:39 p.m. RNC-C was unaware why commodes were not being used until surveyor brought it to her attention. RNC-C indicated in outbreak status it would be expected to be cleaning the toilet in between each use. RNC-C indicated the facility would need more time to have an interdisciplinary team meeting to reevaluate the action plan to correct the ongoing lack of implementation of appropriate infection prevention interventions.

When interviewed on 4/25/22, at 1:02 p.m. medical doctor (MD)-D stated he had been informed of a couple cases of diarrhea in the building quite some time ago and could not recall the date. He had been informed they had some stool samples pending by the NP. The NP would be handling any lab results that are returned.

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 ______	C 04/27/2022

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 880	Continued From page 104	F 880		

Continued From page 104

During an interview on 4/25/22, at 2:22 p.m. RD stated 5 isolation tray came back from the kitchen, three from the 200 wing and two from the 100 wing. RD stated that was even after she had put directions on the trays. RD indicated by bringing potentially infectious items back to the kitchen increased the risk for cross contamination, kitchen staff could inadvertently handle dirty items without having the appropriate PPE on.

When interviewed on 4/25/22, at 3:35 p.m. the medical director (MD)-P stated If two residents had symptoms of loose stools would do a COVID test first, then a test for norovirus.
The immediate jeopardy was removed on 4/27/22, at 1:07 p.m. after it was verified the facility completed the following actions:
-Reviewed applicable policies and procedures for infection outbreak and provided re-education on surveillance/prevention strategies to the designated infection Preventionist. Surveillance logs completed.
-All residents with GI symptoms were confirmed to be on transmission-based precautions with signage in place in addition to ongoing surveillance for early detection.
-Laboratory testing was completed for residents who demonstrated symptoms so appropriate follow-up measures could be taken.
-Facility staff were provided with applicable education per department on infection control practices such as appropriate hand hygiene, disinfecting of equipment, disinfecting surfaces, donning/doffing PPE, and meal service delivery. The education provided to department staff was determined to be successfully implemented.
-Facility developed and implemented an auditing system that ensures ongoing compliance.

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 ______	C 04/27/2022

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 880	Continued From page 105	F 880		

This was verified by observation, interview of staff and residents and document review.

During an observation on 4/19/22, 11:56 a.m. the beverage cart for the noon meal was parked near the dining area. A large pitcher that contained ice was located at the end of the cart. a nursing assistant (NA)-F was observed to reach into the ice pitcher with her bare hand and lift ice with a cup that had been sitting in the pitcher, pour the ice into another cup, and then drop the other cup back into the ice pitcher where it remained. NA-F poured juice into the cup of ice and went down the hall to deliver the juice. Hand hygiene immediately before touching the cup in the ice pitcher was not completed.

During an observation 4/19/22, 12:03 p.m. a registered nurse (RN)-A opened the ice pitcher, reached in, took the cup sitting in the ice, touching the sides of the cup. RN-A scooped ice into a large water mug, and then dipped the scooping cup back into the pitcher of ice. Hand hygiene was not observed prior to touching the ice cup. RN-A then proceeded down the hall and delivered the mug of ice to R5 in his room.

When interviewed on, 4/21/22, 10:02 a.m. the certified dietary manager (CDM) stated ice should not be touched with a bare hand, gloves should be applied after hand hygiene. Ice should not be obtained using a cup to scoop, and such a cup should not be sitting in the ice.

During an observation 4/25/22, 12:44 p.m. a health unit coordinator (HUC) reached into the ice pitcher on the beverage cart with her bare hand, without performing hand hygiene, remove a cup

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 ______	C 04/27/2022

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 880		F 880		

Continued From page 106
that was in the pitcher, fill it with ice, poured the ice into another glass and then drop the first cup back into the ice pitcher.

When interviewed on 4/25/22, 12:46 p.m. a registered dietician (RD) said a scoop for ice should be stored outside of the ice container. RD was not aware the facility staff were scooping ice with a cup from a pitcher on the beverage cart and leaving the cup in the ice. RD said "they [non-dietary staff] just asked for a pitcher of ice" and RD was not aware of what happened after the ice left the kitchen area.

When interviewed on 4/25/22, 12:49 p.m. the director of nursing (DON) stated she had received training related to infection control with ice and ice scoops. DON stated she was aware from her training that an ice scoop should not sit in the ice container. DON said she was unaware that a cup was being used to scoop ice on the beverage cart, nor was she aware that the cup was being touched by multiple staff and left sitting in the ice. DON indicated this was not appropriate and said, "I need to take of this. I'm going right out to take care of this."

When interviewed on, 4/25/22, 1:13 p.m. HUC stated she had worked at the facility for several years and aside from office duties, would help to pass meal trays for residents. HUC felt the use of an ice pitcher with a cup for scooping had been in place for possibly six months. HUC did not recall ever being aware that the practice might be an infection control problem. After considering that multiple people might be touching other things in the environment prior to touching the cup used for scooping, and then multiple residents receiving the ice for consumption, HUC stated she thought

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 ______	C 04/27/2022

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 880	Continued From page 107 it might be an infection control concern. When interviewed on 4/25/22, 1:30 p.m. RD stated she had not been made aware of the ice issues. RD stated she had not been notified by CDM or DON at any time. RD said she thought the pitcher of ice would be filled with water and used to fill beverage glasses. RD brought in a covered steel container and stated she had located a small scoop that would be stored in the container on the beverage cart. A facility policy was requested, but not received.	F 880		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Please note that the Health and Life Safety Code Surveys are being processed in seperate enforcement cycles.
This letter is for the Life Safety Code Survey enforcement cycle.

Electronically delivered
May 9, 2022

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

RE: CCN: 245306
Cycle Start Date: April 20, 2022

Dear Administrator:

On April 20, 2022, a survey was completed at your facility by the Minnesota Departments of 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)).

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 July 20, 2022 (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 October 20, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING ______	04/20/2022

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/20/2022. At the time of this survey, ROCHESTER HEALTH SERVICES WEST was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 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: Electronically Signed
TITLE:
(X6) DATE: 05/17/2022

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
	245306	A. BUILDING **01** B. WING ____________	**04/20/2022**

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
K 000	Continued From page 1	K 000		

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 one-story building with a partial basement.

The original building 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 system with smoke detection in corridors and spaces open to the corridors that is monitored for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING ______	**04/20/2022**

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
K 000	Continued From page 2 automatic fire department notification. The facility has a capacity of 48 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced 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 test the operability of emergency lighting devices per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that 30-second monthly testing of emergency light fixtures was occurring or had been completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	The Maintenance Director completed the 30-second monthly testing of emergency light fixtures. The testing is on the monthly preventive maintenance program and has been revised to list each emergency light separately. The Maintenance Director is responsible to ensure compliance.	5/20/22
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101	K 324		5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING 01 B. WING	04/20/2022

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
K 324	Continued From page 3 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 observation and staff interview, the facility failed to provide proper protection from hazards in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5 and 19.3.2.5.3(9). This deficient finding could have an isolated impact on the residents within the facility. Findings Include:	K 324	The residential stove in the Occupational Therapy Room, was inspected by the Maintenance Director and found to have a working lock. Staff were educated on the need to lock the stove out when not in use. An inspection of the residential stove was added to the monthly preventative maintenance program. The Maintenance Director or designee is responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING	**04/20/2022**

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
K 324	Continued From page 4 On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by observation in the Occupational Therapy Room that the residential stove, which had a disconnect and lock-out device, was found to be in an active and functional state. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324		
K 345 SS=B	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain initiating devices of the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4 and 9.6.2, and NFPA 72 (2010 edition), National Fire Alarm and Signal Code, sections 14.2.1.1.1, 14.2.1.2.2, and 17.14.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by observation that manual fire	K 345	The Maintenance Director replaced the glass break rods in the manual fire alarm pull stations located in the North and South corridors. Monitoring glass break rods was added to the facility s preventative maintenance program. The Maintenance Director is responsible to ensure compliance.	5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING ______	**04/20/2022**

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
K 345	Continued From page 5 alarm pull stations were missing glass break rods at the following locations in the facility: North and South corridors. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.2, and NFPA 13	K 353	The Maintenance Director removed any storage in the 18 inches below a fire sprinkler head in rooms 209, 212 and 219. The Maintenance Director inspected all rooms, removed affected storage if found, and placed a notice that such storage is not allowed. Staff were educated about	6/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING 01 B. WING ______	04/20/2022

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
K 353	Continued From page 6 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by observation that the closets of Rooms 209, 212, 219 items were stacked too high, with less than 18 inches of sprinkler heads 2. On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by observation that sprinkler heads exhibited signs of oxidation in the Kitchen and Dish-washing Area. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	this requirement and asked to monitor and address noncompliance. The Maintenance Director added this task to the TELS system for ensuring monthly inspection and compliance. The Maintenance Director has ordered the replacement of the sprinkler heads in the kitchen that exhibited signs of oxidation. The vendor, Ahern, assured that the sprinkler heads are on order and the work will be completed when they arrive. The Maintenance Director or designee is responsible to ensure compliance.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain portable fire extinguishers documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire	K 355	The Maintenance Director completed the inspection of fire extinguishers. The fire extinguisher inspection is on the monthly preventive maintenance program and has been revised to list each fire extinguisher separately.	5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING ______	**04/20/2022**

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
K 355	Continued From page 7 Extinguishers, section 7.2.1.1, 7.2.4.3 and 7.2.4.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by a review of available documentation that no documentation was available or presented for review associated with the completion of monthly fire extinguisher inspections. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	The Maintenance Director is responsible to ensure 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 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review, and staff interview, the facility was using the corridors as an air plenum which is not in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.5.2.1 and 9.2.1, and NFPA 90A (2012 edition), Standard for the	K 521	The facility is requesting a waiver for K 521.	5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING ____________	**04/20/2022**

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
K 521	Continued From page 8 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 04/20/2022, between 08:00 AM to 11:00 AM, observations and documentation review revealed 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 Maintenance Director verified this deficient finding at the time of discovery.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6 and 4.7.6. This deficient finding could have a	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 the	5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING 01 B. WING ____	04/20/2022

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
K 712	Continued From page 9 widespread impact on the residents within the facility. Findings include: On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed during documentation review that no documentation was presented for review to confirm that a fire drill was conducted for the 1st shift in the 2nd and 3rd quarters, the 2nd shift in the 2nd and 4th quarters, and 3rd shift staff in the 2nd, 3rd, and 4th quarters. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	facility. Monthly fire drills will be reviewed at the QAPI meeting to evaluate compliance. The Maintenance Director and NHA is responsible to ensure compliance	
K 914 SS=C	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated	K 914		5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING ______	**04/20/2022**

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
K 914	Continued From page 10 repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by a review of available documentation that the documentation presented for review did not individually identify the results of the multi-point inspection for each of the individual outlets located in resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	The inspection and testing of all non-hospital grade electrical receptacles was completed by Maintenance Director. The electrical receptacle inspection is on the annual preventative maintenance program and has been revised to list each electrical receptacle separately. The Maintenance Director is responsible to ensure compliance.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing	K 923		5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01** B. WING ______	**04/20/2022**

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
K 923	Continued From page 11 gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/20/2022, between 08:00 AM to 11:00 AM, it was revealed by observation that the Med Gas	K 923	The Maintenance Director has changed the lock on the Med Gas Storage Room to one that remains in the locked position and added a Keypad lock. The Maintenance Director will utilize the TELS system for ensuring the Med Gas Storage Room door is inspected weekly. The Maintenance Director or designee is responsible for compliance.	

PRINTED: 06/14/2022
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
	245306	A. BUILDING **01** B. WING ______	**04/20/2022**

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
K 923	Continued From page 12 Storage Room was found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923		

Electronically delivered
May 13, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: CJZE11

Dear Administrator:

The above facility was surveyed on April 18, 2022 through April 27, 2022 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 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.

Please feel free to call me with any questions.

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

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 ______	C 04/27/2022

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) COMPLETE DATE
2 000	Initial Comments	2 000		

*****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 4/18/22 through 4/27/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you

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 ______	C 04/27/2022

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) COMPLETE DATE
2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5306078C(MN82516); however NO deficiencies were cited due to actions implemented by the facility prior to survey The following complaint was found to be UNSUBSTANTIATED: H5306077C(MN81831). 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 surveyor ' s 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 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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	2 000		

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 ______	C 04/27/2022

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) COMPLETE DATE
2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure appropriate management and routine care of a condom catheter for 1 of 1 resident (R19) reviewed for	2 910	Corrected	6/2/22

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 ____	C 04/27/2022

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) COMPLETE DATE
2 910	Continued From page 3	2 910		

catheter care.

Findings include:

R19's quarterly Minimum Data Set (MDS), dated 2/25/22, included cognitively intact with diagnosis including type 2 diabetes mellitus (DM2), diverticulosis, prostate cancer, cardiac pacemaker, and chronic kidney disease (CKD). R19 required extensive assistance from staff for transfer, dressing, toilet use, and personal hygiene.

R19's physician orders included a condom catheter (a urine collection device that fits like a condom over the penis) change every 72 hours as needed for catheter care starting on 12/15/21, rinse out catheter bag that is removed with vinegar two times a day for catheter care starting on 2/24/22, and foley output every shift for catheter patency starting on 11/19/21.

R19's care plan dated 11/19/21, included use of condom catheter needed due to disease process and history of prostate cancer and incontinence with goal to not have acute complications of urinary catheter use. Staff were directed to change urinary collection bag as needed, report any changes in amount and color or odor of urine, and report to medical doctor (MD) signs of urinary tract infection (UTI) such as blood, cloudy urine, fever, increased restlessness, lethargy, or complaints of pain and burning.

R19's medication administration record (MAR) included, R19's condom catheter was changed zero times in December 2021, one time in January 2022, four times in February 2022, six times in March 2022, and three times in April 2022.

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 ______	C 04/27/2022

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) COMPLETE DATE
2 910	Continued From page 4	2 910		

R19's bladder/incontinence evaluation dated 2/18/22, indicated R19 used a condom catheter but no other information was filled out on the assessment record.

R19's hospital discharge summary dated 2/5/22-2/8/22, indicated R19's urine in catheter was cloudy, had leukocytosis (high white blood cell count) and bladder wall thickening concerning for infection so R19 was started on antibiotics 2/6/22 for a urinary tract infection (UTI).

When interviewed on 4/19/22, at 10:13 a.m. R19 stated the facility does not have the space to clean his catheter equipment properly as he is in a semi-private room. R19 stated most facility staff do not wash out the leg bag with vinegar and water nightly to properly sanitize. R19 stated he finds his leg bag sitting on the floor and sometimes on the floor of the shared bathroom. R19 stated his equipment needs to be washed and hung up to dry properly. R19 stated he, "passed out" in the bathroom approximately two months ago and the hospital discovered he had a UTI. R19 stated the hospital, "got after the facility for wrong doing."

During an observation and interview on 4/19/22, at 4:30 p.m. licensed practical nurse (LPN)-C stated R19 can assist with putting on condom catheter himself. R19 stated the end piece cover to his catheter tubing is currently missing. R19 stated a nurse hung it up over the bathroom sink earlier today; otherwise, it is normally placed on the floor or in a bath basin all curled up without a place to dry.

During an observation on 4/20/22, at 7:24 a.m. R19 was observed sleeping in bed with leg bag

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 ______	C 04/27/2022

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) COMPLETE DATE
2 910	Continued From page 5	2 910		

hanging over the bed rail with the catheter tubing tip touching the bath basin on the floor. R19's condom catheter was observed hooked up to resident's homemade overnight gravity bottle. There was white distilled vinegar and syringe in a bath basin on the floor next to the bathroom sink.

During an observation on 4/20/22, at 9:00 a.m. R19's overnight gravity bottle was observed sitting in a bath basin on the floor with the catheter tubing hanging over the bed rails uncapped.

During an observation on 4/20/22, at 12:09 p.m. R19's overnight gravity bottle was observed next to a shared bathroom toilet. The catheter tubing end was observed touching the dirty bathroom floor uncapped.

During an observation on 4/21/22, at 8:58 a.m. R19's overnight gravity catheter tubing was observed draped over the bed rail uncapped.

During an observation on 4/21/22, at 12:30 p.m. R19's overnight gravity catheter bottle was observed sitting in a bath basin next to the bed with the catheter tubing draping from the bed rail uncapped.

During an observation on 4/21/22, at 2:29 p.m. R19's catheter tubing was observed hanging over the shared bathroom sink in bathroom.

During an observation on 4/22/22, at 8:38 a.m. overnight gravity bottle was observed in a bath basin with catheter tubing hanging over bed rail touching frame of resident's bed.

During an observation and interview on 4/22/22, at 8:59 a.m. R19 observed was wheeling back to

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 ______	C 04/27/2022

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) COMPLETE DATE
2 910	Continued From page 6 room with unbuttoned, soiled pants. R19 explained to nursing assistant (NA)-B he needed a new catheter as the other one fell off. NA-B wheeled R19 back to room, donned gloves, transferred him to bed, pulled curtain divider to roommate, and grabbed residents phone that was ringing out of his left upper shirt pocket. NA-B was observed to not complete hand hygiene upon leaving R19's room. At 9:02 a.m., NA-B was observed back in R19's room without hand hygiene, but donned new gloves and started looking in resident nightstand for new condom catheter. Overnight catheter tubing observed touching the outside of bath basin uncapped. At 9:04 a.m., registered nurse (RN)-A arrived to room to assist R19 but had to leave to gather more supplies central supply room at facility. At 9:06 a.m. RN-A returned and informed NA-B she would take over from here. NA-B doffed gloves and performed hand hygiene upon exit. RN-A observed assisting R19 place new condom catheter and stated catheter should be changed every three days or more often if needed. RN-A stated all catheter supplies and tubing are to be cleaned daily with vinegar and water solution and hung to dry. RN-A stated she had noted other staff to not complete this task daily for R19 as his leg bag on most days is not clean in the morning when she arrives on shift and she works five dayshifts per week. RN-A stated night staff drapes R19's leg bag over the locked nightstand drawer handle if it is cleaned. RN-A verified catheter tubing should never be placed on floor or bathroom floor. RN-A stated a whole catheter system change would be required if found on floor due to potential contamination concerns which could lead to UTI's. RN-A stated R19 had one UTI since admission to facility. When interviewed on 4/22/22, at 12:32 p.m.	2 910		

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 ______	C 04/27/2022

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) COMPLETE DATE
2 910	Continued From page 7 RN-B stated she thought catheter supplies were changed once a month by nightshift staff. RN-B stated she was unaware of cleaning schedule for catheter supplies and tubing as she's, "never done it on dayshift." RN-B stated she did not know what R19's orders for catheter cares were or what they cleansed his equipment with. RN-B stated catheter supplies should never be re-used if found on floors as you, "never know what's on them." When interviewed on 4/22/22, at 12:55 a.m. RN-C stated catheters are changed out once a month or as needed. RN-C stated catheter equipment is cleaned out daily with a vinegar and water solution and set out to dry before re-use. RN-C stated catheter equipment and tubing should never be placed on flooring as it would increase a resident's chance for infection. When interviewed on 4/24/22, at 9:00 a.m. R19 stated his leg bag was not cleaned out with vinegar and water again last night. Overnight gravity bottle and tubing was observed draped over bed rail. When interviewed on 4/25/22 at 10:32 a.m. RN-A stated R19's overnight catheter equipment is getting cleaned by her; however, the night shift has not been completing leg bag cleaning. RN-A stated she's observed the vinegar solution in R19's bathroom to not decrease between her shifts as she will sometimes mark the level with a black sharpie marker. RN-A stated catheter changes should be charted in electronic medical record (EMR). RN-A stated R19's family would have to bring facility new overnight gravity catheter system and extension tubing as it is homemade. RN-A stated R19's condom catheter is changed approximately every two days as it	2 910		

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 ______	C 04/27/2022

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) COMPLETE DATE
2 910	Continued From page 8	2 910		

falls off and it always gets completed on bath day. RN-A stated facility does not use caps on catheter tubing ends when not being used.

When interviewed on 4/25/22, at 11:05 a.m. director of nursing (DON) stated the expectation for R19's condom catheter is to be changed every three days or more often if needed. DON stated expectation for staff nurses to clean catheter equipment with vinegar and water mixture daily keep supplies sanitary which could possibly lead to a potential infection such as a UTI. DON stated R19 and family have been educated and informed about the risks of using his homemade gravity night system; but stated it should not be a concern as long as the system is cleaned out properly every day. DON stated expectation for staff to replace catheter bag and tubing if it was ever accidentally placed on the floor as there would be a potential for cross-contamination leading to infection.

When interviewed on 4/25/22, at 3:09 p.m. nurse practitioner (NP)-A expressed concern facility was not keeping R19's catheter equipment cleaned daily. NP-A confirmed R19 utilized a condom catheter prior to admission at home and was able to maintain it without difficulty. NP-A stated she believed in her medical opinion, R19's admission to hospital on 2/6/22 was caused by facility failure to maintain a sanitary catheter system which ultimately lead to R19's UTI.

The facility policy titled Catheter Care, Indwelling revised 2/22/21 indicated, ensure, if applicable, if the leg bag urine collection device is cleaned/disinfected and stored per policy and manufacturer's guidance. The "stored per policy" was requested from the facility, but never provided upon request.

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 ______	C **04/27/2022**

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) COMPLETE DATE
2 910	Continued From page 9 -Use a dedicated urine collection device with a resident identifier and date. Avoid splashing and prevent contact of the drainage spigot with the nonsterile collecting container when emptying the drainage bag. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could re-educate licensed and unlicensed nursing care on the proper cleaning and storage of urinary supplies, especially catheter equipment, and could provide education on the complications of urinary tract infections and how to reduce these risks through appropriate cleaning of equipment and resident care. DON or designee could initiate audits of catheter care: equipment and resident cleanliness. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 910		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide meals that were palatable in taste, texture, appearance and at an appetizing temperature for 11 residents (R18, R19, R26, R13, R17, R9, R24, R5, R27) of the facility population of 28 observed for dining during the	2 960	Corrected	6/2/22

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 ______	C 04/27/2022

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) COMPLETE DATE
2 960	Continued From page 10 survey. Findings include: On 4/18/22, at 5:21 p.m. the evening meal trays were observed placed on an upright cart with doors to the front and back, but no heating element to maintain temperature. All facility trays had been plated before being brought out in the cart. Plates were covered with a domed cover. When staff began to pass the meal tray, both doors to the cart were opened and remained open until all trays were delivered. No condiments were observed on the trays. Beverages had come to the dining area on an open cart and had been served to residents prior to the trays arriving. A small basket of salt and pepper were observed on a small table away from the tray cart, and none were observed being placed on any tray being served. R18 received a hamburger as the alternative to the main meal of fried fish, and yelled at staff that she could not eat it, and asked staff if they would eat it. The burger was ground meat on a bun and there were no condiments. A licensed practical nurse (LPN)-A was unable to locate any condiments so went to the kitchen and came back with a handful of ketchup packets and also tarter sauce as this had not been provided for the fish meals. When interviewed on 4/19/22, at 10:05 a.m. R19 said, "The food isn't very good. The food is not hot by the time I get them." When interviewed on 4/18/22, at 2:07 p.m. R26 said, "I have ham up to three times per week. If it is not for breakfast it is for supper. The menu just comes. You could get a grilled cheese or hamburger but that's the same thing too, you get tired of the alternative. There are very few fresh	2 960		

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 ______	C 04/27/2022

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) COMPLETE DATE
2 960	Continued From page 11 fruits and vegetables." When interviewed on 4/18/22, at 2:11 p.m. R13 said, "The food is not that great, every once in a while we get something good. Sometimes they cook it too much; the food gets tough to chew, the meats. Sometimes it can be a little charred and burnt on the edges." When interviewed on 4/18/22, at 2:48 p.m. R17 stated the food was, "horrible. The eggs will come cold, like cold snot, the food is lukewarm-y." When interviewed on 4/18/22, at 4:02 p.m. R9 said, "Their food is not the greatest. The food isn't always hot. The meat is sometimes chewy. We get too much ham, now I'm beginning to hate it as we get it too often." When interviewed on 4/18/22, at 6:19 p.m. R24 said, "the hot food isn't always hot and the cold food isn't always cold; most of the time the meals are cold." When interviewed on 4/19/22, at 9:46 a.m. R5 said, "the food is not good, some of the food is dry or burned." When interviewed on 4/19/22, at 11:19 a.m. R27 said he didn't get items he requested and complained the food was often cold. During an observation on 4/19/22, at 11:56 a.m. the beverage cart was observed sitting to the side of the dining area with no ice under or around the milk or juice containers to keep them cold. The outside of the beverages were slightly cool, but not cold to the touch. During an observation on 4/21/22, at 9:02 a.m.	2 960		

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 ______	C 04/27/2022

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) COMPLETE DATE
2 960	Continued From page 12 R18 was seated in the dining room and loudly calling a family member (FM)-A to look at her food. R18 complained that her omelet was burned, and flipped it over for FM-A to see. FM-A then asked another resident seated at the table (R20) to turn his eggs over, and they were observed to be burned as well. During an observation on 4/21/22, at 12:20 p.m. the meal trays were loaded on the cart and transported out to the dining area to be passed to residents in the dining room and on the units. A taste test tray had been requested to be served last, and when all trays were passed, at 12:37 p.m. the temperatures of the plated food were as follows: meatloaf 102.2 degrees, au gratin potatoes at 107 degrees and peas were 105 degrees. The meatloaf was tender and with good flavor, but felt barely warm in the mouth. The potatoes were dry around the edges and lacked significant seasoning, and felt only slightly warm. The peas were not seasoned but felt warmer than the other foods. A registered dietician (RD) also tasted the food and indicated that it did not feel warm, but thought the flavor was pleasant. RD stated the food should be appropriately warm when served to the residents. When interviewed on, 4/21/22, at 2:04 p.m. FM-A stated R18 had been really upset about her breakfast being burned. FM-A said R18 does not often complain of the food, but when she does, it is to say the food is cold. When interviewed on 4/25/22, at 12:46 p.m. the RD stated any cook might accidentally burn food, but it should not be served if it was burned. If omelets were heated in a large pan and not turned over before being served it would be possible to accidentally serve a burnt portion, but	2 960		

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 ______	C 04/27/2022

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) COMPLETE DATE
2 960	Continued From page 13	2 960		

Continued From page 13

RD stated an expectation for food to be examined for being properly cooked before being served. RD stated food that was not properly prepared, that might be burned or was otherwise unpalatable for any reason should not be served and steps taken to remedy the situation.

During an observation on, 4/25/22, at 9:33 a.m. R5 had received bacon and fried eggs for breakfast. The eggs were burned all over to the point that they were hard and brown. R5 said he had called for something else as he felt the eggs were overdone and the bacon was underdone, but had not yet received anything different and thought he had been waiting for about half an hour.

When interviewed on 4/25/22, 9:40 a.m. R17 stated she did not get her breakfast. She had a tray with oatmeal in front of her. Later in the conversation R17 made it clear that she had asked staff to get her something different as the food she had was not what she wanted, and the oatmeal was cold and a solid lump. The oatmeal was observed to be in a mound, shaped like a scoop. R17 did not have any milk, sugar or other to add to her cereal. R17 said she had been waiting for an extended time for her requested alternative to arrive.

A facility policy titled Food: Quality and Palatability dated May 2014 indicated that food was to be prepared by methods that conserve "nutritive value, flavor and appearance. Food is palatable attractive and served at the proper temperatures."

SUGGESTED METHOD OF CORRECTION:

The facility Administrator and contracted food

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 ______	C 04/27/2022

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) COMPLETE DATE
2 960	Continued From page 14 service company could develop a plan for keeping food warm on individual trays until the time of service, utilizing either new warming equipment or devising a change in how food is served so trays are not sitting for an extended period. Kitchen manager could be sure to check all foods for signs of burning, dryness or other problems, and taste test food for palatability and serving temperature. Dietary staff could be educated on the concepts of food palatability related to temperature and appearance as well as flavor. All staff involved in serving residents food could be educated in checking that the food is acceptable to residents with each plate passed at each meal to ensure residents are satisfied with what they have received, offer condiments, offer alternatives and offer to warm food or exchange as needed. Audits could be done to ensure food is satisfactory in appearance, taste and temperature and residents are provided a regular method to give feedback on their meals. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 960		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure refrigerator items	21100	Corrected	6/2/22

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 15	21100		

Continued From page 15

were not stored beyond their expiration dates for 2 of 2 kitchen refrigerators and 2 of 2 kitchen freezers, and failed to ensure refrigerator items were dated, labeled, and stored beyond their expiration dates for 1 of 1 dinette kitchen refrigerators. These failures had the potential to affect all 28 residents in the facility.

Findings include:

During observation on 4/18/22, at 11:50 a.m. Temperature logs for the cooler and freezer had multiple blank entries and identified temperatures that were above safe zones (41 degrees Fahrenheit (F) or lower for cooler and 0 degrees F for freezer). The facility lacked evidence of evaluation and/or interventions when temperatures were above safe zone temperatures. On 2/13/22, freezer log indicated in the morning the freezer door was found to be ajar. The temperature recorded on the log was 30 degrees. On 1/24/22, the cooler temperature was 55 degrees in the morning.

During an initial brief kitchen tour on 4/18/22, at 11:52 a.m. with the dietary manager (CDM) the following items were noted to be undated, unlabeled, and expired in kitchen refrigerators:
-opened and undated carrots, spinach.
-opened bag of coleslaw with use by date of 4/14/22.
-undated and unlabeled sliced tomato and cucumber in zip-lock baggies.
-opened bag of bag of parmesan cheese dated 3/24/22; good for two weeks per certified dietary manager (CDM).
-opened and undated bag of shredded mozzarella cheese; three quarters used.
-opened and undated bag of finely shredded cheddar cheese.

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 16 -opened, undated, and unlabeled cream of wheat and peaches pureed for an unknown resident per CDM. -opened container of cottage cheese on 3/31/22; best if used by date of 4/13/22; good for seven days per CDM. -opened chopped garlic in oil dated 2/24/22; only good for two weeks per CDM. -opened sticky and unlabeled bottle with white liquid substance. CDM confirmed this belongs to dietary aide (DA)-A and white substance is staff's personal coffee creamer. CDM confirmed staff food does not belong in kitchen refrigerators and staff have a breakroom where they can store personal items. -opened and undated Sweet Baby Ray's barbeque sauce. -opened French's Worcestershire sauce dated 12/21; best if used by 6/26/21. -opened soy sauce dated 12/8; best if used by 11/15/21. -opened soy sauce dated 2/6; delivered to facility on 3/11/21; best if used by 11/15/21. -opened and undated thickened dairy drink. -opened and undated liquid whole eggs. -opened and undated Hershey chocolate syrup; best if used by 5/21. -unopened and undated lettuce that was wilted, brown, mushy, and liquefied. -undated and unlabeled onion that was turning brown and mushy. -ham that was undated wrapped in Saran wrap was unknown when it was defrosted. One sliced ham was touching the bottom of the cooler. CDM verified with cook (C)-C that ham was sliced on 4/13/22; however, C-C uncertain on date it was defrosted from freezer. C-C stated she would have to look back on previous week's menus to verify exact date it was sliced and defrosted. C-C confirmed food should be labeled and dated upon	21100		

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 17 opening items in kitchen. During an observation on 4/18/22, at 12:15 p.m. the following items were noted to be undated, unlabeled, and expired in kitchen freezers: -multiple open bags of cookie dough not dated had a thick yellowish layer of ice crystals. -opened undated bags of fish, breaded fish, sausage patties, beef patties, and white turkey. -opened undated bag of cinnamon rolls. -opened undated bag of dinner rolls. -opened undated bag of peas. During an observation on 4/18/22, at 12:30 p.m. the following items were noted to be undated and expired in dry storage: -opened and undated vegetable oil . -dented diced tomatoes. CDM pulled them off of storage rack and stated, "those cannot be used and will have to be tossed out." CDM stated she does all the facility ordering from Sysco, dates all foods with received date, and uses the "first in, first out" method. -opened and undated bread crumbs. -opened, undated, and expired baking soda; expired on 1/28/22. -opened and undated parsley, paprika, garlic salt, ground nutmeg, ground cloves, and oregano. -opened and undated cinnamon; expired on 11/21/21. -opened and undated bay leaves; manufacturers date 7/20/20. -opened and undated fajita seasoning; manufactures date 2/27/20. -opened and undated whole sweet basil; manufactures date 6/30/20. -opened and undated ground thyme; manufactures date 12/24/20. -opened and undated lemon pepper; received on 7/31/20.	21100		

(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
21100	Continued From page 18	21100		

-opened and undated ground rosemary; received 11/24/20.
-opened and undated celery salt; received 7/9/20.
-opened and undated ground ginger; CDM uncertain on date received as label has worn off.
-opened and undated tarragon leaves; received 9/19/19.
-opened and undated allspice; manufactures date 11/18/18.
-opened and undated powdered sugar.
-opened and undated vanilla.

When interviewed on 4/18/22, at 12:48 p.m. CDM stated her expectation for dietary staff was to label and date foods upon opening and to dispose of expired foods. CDM expressed concern could potentially lead to food borne illnesses and unsanitary temperatures. CDM stated refrigerator and freezer temperatures should be checked and verified twice a day in the mornings and evenings. CDM confirmed these temperatures were not being completed in kitchen. CDM stated dishwasher temperatures should be completed three times a day; however, confirmed these were not getting completed either. CDM had to look at dishwasher log sheet to confirm how many times a day temperatures should be checked. CDM stated she would need to reeducate dietary staff right away.

During an observation of the kitchen on 4/18/22, at 1:00 p.m. the kitchen was found to have dirty cooking equipment; the microwave was soiled with dry food particles, the three compartment sink had dishes soaking from breakfast and dry food debris was scattered throughout all three areas, the grill had a very thick layer of black grease, the floor was soiled with dry potato peels, and floors were sticky, counter tops were also not clean in appearance. CDM confirmed grill grease

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 19 should be cleaned daily and, "it had not been done in a very long time." During an observation on 4/18/22, at 1:15 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette refrigerator: -opened and undated tomato juice; best use by 5/4/20. -opened and undated Member's Mark cheesecake. -undated and unlabeled take out meal with can of Sprite in white grocery bag. -undated and unlabeled broccoli and unknown meat with plastic white fork in Glad-wear container; C-C stated a nurse with blonde hair was eating this on 4/18/22 in the morning. -opened and unlabeled bowl of sausage dated 4/18; the aluminum foil cover was torn open with food exposed. -Chobani Greek strawberry banana yogurt; expired on 12/16/21. -opened, undated, and unlabeled crushed peppers. -undated and unlabeled mushy and brownish discolored apple slices. -undated and opened green top jar from R20; C-C uncertain what product inside jar included. -undated, unlabeled, and opened jar of beans and chicken. -opened and undated sweet relish labeled "ARTS". -opened and undated Sweet Baby Ray's barbeque sauce labeled "ARTS". -opened and undated Hershey's chocolate syrup labeled "ARTS". -opened Sara Lea classic white bread found in countertop drawer without twist tie; dated 2/23/22; bread was hardened but not moldy. -opened and unlabeled Great Harvest Ambrosia sliced bread found on top of refrigerator.	21100		

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 20	21100		

When interviewed on 4/18/22, at 1:19 p.m. C-C stated uncertainty if food in dinette refrigerator and freezer was for staff or residents. C-C confirmed food in this refrigerator was not for staff use of personal food items brought into facility. C-C confirmed two packages of room temperature sliced Hormel pepperoni packages were left on countertop area by activities director (ACT). C-C confirmed undated and room temperature leftover steak and chicken found on countertop in Outback Steakhouse brown paper bag belonged to R19. C-C confirmed knowledge of posted sign on outside of refrigerator door that stated, "please mark sure all items are labeled and dated - anything not labeled and dated and/or is 7 days old or older will be thrown away. Unless otherwise specified. Any questions or concerns please see Jamie, dietary manager." An unidentified staff member who was giving a facility tour to a family member walked by and stated "this refrigerator is for resident food only."

When interviewed on 4/18/22, at 1:21 p.m. registered nurse (RN)-B confirmed dinette refrigerator and freezer were for resident food only. RN-B guessed leftover broccoli and meat with plastic fork was possibly a residents but was uncertain. RN-B stated anything labeled "ACTS" was used during resident activities and the activities director was in charge of labeling and dating these items. RN-B tossed leftover meal into garbage as she was not able to identify who it belonged to. RN-B uncertain who cheesecake belonged to or how long it had been opened, but she placed it back in refrigerator.

During an observation on 4/19/22, at 8:40 a.m. the following items were noted to be undated and opened above the kitchen stove:

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 21 -opened ground cumin; received 9/24/20. -opened and undated poultry seasoning, whole celery seed, ground sage, ground ginger, rosemary leaves, and beef base. When interviewed on 4/19/22, at 9:01 a.m. activities director (ACT) confirmed dietary is supposed to be checking temperatures on dinette refrigerator and freezer and making sure everything is dated and labeled. ACT stated nursing or activities staff will assist dietary if they were the ones who obtained and opened the food items first. ACT confirmed all food items should be dated/labeled and only kept for 72 hours after receiving. ACT stated activities foods are to be labeled and dated. During an observation on 4/19/22, at 11:15 a.m. the refrigerator in the kitchen had 4 individual package of ham wrapped in saran wrap dated 4/12/22. One package of ham was not completely wrapped, leaving the ham exposed and touching the bottom of the refrigerator. The bottom shelf of the refrigerator also had a metal pan with defrosted ground beef that was undated. A menu was observed hanging on the side of the refrigerator for 4/19/22. Menu included chicken soft shell taco, green chili rice, and Mexican corn. During an observation on 4/19/22, at 11:25 a.m. C-C was taking temperatures of food that was coming out of the oven and placing the metal pans on the steam table. An unused area of the steam table was covered with a metal lid in order to keep the water hot; the lid was warm to the touch. On top of the lid was metal pan of chopped lettuce and a separate pan with chopped tomatoes and onions (items noted there at 11:15 a.m.); there was no barrier or a pan of ice to keep	21100		

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 22	21100		

the lettuce cool. C-C was not observed to take temperatures of the "cold" items that were on the steam table lid.

During an observation on 4/19/22, at 11:39 a.m. an unidentified nursing assistant (NA) entered the kitchen from the small dinning room door without a hairnet, opened the refrigerator, removed unknown item, and then exited through the same door.

During an interview on 4/19/22, at 11:43 a.m. C-C stated she had not taken temperatures of the "cold" food items, cold food items temperatures, stated "we don't check temps of cold foods". C-C stated they [kitchen staff] did not check cold items because it was cold when they pulled them out of the refrigerator. When C-C was asked how to you make sure those items stay cold, C-C responded by stating because the food was cold. C-C was not able to articulate how cold food items maintained a safe temperature once items were removed from the refrigerator.

During an observation on 4/19/22, at 11:51 a.m. C-C set five plates on the make table and placed menu items on the plates which included the toppers (lettuce/tomato/cheese) that had been sitting on the steam table cover. At 11:53 a.m. C-C with gloved hands, removed shredded cheese from refrigerator, put into a metal pan, placed the pan on the steam table cover next to the lettuce, and with the same gloves on put lettuce and cheese onto the tacos. At 11:58 a.m. C-C with the same gloves on touched the outside of the tray cart, turned the cart around, and without performing hand hygiene picked up clean plates. When C-C picked up 5 more plates during which time her thumb was touching the inside of the plate. With the same gloves on, C-C then

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 23	21100		

placed taco shells onto those plates, used a scoop for the chicken however, when she put chicken on the first plate some of the chicken pieces rolled outside the taco shell, C-C picked up the chicken with her gloved hand and placed it back into the shell.

During an observation on 4/19/22, at 11:56 a.m. beverage cart in the hallway was observed with no ice under the milk or juices. A nursing assistant (NA)-F was observed grabbing ice out of a pitcher with ungloved un-sanitized hands. From 4/18/22 to 4/21/22 resident freezer in the dining room had an open bag of ice with a cup that was used by multiple staff with ungloved un-sanitized hands.

During an observation on 4/19/22, at 12:00 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette freezer:
-opened and undated bag of ice with a facility beverage cup located on bottom shelf to grab ice with.
-undated and unlabeled Devour sweet and tangy pulled pork.
-undated beef soup for R20.
-undated, unlabeled, opened box of ice cream crunch bars and ice cream sandwiches.
-unlabeled and opened container of rocky road ice cream dated 2/16.
-undated and labeled "CAT" Cilantro and Lime burrito.

During an observation and interview on 4/19/22, at 12:02 p.m. dietary assistance (DA)-A was asked by surveyor to take temperatures of the "cold" items that continued to be on top of the steam table lid and had not been temperature checked since removal from the refrigerator. DA-A stated lettuce was 75.0 degrees, tomatoes

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 24	21100		

was 73 degrees, and cheese was 59 degrees. Despite the warm temperatures for these food items, they continued to be on top of the steam table lid until all meals were plated and delivered to the residents at approximately 12:40 p.m.

During an observation on 4/19/22, at 12:05 p.m. "ACT" condiments found in refrigerator the day prior were no longer found. An unidentified female nurse grabbed ice cubes out of dinette freezer with un-sanitized bare hands; poured Shasta soda can for R11 into a covered sippy cup, touched wheelchair arms to adjust resident, then touched resident cup, then went back to refrigerator and then completed hand hygiene using wall mounted hand sanitizer.

During an observation on 4/19/22, at 12:10 p.m. the following items were noted to be undated, unlabeled, and expired underneath popcorn cart located in dinette area:
-opened and undated ranch popcorn seasoning.
-opened and undated nacho cheddar popcorn seasoning.
-opened and undated whole yellow kernel popcorn.
-opened, unlabeled, undated, and uncapped popcorn oil with artificial butter flavor; best if used by 11/21.
-opened, unlabeled, undated popcorn oil with artificial butter flavor; best if used by 3/21.
-opened and undated pure vegetable oil.
-opened and undated Nestle hot chocolate powder.
-opened and undated Great Value honey graham crackers; best if used by 10/2/20.
-opened bottle of Dawn platinum powerwash dish spray.
-opened and unlabeled bottle of clear liquid cleaner.

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 25	21100		

-opened bottle of Oxivir Tb spray cleaner.

During an observation on 4/19/22, at 3:56 p.m. a footlong Subway sandwich and opened Body Armor beverage located inside resident dinette refrigerator.

During an observation and interview of the kitchen on 4/20/22, at 8:36 a.m. the floor remained unchanged and sticky. Grease was still observed on the grill. Right side of grill was dated 2/10. Left side of grill was not dated and more soiled with half inch of grease. C-C stated grill aluminum foils should get changed once a month. C-C stated previous CDM used to complete this task as cooks and dietary aides do not have enough time in their shift to complete. C-C stated current CDM does not help out in the kitchen at all. C-C stated she just sits and watches us struggle to survive in here. C-C confirmed the dishwasher and herself are the only staff in kitchen on most days of the week and it is not enough help. C-C stated current CDM does not work full-time hours and is only at facility between 10 or 11am until 4pm at the very latest.

During an observation on 4/20/22, at 8:42 a.m. NA-B walked into kitchen without a hairnet on and did not perform hand hygiene, grabbed an unidentified item from steam table, and walked out of kitchen with item.

During an observation on 4/20/22, at 3:06 p.m. a saran wrapped plate with tomato, lettuce, and pickle for R11 was found in the resident dinette refrigerator; however, it was undated. A three piece chicken tenders package from Kwik Trip and Body Armor was placed on the counter top

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 26	21100		

next to refrigerator. At 3:08 p.m., a licensed practical nurse (LPN)-D grabbed ice from resident freezer with un-sanitized gloved hands to refill ice water pitcher from medication cart.

During an observation on 4/21/22, at 9:34 a.m. a facility plastic beverage glass was observed sitting inside opened ice cube bag inside resident dinette freezer.

During an observation and interview on 4/21/22, at 9:36 a.m. CDM confirmed grill grease trays have not been cleaned yet. CDM stated her expectation for these to be cleaned once a week or more often if needed. CDM stated the cooks are to change these and she asked C-C to complete on 4/18/22 afternoon via verbal discussion. A cleaning schedule was observed taped to kitchen refrigerator door with numerous blanks last dated in February 2022. CDM confirmed she was the manager in charge in the kitchen to ensure cleaning schedule gets completed on time. CDM confirmed dietary staff check temperatures of resident dinette refrigerator/freezer, ensure everything is labeled and dated, and check once a week to ensure foods have not expired. CDM stated this is her task to complete and it has not been getting completed routinely. A March 2022 temperature log was taped to the outside of dinette freezer. CDM confirmed she did not post a new one and it was not getting completed twice a day. CDM expressed concern potentially leading to food spoilage, thawed frozen foods, improper food temperatures which could lead to food borne illnesses for residents. CDM confirmed the following items found in the dinette refrigerator/freezer:
-kitchen sausage labeled 4/18; CDM stated this should be in the kitchen and not in the resident

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 ________	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 27	21100		

refrigerator.
-2 liter bottle of Mt. Dew dated 2/10; CDM uncertain who this belongs to.
-2 liter bottle of Pepsi dated 3/15 for R2; CDM stated this should be thrown out.
-opened tart cherry juice dated 2/16 for R24.
-opened, undated, unlabeled bottle of ensure; CDM confirmed seal was broken and which resident it was used for.
-opened, undated, unlabeled crunch ice cream bars.
-opened, undated, unlabeled ice cream sandwiches; 2 boxes.
-opened, undated, unlabeled popsicles; CDM confirmed these were freezer burnt and threw them out.
-undated, unlabeled, frozen pulled pork and soup
-undated but labeled "CAT" burrito; CDM stated she's unable to identify "CAT" and uncertain if it's a resident's or employee's food.
-opened Sara Lea Bread in drawer below countertop; CDM stated, "this is very expired, hardened, and can't be served to anyone."

When interviewed on 4/21/22, at 10:05 a.m. CDM stated the kitchen ice machine is unable to keep up with facility needs and the ice machine located in the "coffee room" is not functional currently so nursing staff use the ice placed in the dinette freezer. CDM confirmed all ice should be kept in a sealed container with an appropriate ice scoop that is not left in the bag. CDM confirmed ice was not labeled, dated, closed, or unsure how old it was. CDM threw the bag out immediately. CDM confirmed staff should use hand hygiene, clean gloves, a clean scoop or glass, and not place the scoop inside of bag between using. CDM confirmed ice should be used in their beverage cart container which holds milk and juices to ensure they are kept at appropriate temperatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00941	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 28	21100		

During an observation and interview on 4/21/22, at 10:19 a.m. ACT stated the popcorn machine in dinette kitchen is seldom used and confirmed activities uses it once a month. ACT stated she used the popcorn machine "just the other day," however, it remains soiled and unsanitary today. ACT stated she uses the expiration dates of food items located in popcorn cabinet. ACT confirmed the popcorns expiration date she used "just the other day" had worn off and was unable to identify date. ACT stated she does not think popcorn seasonings need date opened labeled on them, but stated they were considered opened. ACT confirmed vegetable oils, hot chocolate cocoa powder, and graham crackers were opened, undated, and expired. ACT opened unidentified spray bottle cleaner, sniffed it, and stated it was vinegar and water and "I guess it should state what's inside the bottle." ACT stated she was in charge of checking food items in popcorn cart; however, confirmed she only checks items she used and never checked the entire popcorn cabinet. ACT expressed concern of other facility staff using outdated and expired foods. ACT confirmed cleaning supplies with chemicals should not be with resident food items.

When interviewed on 4/21/22, at 10:54 a.m. RN-A stated ice machine in "coffee room" has been broken for a very long time and the one in the kitchen is unable to keep up with demand.

During an observation on 4/21/22, at 11:37 a.m. environmental services manager (EVS)-A observed entering kitchen without hairnet and unwashed hands prior to grabbing an unidentified item off of steam table.

During an observation on 4/21/22, at 11:59 a.m.

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 29	21100		

director of nursing (DON) entered kitchen door, then backed out, and then rummaged through where the hairnets should be kept. DON asked surveyor where she retrieved hairnet from and surveyor said the survey team brings their own. DON then asked CDM where the hairnets are kept and found one to don on her head. A personal staff lunch bag observed sitting on counter in kitchen underneath the bananas located next to steam table. DA-A observed putting away the weekly shipment of foods from Sysco and was not dating items with received date. Food temperatures were not tempted for dinner on 4/20/21. Grill tray observed very heavily soiled with great yet.

During an observation on 4/21/22, at 12:20 p.m. beverage cart was observed without ice underneath milks and juices.

When interviewed on 4/21/22, at 12:56 p.m. registered dietician (RD) stated kitchen has been part of facility quality assurance and performance improvement (QAPI) and part of their plan of correction since the last state survey. RD confirms CDM is supposed to be working full-time at 40 hours per week. RD confirms CDM is salaried and does not have to report hours worked.

During an observation and interview on 4/21/22, at 4:20 p.m. NA-E observed entering kitchen without a hairnet or completing hand hygiene. NA-E stated she was unaware as "nobody ever told me I'm not supposed to walk into kitchen without a hairnet." DON overheard conversation between NA-E and surveyor and quickly wanted to interrupt to do education. DON stated she was going to immediately put up a sign on the kitchen door telling all staff to not enter kitchen without a

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 30	21100		

hairnet. DON observed starring at kitchen door when she realized a sign was already posted on their main door. A sign observed stated, "Stop! Please put on a hairnet before Entering the Kitchen!!!" Hairnets were not observed on the outside of the kitchen but inside the doorway to the kitchen.

When interviewed on 4/21/21, at 4:26 p.m. CDM confirmed she has noticed nursing staff enter kitchen without hairnets. CDM stated she has not told any staff this week. CDM expressed concern could be loose hair getting into resident foods on dishware.

When interviewed on 4/21/21, at 4:28 p.m. RD confirmed kitchen was cleaned on 3/28/22, by another dietary manager from a sister facility. RD was uncertain why CDM did not know this information and why there are two different forms (one in the kitchen and one in the CDM office downstairs in the basement). RD confirmed the kitchen was unsanitary when she arrived this week. RD expected her CDM to ensure facility staff wore hairnets in kitchen at all times and performed hand hygiene. RD expressed concern for the opportunity for hair to get in food and for staff to easily touch their hair and faces which could potentially lead to cross contamination. RD stated expectation for dietary staff to check cold food temperatures before severing as her concern would be potential food poisoning and foods being in the danger zone. RD stated, "I would expect my CDM to know all of this."

When interviewed on 4/22/22, at 1:10 p.m. RD stated she felt fortunate state survey walked into facility this week. RD stated, "I can't find all of this out as my staff change how they act when I'm present in the facility." RD confirmed the

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 31 temperatures and dating foods have been an issue for this facility for a very long time. RD expressed she did not realize how unknowledgeable her CDM really was. RD confirmed CDM had previously been verbally coached on being present in the kitchen and assisting staff with dietary duties and communicating with her team. RD stated CDM "blatantly lies to your face." RD confirmed facility was without dietary staff on 4/17/22 for breakfast as CDM did not confirm a back-up plan with a sister facility. RD stated CDM "dropped the ball." RD confirmed another instance when facility was without dietary staff as a new employee "no called, no showed" and residents were served McDonald's by activities director. RD confirmed she was in contact with North Shore corporate training to obtain Spanish educational materials for current staff as half of dietary speaks and reads Spanish. RD confirmed dietary staff takes quizzes on education and signs off on materials when completed. RD brought surveyor to basement where another freezer and dry storage was located. CDM failed to show surveyor the additional freezer and dry storage located in the basement. Freezer lacked temperature checks since 3/18/22. During an observation on 4/24/22, at 8:09 a.m. a sign is posted on refrigerator door stating, "Please make sure all items are labeled and dated!!!! Anything not labeled and dated and/or is 7 days old or older will be thrown away, unless otherwise specified. Any questions or concerns please see Jamie, dietary manager." Freezer temperatures were not completed in evening on 4/22/22. No temperatures were obtained for refrigerator/freezers until C-D noticed surveyor noticed lack of tempting. C-C and C-D confirmed CDM never assists dietary staff in kitchen and	21100		

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 ____	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 32	21100		

usually is located in downstairs basement office when she is at facility. C-C confirmed CDM did not use a translator or use Spanish educational pamphlets with C-C or DA-A who primarily read and speak Spanish.

During an observation on 4/24/22, at 8:20 a.m. undated and unlabeled Cream Dream donuts were observed sitting on top dinette refrigerator with only one donut leftover. C-D observed tempting resident dinette refrigerator and freezer on March 2022 temperature log for 4/24/22 morning.

The facility policy titled Food: Preparation revised 9/2017 indicated, all foods are prepared in accordance with the FDA Food Code.
-All staff will practice proper hand washing techniques and glove use.
-Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially physical, biological, and chemical contamination.
-The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F, or per state regulation.
-All foods will be held at appropriate temperatures, greater than 135 degrees F (or as state regulation requires) for hot holding, and less than 41 degrees F for cold food holding.
-All TCS foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a "prepared date: (Day 1) and a "use by date" (Day 7).
The facility policy titled Receiving revised 9/2017 indicated, all canned goods will be appropriately inspected for dents, rust or bulges. Damaged

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 33	21100		

cans will be segregated and clearly identified for return to vendor or disposal, as appropriate.
-All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation.
The facility policy titled Food Storage: Cold Foods revised 4/2018 indicated, all perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service.
-Freezer temperatures will be maintained at a temperature of 0 degrees F or below.
-A written record of daily temperatures will be recorded.
-All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.
The facility policy titled Storage: Chemicals revised 9/2017 indicated, all chemicals will be in a separate/secured area.
-All chemicals will be retained in their original containers. If chemicals are not in original container, the holding container will be clearly labeled with the name corresponding with the Safety Data Sheet (SDS).
The facility policy titled Ice revised on 9/2017 indicated, ice will be prepared and distributed in a safe and sanitary manner.
-Ice scoops will be cleaned and stored in a separate container that limits exposure to dust and moisture retention.
-Staff will adhere to proper utensil usage or clean gloved hands for handling.
-In the event of a mechanical malfunction, ice will be purchased from an approved vendor and stored in a manner that maintains proper temperature and prevents cross contamination.

The facility policy titled Staff Attire revised 9/2017 indicated, all staff members will have their hair off

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 34	21100		

the shoulders, confined in a hair net or cap, and facial hair properly restrained.

The facility policy titled Equipment revised 9/2017 indicated, all foodservice equipment will be clean, sanitary, and in proper working order.
-All good contact equipment will be cleaned and sanitized after every use.
-All non-food contact equipment will be clean and free of debris.

The facility policy titled Environment revised 9/2017 indicated, all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.
-The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.
-All food contact surfaces will be cleaned and sanitized after each use.

The facility policy titled Food: Safe Handling for Foods from Visitors revised 7/2019 indicated, when food items are intended for later consumption, the responsible facility staff member will:
-Ensure that the food is stored separate or easily distinguishable from the facility food.
-Ensure that foods are in a sealed container to prevent cross contamination.
-Label foods with the resident name and the current date.
-Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and have temperature monitored daily for refrigeration less than or equal to 41 degrees F and freezer less or equal to 0 degrees F. Daily monitoring for refrigerated storage duration and discard of any food items that have been stored

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 ______	C 04/27/2022

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) COMPLETE DATE
21100	Continued From page 35 for greater than or equal to 7 days. (Storage of frozen foods and shelf stable items may be retained for 30 days.) Cleaned weekly. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could educate the staff on why regular temperature monitoring and proper sanitization is important in the storage of perishable foods including the risk for food born illness. A method of ensuring temperatures are taken, documented, reviewed and acted upon if needed could be developed and assigned to the appropriate staff. The dietary manager or designee could initiate audits of temperature logs, and food storage. TIME PERIOD FOR CORRECTION: Twenty one (21)days	21100		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure infection control procedures were implemented to reduce the risk and spread of an unknown gastrointestinal (GI) illness in the facility resulting in 10 of 28 residents (R82, R27, R1, R20, R18, R19, R26, R15, R13, and R9) developing GI symptoms and the facility lacked any investigation of causal factors and or testing for pathogen. In addition, the facility failed	21375	Corrected	6/2/22

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 36	21375		

to implement timely isolation of symptomatic residents, and failed to perform hand hygiene following care of symptomatic residents, placing this vulnerable population of residents and health care workers at risk of serious illness. Further, the facility failed to use sanitary practices when passing ice water to residents, using bare hands and a cup inside with the ice to scoop, this had the potential to affect all 28 residents currently residing in the facility.

Findings include:

When interviewed on 4/20/22, at 2;39 p.m. the director of nursing stated they had some GI illness in the facility but it was resolved at this point. The DON stated they treated it as an outbreak and notified Olmstead County Public Health and notified the nurse practitioner and the medical director. One test had been ordered for R9, but canceled because R9 went to the hospital and they determined her symptoms were from constipation. Another specimen was ordered, but pending. Some staff had been ill with GI symptoms, but did not come back to work until all symptoms were gone. The DON had not tracked which staff had been ill. They were questioning if they had a norovirus (gastro-intestinal illness that is highly contagious), but did not have confirmation of that. The DON stated they put anyone who had one to two loose stools on precautions and anyone who had an emesis immediately. Staff were to wear gowns and gloves in any symptomatic resident room. Also, they placed the residents on, "enhanced barrier protection," which meant staff were also supposed to use soap and water for washing hands after any cares rather than hand sanitizer.

R82's admission Minimum Data Set (MDS) dated

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 37	21375		

Continued From page 37

4/13/22, identified moderate cognitive impairment, with diagnosis of heart failure and dementia. R82 required extensive assistance with toileting and was frequently incontinent of stool.

R82's care plan dated 4/15/22, identified a gastro-intestinal illness related to an outbreak of Clostridium Difficile Colitis, (an inflammation of the colon caused by the bacteria Cloststridium difficile, often resulting from disruption of normal healthy bacteria in the colon, often from antibiotics. C. Diff can also be transmitted from person to person by spores and spores are not killed by hand sanitizer, they can be washed off with judicious hand washing with soap and water). Staff were directed to, "Maintain droplet precaution as indicated for cdiff," and monitor for signs of dehydration. The care plan did not direct staff on contact precautions or direct them to use soap and water for hand washing rather than hand sanitizer and did not give any direction on cleaning room or dedicating equipment to prevent the spread of infection.

R82's medication administration record dated 4/15/22, identified "enhanced barrier precautions for cdiff."

R82's bowel record showed she had frequent loose stools, up to several times per day since admission on 4/6/22.

The facility GI illness tracking log identified R82, but did not identify the start date of loose stool, it indicated, "Ongoing," only. The map of GI illness had R82 listed as being, "C. Diff."

During observation on 4/19/22, at 4:10 p.m. R82's door was closed and there was a sign on the door indicating, "enhanced barrier precautions," and

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 38	21375		

instructed to staff to clean hands and there was picture of a bottle of hand sanitizer on it, use of gloves and gown. A bottle of hand sanitizer was on top of the cart and some disinfectant wipes.

During observation on 4/20/22, at 8:20 a.m. NA-B entered R82's room with a meal tray. NA-B did not put on gown or gloves. NA-B set the meal tray on R82's over-bed table and with bare hands moved the table towards R82 and arranged items on the tray table. NA-B then took the plate cover off and left the room without performing any hand hygiene. NA-B placed the plate cover on the tray cart, then proceeded to move the cart down the hall with her bare hands. When interviewed at this time, NA-B stated R82, "might have C. Diff." NA-B stated she had been told to wear a gown and gloves if she was working with, "body fluids," and did not wash her hands due to being in a hurry. NA-B stated she should have used hand sanitizer and was unaware C. Diff spores are not removed by using hand sanitizer and hand washing with soap and water should be used instead.

When interviewed on 4/20/22, at 9:38 a.m. the environmental services supervisor (EVS)-A stated hand sanitizer should be used before going into a resident room and after leaving the room. In the case of C. dif, EVS-A stated she was not aware of any difference, stating, "we typically use hand sanitizer, it is quicker." EVS-A stated infection control education had been provided at the facility, but did not recall receiving anything specific related to washing hands with soap and water in the case of C. dif. or Rotavirus.

When interviewed on 4/20/22, a 9:46 a.m. licensed practical nurse (LPN)-A stated, for residents such as R82 who had C. Diff, the

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 39 resident should have separate dedicated equipment, staff should use gown and gloves and hands should be washed with soap and water instead of hand sanitizer. LPN-A stated staff should be using hand washing with soap and water for any residents with vomiting or diarrhea symptoms. LPN-A was not sure why the TBP sign indicated hand sanitizer was to be used for R82. During observation on 4/21/22, at 10:50 a.m. occupational therapist (OT)-A was observed assisting R82 to the bathroom, R82 had an incontinent loose stool and OT-A wearing gown and gloves assisted R82 with cleaning up, when completed OT-A placed the soiled items in a bag. OT-A removed her gloves and gown and left the room with a tablet, OT-A set the tablet down and used hand sanitizer. When interviewed, OT-A stated R82 had an infection, but was unsure what type of infection. OT-A did not know R82 had C. Diff and hand washing should be used instead of hand sanitizer. OT-A had not sanitized her tablet after it had been in R82's room and touched by OT-A with contaminated hands. It was noted at this time, R82 shared a bathroom with R15 in an adjacent room. When interviewed on 4/21/22, 10:59 a.m. a registered nurse (RN)-C stated staff would know what type of transmission based precautions (TBP) a resident required if infectious by the sign posted on their door. RN-C also said that staff should use soap and water hand washing instead of alcohol based sanitizer when working with a person with C. dif, but was unsure it that information was posted on the door, or how staff knew that. After checking R82's door, and not finding such information, RN-C stated he was going to post a sign immediately.	21375		

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 40 When interviewed on 4/21/22, 11:30 a.m. the director of nursing stated there had been some gastro-intestinal (GI) infections in the facility over the past week, but normally they did not consider it to be an outbreak until they had three or more cases of diarrhea in residents. DON said the physicians and nurse practitioners (NP) had been notified, but said they, "didn't think anything of it," but DON stated in her past experience they would have been hyper-vigilant. Three residents had received orders for testing, but DON said they had been unable to gather a sample for one resident, and the orders for another had been canceled. The test for R82 had indicated R82 was positive for C. Dif. DON said in the case of a GI outbreak, residents with symptoms would be monitored, signs regarding TBP would be posted, and personal protective equipment (PPE) supplies would be placed outside the room. DON said she was unsure if there was a sign posted about using soap and water instead of hand sanitizer in the case of C. Dif. DON said she had not posted a sign, but had started educating staff between 9:30 a.m. and 10:00 a.m. and she would go post the sign right away. DON said she was going to start PPE and handwashing audits. DON said R15 and R26 had developed symptoms of GI illness, and she had placed them in "enhanced barrier precautions and droplet precautions" and was going to talk with the medial providers and "strongly encourage" testing to be done on them, and any residents who developed GI symptoms. DON said R15's FM should not use the bathroom shared with R82, but was unsure if there was a sign on the door or in the bathroom. R27's admission MDS dated 3/28/22, identified cognitively intact and had heart disease and diabetes. R27 required limited assistance with	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00941	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 41	21375		

toileting and was continent of bowel.

R27 was not shown on the facility GI illness tracking log.

R27's medical record identified R27 had loose watery stools and emesis on 4/12/22, and had been placed on TBP, which were removed on 4/14/22.

When interviewed on 4/22/22, at 9:00 a.m. R27 stated he had gotten ill about 10 days ago and has had loose stools off and on since then.

When interviewed on 4/22/22, at 10:19 a.m. the DON stated a stool collection order was not obtained for R27 as they only had vomiting and no diarrhea. The DON was not aware R27 reported he had loose stools along with the vomiting on 4/12/22.

During an observation and interview on 4/22/22, at 10:31 a.m. RN-C was observed leaving R27's room and proceeded going from room to room on south hall completing vital signs on each resident. RN-C observed using hand sanitizer outside each resident room instead of hand washing. RN-C was observed not sanitizing thermometer and pulse oximeter equipment between resident use. RN-C stated he should have disinfected the equipment between each resident and used soap and water for hand washing.

R1's annual MDS dated 4/1/22, identified cognitively intact with diagnosis of heart disease. R1 required extensive assistance to toilet and was frequently incontinent of stool.

R1's bowel record identified loose stools as early

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 42	21375		

as 4/9/22, with multiple daily loose stools starting on 4/12/22.

R1's care plan dated 4/22/22, identified a gastro-intestinal illness related to C. diff and Rotavirus, staff were to educate on signs and symptoms of GI outbreak, frequent handwashing and encourage to stay in room along with contact precautions, and to monitor for signs of dehydration. The care plan also directed to use soap and water for hand washing.

R1 was identified on the facility map of GI infections as being in one room but moved due to GI illness symptoms to another room where she did not have a room mate and a stool specimen was sent on 4/23/22. The line listing of GI illness identified R1 as starting symptoms on 4/20/222, with the word, "again." A stool specimen had been sent and was back, with no information on pathogen.

R1's Clinical Communication from Mayo Clinic lab identified they had received a stool specimen on 4/23/22, and the stool contained Rotavirus and C. Diff and directed facility to place R1 on isolation and provide proper infection control processes and a report was sent to community heath. Vancomycin (antibiotic used to treat C. Diff) was ordered.

R1's progress note dated 4/23/22, at 10:42 p.m. included, "Call received from [physician] from clinic with lab results for resident. Stool was tested and resulted with positive results for Rotavirus and C-diff. Pharmacy notified, as [physician] gave telephone order for Vancomycin 125 mg to start within 24 hrs. Pharmacy will be sending enough med through back up pharmacy to be started tomorrow morning."

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 ________	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 43	21375		

When interviewed on 4/24/22, 8:17 a.m. RN-C stated R1 had developed GI symptoms the previous evening, and had to be moved to a private room. Testing had been completed immediately and returned results indicated R1 had Rotavirus and C. Diff. RN-C stated staff were to isolate the resident, wear PPE of gown, gloves and mask and wash hands with soap and water.

R20's quarterly MDS dated 3/2/22, identified cognitively intact and diagnoses including irritable bowel syndrome with diarrhea and a stroke. R20 required extensive assistance with toileting, but was always continent of bowel.

R20's bowel and bladder elimination log for April 2022 identified loose stools starting on 4/14/22, had two loose incontinent stools on 4/15/22 and again on 4/21/22. R20's progress notes identified the DON had been notified of loose stools and R20 was placed on transmission-based precautions (TBP).

R20 was identified on the facility GI illness tracking log as starting symptoms on 4/21/22. The map of GI illness's identified R20 as having Rotavirus and GI symptoms.

R20's Clinical Communication from Mayo Clinic identified a stool sample had been obtained by the lab on 4/22/22, and on 4/25/22 the specimen identified Rotavirus (a very contagious virus that causes diarrhea, vomiting, fever and/or abdominal pain and can lead to dehydration or even death). The communication identified public health would need to be notified of this contagious virus. A nurse practitioner note dated

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 44	21375		

4/22/22, also identified R20's stool sample was positive for Rotavirus.

During observation on 4/22/22, at 9:50 a.m. nursing assistant (NA)-B was in R20's room and arranged items on the bedside stand, removed gloves and left the room without washing hands. NA-A touched R20's door handle, then went to a mechanical lift in the hallway and brought it to the communal bath hallway. NA-A then went into R3's room and went into the bathroom where she washed her hands. NA-A did not disinfect the door handle or the lift after touching with contaminated hands.

During observation on 4/22/22, at 9:58 a.m. medical doctor (MD)-C was observed to have assisted R20 with toenails, when MD-C exited the room he used hand sanitizer outside of the room. According to the Center for Disease Control (CDC) updated 2021, hand washing with soap and water is most effective for removing Rotavirus from hands versus hand sanitizer. MD-C used his personal laptop, touched a backpack then used personal cell phone from shirt pocket and proceeded to R30's room. MD-C donned gloves without washing hands with soap and water and assisted R30 with toenails. When interviewed on 4/22/22, at 12:11 p.m. MD-C stated staff had instructed him to don/doff gloves at door, but did not specify the type of illness the residents who were on TBP had. If he had known, he would have used soap and water versus hand sanitizer.

During observation on 4/24/22, at 9:25 a.m. R18 attempted to bring a bottle of sparkling water to R20 whose room is directly across the hall. The regional nurse consultant (RNC)-B instructed R18 she could not take items from one room to

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 45	21375		

another without using a bleach wipe on it.

During observation on 4/25/22, at 8:27 a.m. the health unit coordinator (HUC) knocked on R20's door, donned personal protective equipment (PPE) and entered the room with a meal tray. The HUC set the tray on the bedside table, moved R20's urinal off the bedside table, removed gloves and stepped outside the room, where she punched a code into the utility room door and used the door handle to open the door. The HUC then washed her hands, but did not disinfect the code buttons or the door handle that she had touched with potentially contaminated hands.

The facility provided room tracking log identified R20 as having GI symptoms, and the GI illness tracking log identified R20 as beginning symptoms on 4/21/22, even though loose stools were noted prior to that date.

R18's significant change MDS dated 2/24/22, identified cognitively intact with diagnosis of multiple sclerosis. R18 required extensive assistance with toileting and was frequently incontinent of stool.

R18's bowel record identified loose watery stools on 4/14/22. R18's medical record identified she had been placed on TBP on 4/16/22, but was removed on 4/18/22.

A progress note identified a note was sent to R18's physician on 4/22/22 indicating she had loose stools again, so isolation precautions were started again.

R18 was identified on the facility GI illness log as starting symptoms on 4/22/22.

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 46 During an observation on 4/24/22, at 8:08 a.m. a new isolation cart was located outside R18's room. During an observation on 4/24/22, at 8:47 a.m. R18 was observed coming outside of her isolation room and into hallway. LPN-A glanced over and asked R18, "What's up?" and did not provide redirection to R18 to go back into her room. Family member (FM)-A was observed leaving another resident room on north hallway and redirected R18 to go back into her room. FM-A donned PPE and assisted R18 back to room. During an observation on 4/24/22, at 8:54 a.m. R18 was observed back in hallway requesting help to get to the bathroom. LPN-A observed at medication cart; while FM-A ran down the hallway to assist. FM-A requested help from DON; however, DON told FM-A to, "hold on." R18 stated she couldn't wait. R19's quarterly MDS dated 2/25/22, identified cognitively intact with diagnosis of diabetes and prostate cancer. R19 required extensive assistance for toileting and was always continent of bowel. When interviewed on 4/19/22, at 11:35 a.m. R19 stated he had become ill with severed diarrhea starting 4/16/22. R19 stated staff were aware of his diarrhea and had placed incontinent pads on his bedding as he was unable to control the loose stools. R19 stated he had started to feel better on 4/18/22 in the evening, but was still unable to eat much dinner. R19 stated he had never been placed on any time of precautions and he went out to eat Easter lunch on 4/19/22, but was unable to eat as he still felt ill.	21375		

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 47	21375		

R19's bowel elimination record for April 2022, identified regularly formed stools until 4/16/22, then had incontinent watery/diarrhea bowel movements after 4/16/22.

R19's progress notes did not show any identification of the diarrhea, nor did R19's medical record show any evidence the physician had been notified of the illness or any monitoring of R19's illness.

When interviewed on 4/22/22, at 10:19 a.m. the DON stated . DON confirmed she was aware R19 had diarrhea on 4/16/22 as she worked an overnight shift. DON failed to inform medical provider of gastrointestinal symptoms. DON confirmed R19 was never placed on isolation precautions and his symptoms still existed on 4/18/22. No stool sample had been sent to the lab.

A facility provided map of GI illness symptoms, undated, identified several residents who had GI illness, but R19 was not identified as having any GI illness. A line listing of residents who had been ill with a GI illness dated 4/24/22, also did not identify R19.

R26's quarterly MDS dated 3/26/22, identified cognitively intact with diagnosis of heart failure. R26 required extensive assistance with toileting and was frequently incontinent of bowel.

R26 was identified on the facility GI illness tracking log as beginning GI symptoms on 4/21/22. The map of illness showed she had GI symptoms.

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 ________	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 48	21375		

Continued From page 48

R26 has 2 loose stools on 4/19/22, 4/20 had one loose, one formed, 4/21 had 7 loose stools, was put on isolation the 21st.

During an observation on 4/21/22, 10:29 a.m. R26 had a sign on her door indicating the need for "droplet precautions," but the door was wide open and R26 was sleeping without cough or obvious symptoms of respiratory disease noted.

R26's bowel record showed R26 had loose stools on a regular basis, but had an increase in frequency on 4/21/22.

R26's clinical communication from Mayo clinic identified R15's stool sample had been obtained on 4/22/22, and was identified to be Rotavirus and community health was to be advised.

R15's admission MDS dated 2/24/22, identified cognitively intact, required extensive assistance with toileting, and was frequently incontinent of bowel and had a diagnosis of ulcerative colitis, Chrohn's disease or an inflammatory bowel disease.

R15's bowel record showed she had started having loose stools on 4/16/22. R15's physician orders dated 4/24/22, identified staff were to collect a stool specimen for diarrhea over 7 days.

The facility GI illness tracking log identified a start date of symptoms as 4/20/22. The map of infections identified her as having a GI illness.

During an observation on 4/21/22, at 10:49 a.m. it was noted R15 shared a bathroom with R82 who had been placed on precautions for GI illness. Family member (FM)-C was visiting R15, but was

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 49	21375		

not wearing a gown, gloves or mask. He was overheard on the phone to not visit as R15 had a case of, "stomach flu." FM-C went into the shared to the bathroom. FM-C came out of the bathroom. At 10:57 a.m. FM-C said he was aware of R15's illness and also R82's illness. FM-C said persons should not enter without wearing a gown and gloves. FM-C stated it was too far to walk all the way down the hall to dump things such as unconsumed beverages, so he had gone in the bathroom to dispose of them. He said he had been told he should not use the bathroom. He stated there was no posted information in the bathroom regarding use of the toilet or handwashing.

R15's progress note dated 4/22/22, at 8:45 a.m. identified R15 had developed, "GI symptoms that have been going around the facility."

R13's quarterly MDS dated 4/21/22, identified cognitively intact with diagnosis of a stroke. R13 required extensive assistance to toilet and was frequently incontinent of stool.

R13 was identified on the GI illness tracking log that he had developed symptoms and was placed on isolation on 4/21/22.

R9's quarterly MDS dated 2/10/22, included cognitively intact with diagnoses including cerebral palsy. R9 required extensive assistance with toileting and was always continent of bowel.

A progress note dated 4/12/22, at 1:29 p.m. indicated R9 had four episodes of emesis which started at 7:15 a.m. Registered nurse (RN)-A documented R9 suddenly awoke this morning and threw up without no warning. R9 had one

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 50	21375		

small, hard bowel movement but has refused enema at this time. RN-A documented there were reports of other residents with symptoms on emesis at the skilled nursing facility.

A progress note dated 4/13/22, at 10:08 a.m. indicated R9 requested to go to emergency room for evaluation as she was not feeling well. R9 stated she felt weak and had abdominal discomfort. R9 refused enema at this time. At 4:50 p.m., R9 returned to facility.

An emergency department note dated 4/13/22, at 1:47 p.m. indicated R9 was likely to have constipation; however, abdominal pain and vomiting resolved without further intervention. A fleets enema offered to R9, but she declined since her abdominal pain resolved.

A progress note dated 4/16/22, at 10:21 a.m. indicated R9 had two emesis and two loose stools which was reported to director of nursing (DON). At 10:09 p.m., R9 had three emesis and diarrhea. On 4/17/22, at 6:30 p.m. licensed practical nurse (LPN)-A indicated R9 had no emesis or loose stools on this shift and the issues were resolved.

When interviewed on 4/18/22, at 4:02 p.m. R9 stated she became violently ill on 4/12/22 with gastrointestinal signs and symptoms of vomiting and diarrhea. R9 stated she was so ill that "it was coming out both ends at the same time." R9 stated she requested to be transferred to the local emergency department on 4/13/22. R9 stated other resident's down the south hallway with similar gastrointestinal symptoms. R9 stated she was sick all week with nausea, vomiting, and diarrhea and could barely eat as her stomach did not feel well. R9 stated the facility placed her on

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 ________	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 51	21375		

isolation precautions; however, the isolation cart which was located outside R9's room was not utilized on 4/18/22 and no door signs were posted.

When interviewed on 4/22/22, at 10:19 a.m. the DON stated the nurse practitioner (NP)-A had canceled a stool specimen for R9 as she had issues with constipation not diarrhea and was maybe not part of the GI illness outbreak.

When interviewed on 4/21/22, at 12:27 p.m. the facility social worker (SW) stated she had not received any new infection control training today.

When interviewed on 4/21/22, at 12:31 p.m. RN-E stated she had not received any recent infection control training.

When interviewed on 4/22/22, at 11:18 a.m. the DON stated it was important for staff to be using a bleach based cleaning solution for surfaces, but had not switched out their standard disinfectant with bleach. The DON stated they would do that right away.

When interviewed on 4/22/22, at 10:19 a.m. the DON stated no stool samples had been obtained yet, they had received orders, and sent specimens in the wrong type of specimen cup so they had been rejected by the lab on 4/21/22.

When interviewed on 4/24/22, 8:39 a.m. DON stated one staff person had developed GI symptoms 4/22/22 and was sent home, and another had called in sick overnight; R1 was moved due to symptoms and confirmed GI infections

The facilities GI illness outbreak log identified a

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 52	21375		

dietary aide had come down with GI symptoms on 4/22/22 and a nurse had on 4/24/22.

When interviewed on 4/24/22, 8:39 a.m. DON stated one staff person had developed GI symptoms 4/22/22 and was sent home, and another had called in sick overnight; R1 was moved due to symptoms and confirmed GI infections. DON also said R18 had started to develop some GI symptoms on 4/22/22 in the afternoon. DON said she had done some staff audits on PPE use and handwashing for the facility IJ removal plan that morning when arriving at the facility. DON stated a regional nurse consultant (RNC)-B had come in to help, and they had been going through their infection control policies in the last two days.

When interviewed on 4/24/22, 8:59 a.m. RNC-B stated she was not sure if the correct cleaning products were out on the isolation carts for staff to use, but then brought in a container of "Oxivir TB" wipes containing peroxide, and said they did have the correct cleaning solution. Shortly after this, an observation revealed there were no bleach, peroxide or Oxivir TB wipes on any isolation carts or with the shared equipment in the facility such as mechanical lifts.

During an observation on 4/25/22, at 8:14 a.m. NA-F walked across the north hallway carrying unbagged laundry against her clothing to the dirty clothes bin. NA-F then washed hands located near the laundry receptacle. NA-F did not change her potentially contaminated clothing. When interviewed at 8:17 a.m. NA-F stated she should have bagged the laundry and not carried it against her clothing.

During an observation on 4/25/22, at 8:27 a.m.

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 53 HUC knocked on R20's door, donned appropriate PPE, entered the room with R20's breakfast tray, set the breakfast tray down the bed side table, moved R20's urinal off the bedside table, removed gloves, stepped outside the threshold of R20's room, removed her gloves, walked to the utility room door, punched the code in, used the door handle to open the door, entered and washed her hands with soap and water, exited the room and walked away. HUC did not disinfect the door handle. During an interview on 4/25/22, at 8:39 a.m. RNC-C indicated she had seen the HUC contaminate the door code and handle, and indicated more infection control audits of the staff needed to be completed. When interviewed on 4/25/22, at 9:29 a.m. registered dietician (RD) indicated even though she had educated nursing staff to not return trash from isolated resident trays back to the kitchen, the practice continued. RD indicated in order to mitigate this she had made signs so that this practice was stopped. When interviewed on 4/24/22, at 10:01 a.m. RNC-B and the administrator stated they had updated all resident care plans and had ordered disinfectant that works on Rotavirus and C. Diff. They had placed spray bottles of bleach solution for staff to use on each wing. Lab results for R20 and R26 had come back and were positive for Rotavirus. When interviewed on 4/25/22, at 11:28 a.m. RD stated even with all the signs on the resident doors who are on isolation and again talking to nursing staff, nursing brought back 5 trays from isolation rooms with garbage back to the kitchen.	21375		

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 54 One was tray was even set on a kitchen countertop. During an observation on 4/25/22, at 11:49 a.m. R21 wheeled down to use the communal bathroom in the hallway and then returned to her room. R21's roommate remained on TBP for GI illness. The toilet bowel in the bathroom was observed to have brown spots all over the toilet bowel. At 11:57 a.m. NA-B walked down the hallway with gloves on carrying a used mattress protector up against her chest. NA-B then walked to a mechanical lift located down the hallway and used the appropriate disinfectant to wipe it off, then washed her hands with soap and water. NA-B did not change her contaminated clothing. At 11:59 a.m. NA-B assisted R9 onto mechanical lift and put her on the toilet in the communal bathroom, even though the brown spots on the toilet seat had not been cleaned off. During an interview on 4/25/22, at 12:04 a.m. NA-B confirmed she put R9 onto the toilet in the communal bathroom and stated R10 who was on TBP and was R21's roommate. NA-B stated R21 had a formed bowel movement, stated she had wiped down the toilet seat however did not clean the toilet bowel prior. NA-B indicated the toilet bowls were not cleaned between residents, the toilet had overflowed over the weekend, the brown spots on the bowl had been there the whole weekend, and housekeeping had not cleaned it after it overflowed. NA-B stated she knew that brown stuff has been there since Saturday, "that's when I noticed it" During an interview on 4/25/22, at 12:13 p.m. HSK stated she had been the housekeeper on Saturday. HSK indicated she had been told to clean only the resident room bathrooms and did	21375		

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 55	21375		

not clean the communal bathrooms and/or toilets on Saturday.

During an observation and interview on 4/25/22, at 12:21 p.m. EVS-A completed cleaning the toilet in the communal bathroom, brown spots were not longer observed in the toilet bowl. EVS-A verified the condition of the toilet bowl prior to cleaning. EVS-A stated that was the first time she had cleaned the bathroom/toilet today. Indicated she had not cleaned it prior because the bathroom had been busy. EVS stated the toilet bowls were not disinfected after each resident and were cleaned after breakfast, after lunch, and before leaving at the end of the day. EVS-A stated she had worked on Sunday and did not notice the dirty toilet bowl.

During an interview on 4/25/22 at 12:39 p.m. RNC-C was unaware why commodes were not being used until surveyor brought it to her attention. RNC-C indicated in outbreak status it would be expected to be cleaning the toilet in between each use.

When interviewed on 4/25/22, at 1:02 p.m. medical doctor (MD)-D stated he had been informed of a couple cases of diarrhea in the building quite some time ago and could not recall the date. He had been informed they had some stool samples pending by the NP. The NP would be handling any lab results that are returned.

During an interview on 4/25/22, at 2:22 p.m. RD stated 5 isolation tray came back from the kitchen, three from the 200 wing and two from the 100 wing. RD stated that was even after she had put directions on the trays. RD indicated by bringing potentially infectious items back to the kitchen increased the risk for cross

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 56 contamination, kitchen staff could inadvertently handle dirty items without having the appropriate PPE on. When interviewed on 4/25/22, at 3:35 p.m. the medical director (MD)-P stated If two residents had symptoms of loose stools would do a COVID test first, then a test for norovirus. During an observation on 4/19/22, 11:56 a.m. the beverage cart for the noon meal was parked near the dining area. A large pitcher that contained ice was located at the end of the cart. a nursing assistant (NA)-F was observed to reach into the ice pitcher with her bare hand and lift ice with a cup that had been sitting in the pitcher, pour the ice into another cup, and then drop the other cup back into the ice pitcher where it remained. NA-F poured juice into the cup of ice and went down the hall to deliver the juice. Hand hygiene immediately before touching the cup in the ice pitcher was not completed. During an observation 4/19/22, 12:03 p.m. a registered nurse (RN)-A opened the ice pitcher, reached in, took the cup sitting in the ice, touching the sides of the cup. RN-A scooped ice into a large water mug, and then dipped the scooping cup back into the pitcher of ice. Hand hygiene was not observed prior to touching the ice cup. RN-A then proceeded down the hall and delivered the mug of ice to R5 in his room. When interviewed on, 4/21/22, 10:02 a.m. the certified dietary manager (CDM) stated ice should not be touched with a bare hand, gloves should be applied after hand hygiene. Ice should not be obtained using a cup to scoop, and such a cup should not be sitting in the ice.	21375		

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 _______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 57 During an observation 4/25/22, 12:44 p.m. a health unit coordinator (HUC) reached into the ice pitcher on the beverage cart with her bare hand, without performing hand hygiene, remove a cup that was in the pitcher, fill it with ice, poured the ice into another glass and then drop the first cup back into the ice pitcher. When interviewed on 4/25/22, 12:46 p.m. a registered dietician (RD) said a scoop for ice should be stored outside of the ice container. RD was not aware the facility staff were scooping ice with a cup from a pitcher on the beverage cart and leaving the cup in the ice. RD said "they [non-dietary staff] just asked for a pitcher of ice" and RD was not aware of what happened after the ice left the kitchen area. When interviewed on 4/25/22, 12:49 p.m. the director of nursing (DON) stated she had received training related to infection control with ice and ice scoops. DON stated she was aware from her training that an ice scoop should not sit in the ice container. DON said she was unaware that a cup was being used to scoop ice on the beverage cart, nor was she aware that the cup was being touched by multiple staff and left sitting in the ice. DON indicated this was not appropriate and said, "I need to take of this. I'm going right out to take care of this." When interviewed on, 4/25/22, 1:13 p.m. HUC stated she had worked at the facility for several years and aside from office duties, would help to pass meal trays for residents. HUC felt the use of an ice pitcher with a cup for scooping had been in place for possibly six months. HUC did not recall ever being aware that the practice might be an infection control problem. After considering that multiple people might be touching other things in	21375		

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 58	21375		

the environment prior to touching the cup used for scooping, and then multiple residents receiving the ice for consumption, HUC stated she thought it might be an infection control concern.

When interviewed on 4/25/22, 1:30 p.m. RD stated she had not been made aware of the ice issues. RD stated she had not been notified by CDM or DON at any time. RD said she thought the pitcher of ice would be filled with water and used to fill beverage glasses. RD brought in a covered steel container and stated she had located a small scoop that would be stored in the container on the beverage cart.

A facility policy was requested, but not received.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could further develop policies and procedures to clearly delineate how the Infection Prevention (IP) program will meet state and federal regulations for infection surveillance; additionally, the DON or designee can design or choose forms that will guide nurses not only in data collection related to infections, but in the analysis of the data to form an informed response to not only control current infections, but to prevent future issues. The DON or designee could provide on-going education on infection identifical, reporting and response, including proper hand washing and the use of transmission based precautions. The DON or designee could design an on-going audit system to utilize for investigation of facility practice for the control and prevention of contagious disease. The Administrator could ensure that the nurse assigned as the facility Infection Preventionist receives adequate training and time to oversee the IP program.

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 ______	C 04/27/2022

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) COMPLETE DATE
21375	Continued From page 59 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21375		
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, 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 screening for possible active tuberculin symptoms with tuberculin skin test (TST) and complete a TB symptom screening was completed for 3 of 4 residents (R16, R27, R82), reviewed for the Tuberculosis program.	21426	Corrected	6/2/22

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 ______	C 04/27/2022

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) COMPLETE DATE
21426	Continued From page 60	21426		

Findings include

R16's admission Minimum Data Set (MDS) dated 1/12/22, identified R16 was admitted to the facility on 1/5/22. R16's medication administration record (MAR) identified a physician's order to administer the TST on 1/19/22. The MAR had a checked marked box with staff initials indicating that the test was administered. R16's record lacked the results of the 1st step TST. No other information pertaining to follow-up results and/or testing was found. In addition, R16's record lacked evidence of TB symptom screener.

R27's admission MDS identified R27 was admitted to the facility on 3/21/22, R27's record lacked evidence of completed TB baseline symptom screener upon admission to the facility.

R82's admission MDS dated 4/13/22, identified R82 was admitted to the facility on 4/6/22. R82's record lacked evidence of two step TST's were completed after admission. In addition, a TB baseline symptom screener was not evident in R82's record.

During an interview on 4/25/22, at 2:51 p.m. regional nurse consultant (RNC)-A verified lack of symptom screeners and TST's for R82. RNC-A indicated the TB program is not well organized.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor resident and employee

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 ______	C **04/27/2022**

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) COMPLETE DATE
21426	Continued From page 61 TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R24) observed to self-administer nebulizer medications. Findings include: R24's significant change Minimum Data Set (MDS) dated 4/8/22, included cognitively intact with diagnoses including schizoaffective disorder, anxiety disorder, congested heart failure (CHF), chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, asthma, pulmonary embolism, and obstructive sleep apnea. R24 required extensive assistance from staff for dressing and personal hygiene. R24's Order Summary Report dated 4/24/22, included Ipratropium-Albuterol Solution (medicine that is used to treat air flow blockage and prevent worsening of COPD, asthma or other lung	21565	Corrected	6/2/22

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 ______	C 04/27/2022

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) COMPLETE DATE
21565	Continued From page 62	21565		

diseases) 0.5-2.5 (3) mg/3 ml 1 vial inhale orally four times a day for shortness of breath. The physician orders lacked self-administration of medications.

R24's care plan dated 6/1/21, included R24 had risk for respiratory impairment related to CHF, COPD, sleep apnea, and asthma, but interventions had not included self-administration of medications.

During an observation and interview on 4/18/22, at 6:32 p.m. R24's nebulizer equipment in room was set up on nightstand table with clear fluid in chamber and moisture bubbles. R24 stated facility staff have her hold nebulizer treatment onto face while it is administering and she's supposed to turn on call light when the medication is done dispensing.

During an observation and interview on 4/22/22, at 11:55 a.m. R24 was observed holding nebulizer equipment up to face without a nurse present. R24 stated the nurse told her to press her call light button when medication was finished administering.

When interviewed on 4/22/22, at 12:32 p.m. registered nurse (RN)-B confirmed R24 did not have a current self-administration of medications order or an assessment completed by the interdisciplinary team from physician and stated R24 had self-administered the noon dose.

When interviewed on 4/25/22, at 11:05 a.m. director of nursing (DON) stated residents should not self-administer nebulizer's without a nursing assessment to observe for safe administration and a current physician's order.

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 ______	C 04/27/2022

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) COMPLETE DATE
21565	Continued From page 63 The facility policy titled Medication Self Administration dated 6/1/17 indicated, residents are not permitted to administer or retain any medication in his or her room unless their attending physician writes an order for self-administration of the medication, and the resident is assessed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could initiate audits to assure residents are not left to self-administer nebulized or other medications if not yet evaluated as competent to self-administer medications. DON could provide training to all staff who administer medications within the facility and ensure resident records clearly indicate which medications or modalities individual residents may safely administer. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		