

Protecting, Maintaining and Improving the Health of All Minnesotans

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Michig

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

DEPARTMENT OF HEALTH CENTERS FOR MEDICARI					FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	245306	B. WING				C 27/2022
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER HEALTH SERV	CES WEST			215 HIGHWAY 52 NORTH OCHESTER, MN 55901		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000 Initial Comments		EO	000			
compliance with A Preparedness Rec conducted during a	h 4/27/22, a survey for opendix Z, Emergency juirements, §483.73(b)(6) was a standard recertification y was in compliance.					
signature is not rec page of the CMS-2 correction is requir	led in ePOC and therefore a quired at the bottom of the first 2567 form. Although no plan of ed, it is required that the facility pt of the electronic documents. TS	FO	000			
recertification surv facility. A complain conducted. Your fa compliance with th	h 4/27/22, a standard ey was conducted at your t investigation was also icility was found to be NOT in e requirements of 42 CFR 483, ements for Long Term Care					
SUBSTANTIATED however NO defici	plaint was found to be : H5306078C(MN82516); encies were cited due to ed by the facility prior to survey					
	plaint was found to be ED: H5306077C(MN81831).					
review, the facility allegations of abus residents (R9, R24 assistant (NA-A) a resulted in an imm R5 and R17 who e psychosocial harm	tion, interview and document failed to thoroughly investigate e and neglect made by 4 4, R5, and R17) about 1 nursing nd an unidentified NA. This ediate jeopardy for R9, R24, xpressed distress and as they had not been					
LABORATORY DIRECTOR'S OR PROVI Electronically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 05/23/2022

Electronically Signed

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.

		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245306	B. WING				C 2 7/2022
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
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F 000	protected from NA- towards them and r The IJ began on 4/2 NA-A had multiple a verbally abusive be behaviors made ag not thoroughly invest during an investigat director of nursing (notified of the IJ on was removed on 4/ noncompliance rem severity level of G - level, with actual has In addition: Based on observati review the facility fa procedures were in and spread of an un illness in the facility fa procedures were in and spread of an un illness in the facility fa procedures were in and spread of an un illness in the facility (R82, R27, R1, R20 and R9) developing lacked any investig- testing for pathoger to implement timely residents, and failer following care of sy this vulnerable popu- care workers at risk the facility failed to passing ice water to and a cup inside wi the potential to affer residing in the facili	A being verbally abusive rough with them. 20/22, when it was identified accusations of rough and havior and neglectful ainst her and the facility had stigated or protected residents tion. The administrator and (DON) of the facility were 4/20/22, at 2:13 p.m. The IJ 21/22 at 5:00 p.m., but nained at the lower scope and isolated scope and severity arm that is not immediate. on, interview and document illed to ensure infection control plemented to reduce the risk nknown gastrointestinal (GI) resulting in 10 of 28 residents 0, R18, R19, R26, R15, R13, g GI symptoms and the facility ation of causal factors and or n. In addition, the facility failed visolation of symptomatic d to perform hand hygiene mptomatic residents, placing ulation of residents and health at of serious illness. Further, use sanitary practices when o residents, using bare hands th the ice to scoop, this had ct all 28 residents currently	FO	00			

Facility ID: 00941

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	OMB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` ́COMI	E SURVEY PLETED	
		245306	B. WING				C 27/2022	
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHE	STER HEALTH SERVIO	SES WEST		2	2215 HIGHWAY 52 NORTH			
NOOTIL.	STER HEALTH SERVIC			F	ROCHESTER, MN 55901			
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F 000	when the facility fail procedures were im and symptoms of G spread of unknown on 4/22/22. The ad nursing (DON) were at 1:31 p.m. The IJ 1:07 p.m. when the with symptoms of G transmission-based place. All residents illness, the physicia procedures were re educated, high touc tracking was started audits of handwash the non-compliance and severity of an F severity level, which potential for more th immediate jeopardy The above findings quality of care, and conducted from 4/2 The facility's plan of as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electroni be used as verificat	led to ensure infection control pplemented related to signs il illness to reduce the risk of Gl illness and was identified lministrator and director of e notified of the IJ on 4/22/22, was removed on 4/27/22 at facility ensured all residents illness were placed on d precautions with signage in swere screened for signs of Gl n was notified, policies and eviewed, all staff were ch areas were disinfected, d for employee call in's, and ing were started. However, e remained at the lower scope -widespread scope and n indicated no actual harm with han minimal harm that is not /. constituted substandard an extended survey was 0/22 to 4/27/22. f correction (POC) will serve of compliance upon the bance. Because you are rour signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an r facility may be conducted to compliance with the	F	000				

Facility ID: 00941

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		AND HUMAN SERVICES					APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (X3)		E SURVEY PLETED
		245306	B. WING			C 04/27/2022	
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETIC DATE
F 554	Continued From pa	ge 3	F ٤	554			
F 554 SS=D	Resident Self-Admi CFR(s): 483.10(c)(in Meds-Clinically Approp 7)	F٤	554			6/2/22
	medications if the in defined by §483.21 this practice is clinic This REQUIREMEN by: Based on observat review, the facility fa practice of self-adm safe for 1 of 1 resid self-administer neb Findings include: R24's significant ch (MDS) dated 4/8/22 with diagnoses inclu anxiety disorder, co chronic obstructive acute and chronic r pulmonary embolisi apnea. R24 require staff for dressing ar R24's Order Summ included Ipratropiur that is used to treat worsening of COPE diseases) 0.5-2.5 (3 four times a day for	NT is not met as evidenced tion, interview, and document ailed to determine if the ninistration of medications was lent (R24) observed to ulizer medications. ange Minimum Data Set 2, included cognitively intact uding schizoaffective disorder, ongested heart failure (CHF), pulmonary disease (COPD), respiratory failure, asthma, m, and obstructive sleep ad extensive assistance from and personal hygiene. ary Report dated 4/24/22, m-Albuterol Solution (medicine air flow blockage and prevent 0, asthma or other lung 3) mg/3 ml 1 vial inhale orally shortness of breath. The			F 554 A medication self-administration assessment was completed for R 24 a physician orders updated based on res of assessment on May 17, 2022 Residents who self-administer nebulize after nurse set up of device have the potential to be impacted by the alleged practice. Self-administration assessme were completed for like residents and physician orders updated based on res 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 order for residents who complete nebulizers after nurse sets up administration of nebulizer for resident. Education include information on remaining with residents who are unable to maintain position of handheld nebulizer or mask nebulizer.	ults ers ints ults o ers led s	
	medications. R24's care plan dat	cked self-administration of ted 6/1/21, included R24 had impairment related to CHF, a, and asthma, but			Audits for compliance with professiona standards for self-administration of nebulizer treatments will be completed weekly for four weeks through direct observation and review of documentati by the director of nursing or designee.		

Facility ID: 00941

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		245306				04/2	C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) Completic Date
F 554	Continued From pa	age 4	F t	554			
interventions had not included self-administration of medications.			2022. The results of the	Audits will be initiated the week of 2022. The results of the audits will forwarded to the facility quality co	Ibe		
	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.				for review and recommendations.		
	During an observation and interview or at 11:55 a.m. R24 was observed holdin nebulizer equipment up to face without present. R24 stated the nurse told her her call light button when medication w administering.	was observed holding ht up to face without a nurse d the nurse told her to press					
	registered nurse (F have a current self- order or an assess interdisciplinary tea	on 4/22/22, at 12:32 p.m. RN)-B confirmed R24 did not -administration of medications ment completed by the am from physician and stated histered the noon dose.					
	director of nursing not self-administer	on 4/25/22, at 11:05 a.m. (DON) stated residents should nebulizer's without a nursing erve for safe administration ician's order.					
	Administration date are not permitted to medication in his o attending physician	tled Medication Self ed 6/1/17 indicated, residents o administer or retain any r her room unless their n writes an order for of the medication, and the ed.					

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RE & MEDICAID SERVICES	1		FORM OMB NO	06/07/2022 APPROVED 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED C		
245306	B. WING			27/2022	
IER	·	STREET ADDRESS, CITY, STATE, ZIP COE			
RVICES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE	
	F 60	00		6/2/22	
s the right to be free from abuse, ropriation of resident property, as defined in this subpart. This not limited to freedom from ment, involuntary seclusion and chemical restraint not required to nt's medical symptoms. facility must- ot use verbal, mental, sexual, or corporal punishment, or usion; WENT is not met as evidenced rvation, interview and document ity failed to thoroughly investigate buse and neglect made by 4 R24, R5, and R17) about 1 nursing) and an unidentified NA. This nmediate jeopardy for R9, R24, o expressed distress and irm as they had not been NA-A being verbally abusive nd rough with them. n 4/20/22, when it was identified be accusations of rough and e behavior and neglectful e against her and the facility had nvestigated or protected residents igation. The administrator and ng (DON) of the facility were on 4/20/22, at 2:13 p.m. The IJ		 investigated beginning 4/19/22 reports submitted by required R5 and R9 allegations were re 04/19/22 with final reports subwithin required time frame. Er NA-A and NA-B are no longer at the facility. R5, R9, and R 2 to have weekly PHQ-9 assess completed and have demonst at or below usual baseline. R chosen not to complete repeat assessments. Residents who receive care a at the facility have the potential impacted by the alleged pract are completed five times week morning meeting to determine 	2 with final time frame. eported on omitted nployee employed 24 continue sments trated scores 17 has trated scores 17 has trated scores al to be ice. Audits kly during e if any		
	JER RVICES WEST STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) e and Neglect (a)(1) om from Abuse, Neglect, and s the right to be free from abuse, propriation of resident property, as defined in this subpart. This not limited to freedom from ment, involuntary seclusion and chemical restraint not required to nt's medical symptoms. facility must- lot use verbal, mental, sexual, or corporal punishment, or usion; MENT is not met as evidenced rvation, interview and document ity failed to thoroughly investigate buse and neglect made by 4	ARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 1 245306 B. WING	Image: Second state of the facility must-like of the facility faciled to thoroughly investigate on an outget of the facility have the potential reserved to the must-like of the facility have the potential of the facility have the potential and the facility have the potential mage of the facility have the potential and the facility have the potential ministrator and the global and the facility have the potential ministrator and the	TH AND HUMAN SERVICES FORM IRE & MEDICAID SERVICES OMB NO. (X1) PROVIDERSUPPLERCLA (X2) MULTIPLE CONSTRUCTION IX3 PARCENT IER STREET ADDRESS. CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH RVICES WEST STREET ADDRESS. CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH RVICES WEST ID PROVIDER'S PLAN OF CORRECTION RVICES WEST ID PROVIDER'S PLAN OF CORRECTION STREET ADDRESS. CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901 COMESTRE, MN 55901 STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION STATE HADRING AND ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901 FGOO PREFIX PROVIDER'S PLAN OF CORRECTION ATION ADD ADDRESS, CITY, STATE, ZIP CODE ZIP ADDRESS, CITY, STATE, ZIP CODE STATE TADDRESS, CITY, STATE, ZIP CODE ZIP ADDRESS, CITY, STATE, ZIP CODE STATE TADDRESS, CITY, STATE, ZIP CODE ZIP ADDRESS, CITY, STATE, ZIP CODE STATE TADDRESS, CITY, STATE, ZIP CODE ZIP ADDRESS, CITY, STATE, ZIP CODE STATE TADDRESS, CITY, STATE, ZIP CODE ZIP ADDRESS, CITY, S	

Facility ID: 00941

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245306	B. WING				C 27/2022
	PROVIDER OR SUPPLIER	CES WEST		2	TREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHWAY 52 NORTH ROCHESTER, MN 55901	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 600	noncompliance rem severity level of G level, with actual has Findings include: R9's quarterly Minin 2/10/22, included c including cerebral p depressive disorde cares were noted. R9's care plan revis vulnerable adult an related to being a lo adaptive equipmen for activities of daily indicated facility sta reporting abuse am potentially dangero remain free of retal reported. Facility st in mood, behavior, cognition. R9's ca verbalized specific provide care to her this included, it wou conferences how it been made aware of During an observat at 3:41 p.m. R9 state what to do!" R9 state state state state state state state state state s	nge 6 hained at the lower scope and isolated scope and severity arm that is not immediate. mum Data Set (MDS) dated ognitively intact with diagnoses balsy and recurrent major r. No behaviors or rejection of sed 8/3/21, indicated R9 was a d at risk for potential abuse ong term resident that utilized t and required staff assistance y living (ADL's). R9's care plan aff would be educated on d would redirect from us situations. R19 should iation if alleged abuse was aff would observe for changes psychosocial needs and re plan also included, "Has staff that she prefers not to ." The only interventions for ild be reviewed at care was going and, "Staff have of resident preferences." ion and interview on 4/18/22, ted nursing assistant (NA)-A ass and does not listen to her ed NA-A told her, "don't tell me ted NA-A is two faced; stating eally sweet and the next time ek on you. R9 disclosed NA-A (ACT)-B were family members. -B to assist her with elevating	F6	00	to abuse investigations. Abuse investigations are reviewed by the f interdisciplinary team and approved Director of Clinical Services or Vice President of Operations prior to sub the five-day report. The leadership team was educated an ad hoc Quality Assurance meetir regarding reporting requirements by clinical support team on April 20, 20 Education was presented by the Executive Director or designee beg April 20, 2022, to facility staff on the guidelines for reporting and investig allegations of abuse. Post-tests to v understanding were completed beg April 20, 2022. Education was repe the Director of Nursing or designee direct care staff beginning May 18, The Executive Director or designee completes audits three times week twelve weeks or until substantial compliance is achieved. Audits wer initiated April 20, 2022. Results of a will be forwarded to the facility qual committee for review and recommendations.	I by the pomitting during ng y the 022. inning ating validate inning ated by to 2022. y for e uudits	

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		AND HUMAN SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245306	B. WING			C 27/2022	
NAME OF I	PROVIDER OR SUPPLIER	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	TER HEALTH SERVI	CES WEST	2	2215 HIGHWAY 52 NORTH			
Rooned			F	ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	on 4/11/22, and yell resident's legs into you don't know what doing it right." R9 si into bed and it hurt R9 stated she felt N on purpose. R9 statincident to manage would have notified often make her feel someone without a to her. NA-A would what she was doing cares, well-being, a was observed teary speaking to survey stated she felt NA-/ physically hurt her I own body, she has NA's how to do thei improperly trained a When interviewed of stated NA-A is, "jus stated she wished N as she gets very ne her. R9 stated she NA-A's, "psychosod abuse, and being ro had informed other director of nursing (done about it. R9 si do anything at all, to cringed at the sight north hallway, "let a	ed. NA-A entered R9's room led at ACT-B for assisting bed, stating "you can't do that, at you're doing, and you're not tated NA-A, "threw," her legs her legs and hurt her pride. VA-A treated her legs roughly ted she did not report the ment, but thought ACT-B them. R9 stated NA-A would I, "less than human and as brain," when providing cares often tell R9 she did not know g when it came to her own and knowing her own body. R9 v eyed and saddened when or about the incident. R9 A verbally abused her and egs. R9 stated she knew her full cognition, and has to tell ir jobs as most of them are at facility. on 4/19/22, at 8:24 a.m. R9 t a thorn in my side." R9 NA-A wasn't even at the facility ervous when NA-A is around has told facility staff about cial mistreatment, verbal ough," with her. R9 stated she NA's, activity staff, and the (DON) but nothing was ever tated she felt the DON, "didn't o be honest." R9 stated she of seeing NA-A out in the lone, when she comes into my erved shaking and teary eyed	F 600				

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TATEMENT	OF DEFICIENCIES OF CORRECTION	KANNER STATE STREAM STREA			CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245306	B. WING			04	C /27/2022	
	PROVIDER OR SUPPLIER	CES WEST		221	EET ADDRESS, CITY, STATE, ZIP CODE 5 HIGHWAY 52 NORTH CHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 600	When interviewed of activities director (A of the situation invo ACT-B did not men ACT-B should not I of daily living (ADL) bed for R9. ACT-B interview. When interviewed of director of nursing unaware of an incid ACT-B where R9 m verbally abused he by throwing her leg stated numerous the immediately suspe investigation. DON the facility manage investigations right NA-A had a concer but there were no r DON was notified F talking about NA-A. the sight of NA-A. I would be suspende A facility reported in identified R9 had re had transferred her unsubstantiated by When interviewed of licensed practical m no knowledge of R against NA-A.	AD)-A stated she was unaware olving R9, NA-A, and ACT-B as attion it to her. AD-A stated have been completing activities 's) such as assisting legs into was not available for on 4/19/22, at 9:25 a.m. the (DON) stated she was dent involving R9, NA-A, and hade an accusation NA-A had r and provided rough treatment s into bed roughly. DON mes the facility was nding NA-A pending an internal stated she was going to notify ment team and start an away. DON stated R9 and n approximately one year ago, recent concerns noted. The R9 was very tearful when and R9 stated she cringes at DON confirmed again NA-A ed. ncident dated 8/19/21, eported NA-A and another NA r roughly, this was found to be the facility investigation. on 4/20/22, at 7:56 a.m. nurse (LPN)-A stated she had 9 making any allegations	F 6	00				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		245306	B. WING				C 27/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 600	R9 shared with her sometime in the parexact date. EVS-AI the following mornin incident happened to was working. NA-A we are going to do EVS-A stated R9 w raised her voice, an it. EVS-A immediate did not know if anyt EVS-A reported DC meetings so EVS-A EVS-A reported DC meetings so EVS-A EVS-A stated she h grapevine," that NA at the facility, but ha When interviewed of stated she had with resident cares and Once in December R9's shoes, "so qui NA-A to slow down had stayed in R9's i her, "I was so thank and were here." SW her that she was, "t she had reported th (RN)-D, however, F came back to her a told SW, "this is non When interviewed of DON stated R9 and and had gone back not like NA-A becau and a know it all." N	ge 9 an incident that occurred st month but was uncertain of brought laundry to R9'S room ng. R9 informed EVS-A an the evening prior when NA-A yelled at R9 telling her, "No it my way, not your way." as visibly upset about this, nd shook as she spoke about ely reported it to the DON, but hing had been done about it. 2N has bimonthly nursing staff assumed it was addressed. has heard, "through the -A can be rough with residents ad not witnessed this herself. on 4/20/22, at 9:30 a.m. SW essed NA-A, "rushing," has told NA-A to slow down. 2021, NA-A was putting on ck it hurt her." SW had told and NA-A got defensive. SW room afterwards and R9 told cful you stayed in the room V stated R9 had confided in errified," of NA-A. SW stated he episode to registered nurse RN-D told NA-A and then NA-A nd NA-A became upset and ne of your business."	F	500			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OM						
	EDICAID SERVICES PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 SURVEY
	DENTIFICATION NUMBER:					PLETED
	245306	B. WING				C 27/2022
NAME OF PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER HEALTH SERVICES W	VEST			215 HIGHWAY 52 NORTH		
			R	COCHESTER, MN 55901		
(X4) ID PREFIX TAG SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDEN	BE PRECEDED BY FULL			BE	(X5) COMPLETION DATE	
required delicate care." T were residents on the oth considered delicate too a moved back to the hall with When interviewed on 4/2/ administrator stated she with involving R9, ACT-B, and typically does the initial re- but stated she kept a full incidences reported. The allegations of abuse from When interviewed on 4/2 stated she cringed every working and especially if north hall. R9 stated NA- deal of pain when she, "g other staff has ever done stated she found out toda coming back and she wa be abused again. R9 state end of her rope" with the NA-A. R9 stated she was disrespect and this made When interviewed on 4/2 stated knowing NA-A was load off of her shoulders. many times behind close treatment she received fr facility staff were aware N inside her resident room,	stated R9 was, to be in control," and hings done and does not their own opinion. The nes with any resident who The DON stated there her hall that would be and NA-A was eventually where R9 resides. 20/22, at 1:40 p.m. the was unaware of incident d NA-A. The DON eport to the state agency, paper copy of all e administrator had not n R9. 21/22, at 8:51 a.m. R9 single time NA-A was she was assigned to the the the before. R9 ay that NA-A was not as happy she would not ted she was "about at the e cares she received from s treated with much e her feel mad. 25/22, at 9:25 a.m. R9 s gone that it took a big . R9 stated she cried ed doors from the rom NA-A. R9 stated NA-A was not welcome	F 6	600			

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DEPARTMENT OF HEALTH					FORM	APPROVED	
CENTERS FOR MEDICARE					OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY PLETED	
						С	
	245306	B. WING	;			27/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHESTER HEALTH SERVIC	ES WEST			2215 HIGHWAY 52 NORTH			
				ROCHESTER, MN 55901			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			BE	(X5) COMPLETION DATE		
 which caused several R9 stated she almost bed once as NA-A, 'fast." R9 stated she which included NA's preferred NA-A to not never happened as by facility staff. R9 stime until she could treatment only got worebally and physical R24's significant char included cognitively including schizoaffed disorder, fibromyalgic chronic pain syndrom of cares were noted R24's care plan date a vulnerable adult at to requiring assistant living (ADL's) and so making. R24's care were educated on redirect from potentit R19 should remain f abuse was reported for changes in mood needs and cognition When interviewed on stated some of the redirect stated s	d would, "just yank my legs e pain in my back and legs." st slipped off the edge of her "yanked on me so hard and told multiple facility staff s, SW, and DON that she of be in her room, but this R9 felt she was never heard tated she kept quiet for a long not take it anymore as the vorse. R9 stated she felt NA-A ally abused her at facility. ange MDS dated 4/8/22, intact with diagnoses ctive disorder, anxiety ia, rheumatoid arthritis, and me. No behaviors or rejection ed 4/16/21, indicated R24 was t risk for potential abuse due nce for all activities of daily ome assistance for decision plan indicated the facility staff eporting abuse and would ially dangerous situations. free of retaliation if alleged . Facility staff would observe d, behavior, psychosocial	F	600				

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		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF	PROVIDER OR SUPPLIER	•	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP CODE		
POCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH		
KOCHES	DIER HEALTH SERVI			ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 600	change her afterwa her the bedpan was the facility does not she did not want to not okay with her. F information on who observed to be tear appeared to be hes specific to NA. When interviewed of stated she spoke to informed her of the to share information room. R24 informed When interviewed of stated R24 informed was NA-A and was When interviewed of stated the NA she f R24 stated NA-A or grab her arm so ha grabbed her arm so bed. R24 also stated on her, "private par scrubbing board." F bruises on her arms stated having to be a toll," on her menta depressed over it. O boosted up in bed b do it herself. When unable to do that, N in bed all the time, s that point R24 tried	age 12 er depends and they would rds. R24 stated the NA told is not big enough for her and ituilize bedpans. R24 stated go in her pants and this was R24 would not provide specific this NA was. R24 was y eyed during interview and itant in providing information on 4/19/22, at 3:27 p.m. R24 o SW earlier today and NA's name but was unwilling n as her roommate was in the d surveyor NA was a female. On 4/19/22, at 4:43 p.m. SW d her the alleged perpetrator very focused on this NA. On 4/21/22, at 1:36 p.m. R24 nad concerns with was NA-A. In multiple occasions would rd it would hurt. Once she o hard it lifted her right off the ed NA-A would scrub so hard ts," that she felt like, "a R24 stated NA-A had left s and legs at times. R24 cared for by NA-A had, "taken al health and she was Dnce R24 requested to be by NA-A and NA-A told her to R24 told NA-A she was IA-A told her if she didn't stay she would be able to do it. At to explain her medical nd NA-A just walked out of the	F 60			

Facility ID: 00941

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		AND HUMAN SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH		
				ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	didn't know why NA her. "I feel like a big her eyes. R24 had time she would say take it out on her. F been physically and multiple occasions. When interviewed of stated R24 had no than refusing cares could be, "needy" a staff. R5's annual MDS of had had a slight de from being fully cog being moderately ir mild depression. Th require assistance skills (ADLs). R5's care plan had 4/16/20: ADL self-co limitations. Associa NAs to provide ass including bathing an how many persons his care. Additional Resident was at ris requiring assistance goal indicated he w abuse during his st indicated staff would	s speaking. R24 stated she A-A was so rough and mean to g fat nobody." R24 had tears in not reported it, stating every something, NA-A would be R24 stated she felt she had d verbally abused by NA-A on	F 60			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 600 Continued From page 14 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 fett 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 fett 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 na mocking tone and said, "why don't you call the ombudsman or your caseworker?" R5 was unable to recent 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 the had been treated roughly and rudely on Her			AND HUMAN SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391
245306 B. WING 04/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 221315 HiGHWAY 52 NORTH ROCHESTER HEALTH SERVICES WEST STREET ADDRESS, CITY, STATE, ZIP CODE 221315 HiGHWAY 52 NORTH Wai ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BO VILL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 000 F 600 Continued From page 14 When interviewed an 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 the NA might come back and say she had not found anyone to help and would leave again. R5 stated here was aluers for help. R5 stated here active would eave 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						COM	IPLETED
ROCHESTER HEALTH SERVICES WEST 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901 (x4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILTS DE PRECEDED BY FULL REBULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued PREFIX TAG F 600 Continued From page 14 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 ombudisman 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			245306	B. WING			
ROCHESTER HEALTH SERVICES WEST ROCHESTER, MN 55901 Image: Colspan="2">Description: Summary stratement of Deficience with the PRECENCE by Full, REGULATORY OR LSC IDENTIFYING INFORMATION) Description: With Service Precence by Full, REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 14 F 600 F 600 View of 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 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	NAME OF F	PROVIDER OR SUPPLIER	•			_	
(X4) ID PREFIX TAG ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (COMPETIN TAG 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 affer 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 feit 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 feit 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 feit he had been treated roughly and rudely on	ROCHES	TER HEALTH SERVI	CES WEST				
F 600 Continued From page 14 F 600 When interviewed on 4/19/22, 9:30 a.m. R5 F 600 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 fet! 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 fet! 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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETION
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 feit 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	IAG	REGULATORTORE	SCIDENTIFTING INFORMATION)	TAG		TRATE	
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	F 600	When interviewed of stated there was a only able to describ name possibly start respond to his requi- after a bowel move 'I need to find some will leave and it will the NA might come found anyone to he felt he had waited u stated he was able could be provided, observed during the asked for someone with him, but felt the requests. R5 also re complained to a NA rough and caused I the NA responded t said, "why don't you caseworker?" R5 v of the NA. R5 state representative to re no-one was respon felt he had been tre multiple occasions On 4/19/22, 4:31 p. in evidence of a pas and also the nursing 4/10/22 that had be R5's allegations. Th only person with a r worked on 4/7/22 p and stated that indi- description, so they suspend while they	on 4/19/22, 9:30 a.m. R5 nursing assistant, that he was be as a black woman (her ting with a "T") who would not lest for assistance to clean up ment. R5 stated, "she will say, eone to help me', but then she be an hour or so." R5 stated back and say she had not lip and would leave again. R5 up to four hours for help. R5 to turn himself in bed so cares and his ability to turn was e interview. R5 stated he had a in leadership to come talk ey did not respond to his eported that he had about his care, feeling it was him pain. R5 further reported, to him in a mocking tone and u call the ombudsman or your was unable to recall the name d he had called his personal eport his concerns since he felt ding to his request to talk. R5 eated roughly and rudely on by this NA. m. the administrator brought st investigation related to R5, g schedule for 4/7/22 through een reviewed in response to ne administrator stated the name starting with "T" had rior to R5's stated concerns, vidual did not fit the r had no one they could investigated. Administrator	F 600			

Facility ID: 00941

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245306	B. WING			04	C /27/2022
NAME OF	PROVIDER OR SUPPLIER	-			EET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			5 HIGHWAY 52 NORTH CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 600	not yet spoken with reported concern a facility worked with worker-advocate (0 "what he [R5] was administrator was management spea came. A review of a Griew 4/13/22 indicated th concern from R5's was provided to the worker (SW). The concerns with the I starting with "T") th had requested ass statement that NA knowledge of how resident in it [stand indicated NA did no the form included a took two hours to b the same NA had t scheduled to leave A subsequent revie 4/8/22 and 4/9/22 of assistants with a no When interviewed providing support t similar concerns in so, R5 had stated a not providing care for assistance after reported rude, mod	age 15 n R5 since receiving the rt 10:47 a.m. because the R5's representative, a case CW) instead, saying that was comfortable with." The unaware R5 had requested k with him, but no one ever ance/Complaint form dated he facility had received a CW. It indicated the complaint e administrator and social grievance outlined R5's NA (a person of color, name uning off the call-light after he istance, and included a had indicated lack of to change a bed with a lard of care for NA]. Grievance ot return for four hours. Also, a grievance that the same NA oring a glass of ice, and also old R5 to "hurry up" as NA was e soon as it was almost 10 p.m. ew of the nursing schedule for did not show any nursing ame starting with the letter "T." on, 4/20/22, 8:54 a.m. CW, o R5, stated R5 had had the past. In the last week or a similar complaint of a person when he had turned his light on r he had a BM. R5 had cking and disrespectful ing assistant to CW. CW	F 6	00			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				1	0938-0391
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION		E SURVEY PLETED
							C
		245306	B. WING	<u> </u>		04/:	27/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH		
					ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	administrator to file another way to file a requested to talk to administrator, DON responded to his re assisted R5 by calli grievance on 4/12/2 CW said the facility investigate his cond and try to talk with the R5's concerns. CW the name of the NA a "T," and the incide Friday 4/8/22 or Sa evening shift. CW sa advocate for R5, bu facility did not often there was little char concerns brought for When interviewed of stated she had spo CW had been cond turned off his call lig not give him ice and soiled undergarmen stated the CW was should have been r and investigated. When interviewed of stated she usually t and R5 would requi almost every morni urinal use. NA-F sta at that time becaus use the Hoyer lift, b stated R5 only requi	a grievance. I didn't know a complaint." CW said R5 had anyone in leadership, the l, but said no-one had equest. CW stated she ng the facility to file a 22. In response to that call, rindicated they would cerns, pull a call-light report the staff person to address also said R5 could not recall a, but it might have started with ent had occurred possibly turday 4/9/22 during the stated she attempted to at felt it was difficult as the reach out to her and she felt nge in response to any	F	003			

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED
		245306	B. WING	i			C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH		
				R	ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From pa	ae 17	E E	600			
		nens and provide personal					
	cares to R5 indepe	ndently without assistance					
		5 sometimes had refused to ted, but one person could					
		s when he was accepting of					
	them.						
		on 4/25/22, 9:33 a.m. R5 again about being left in BM					
	unattended, and be	ing talked to in a mocking					
		tated it made him feel, "so, so like you're, like you're not					
		had difficulty speaking this,					
	turned away and ha						
		ange MDS dated 2/24/22, y intact and had no behavior					
		uired extensive staff					
		t activities of daily living					
		Id feed self with set up. R17 heart, kidney and respiratory					
	failure.	neuri, Runey and respiratory					
	R17's care plan dat	ted 9/23/21, included					
	paranoia/suspicious	sness related to life					
		of unhealthy relationships.					
		eel safe and secure in the were directed to, use					
		tine and caregivers, praise for					
		or and explain procedures.					
		area was, ruminating and avior. Staff were directed to					
	keep details to a mi	inimum, remain positive, and					
		be left alone for a while. In					
		lan identified R17 as a d d was at risk for abuse. Staff					
	were to be educate	d on abuse reporting and R17					
	would be encourage	ed to verbalize concerns or					

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Pi		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245306	B. WING				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVIC	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	problems. When interviewed of stated she was uns an incident which of September 2021 wi unsure of the date, and had been able she had not been a toilet stool and had for paper towels to realized she had not NA-A to wait. R17 m "Jesus Christ [R17's had been another in had come to collect on the toilet, and R yet done with the tra figures." R17 stated drink, a dish of swe R17 said, "sweet po When R17 returned had removed the tra dessert. R17 said s done with the sweet room, cursing unde you," and slammed tried to talk with NA told NA-A she could said NA-A had repli me!" R17 said she of the DON. R17 said bed with her head in so short [staffing]." you going to have s here?"	on 4/18/22, at 2:31 p.m. R17 sure of the date, but there was ccurred possibly in August or ith NA-A. R17 stated she was but she had been stronger to get up to the toilet. R17 said ble to get fully seated on the dribbled on it, so asked NA-A clean it. Then R17 said she of finished urinating and asked eported that NA-A had said, s name]." R17 stated there incident with NA-A where NA-A t her meal tray while R17 was 17 had told her she was not ay, and heard NA-A say, "that d she still had her beverages to be potatoes and dessert left. Datoes are my favorite thing." d to her room she found NA-A ay but left her beverages and the told NA-A that she was not t potatoes and NA-A left the er her breath, saying, "Fuck the door. R17 said she had A-A about her treatment and d not talk to her like that. R17 ed, "look at the way you talk to did report NA-A's behavior to the DON sat on the foot of the n her hands and said, "I'm just R17 said she had replied, "are someone so abusive work	F 6	00			
		ncident dated 6/14/21, ne resident stated to facility					

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				1	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
							C
		245306	B. WING	;		04/:	27/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHE	STER HEALTH SERVIO	CES WEST			2215 HIGHWAY 52 NORTH		
			10		ROCHESTER, MN 55901		0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	interim Administrato around 6 pm, she v stated the evening her dinner tray, wal slammed the door. repeatedly asked/to eating yet. The aller as NA-A, had been investigation. The in 6/23/21, identified N been polite to R17. a different group of to, "Cares in Pairs." When interviewed of reported the DON a come to talk to her asked if NA-A had I said, 'no, it was ver she can't remembe When interviewed of voiced frustrated or the past, stating hor that she felt it was a facility did not prote NA-A. On 4/25/22, 9:40 a. talk about her exper repeated that she h described her feelir treated. R17 said, " up. I didn't feel safe thought she would s pissed me off, and tried to talk to her in	b that on Monday night vas abused. The resident aide came into the room, took ked out of her room and The resident stated she old the aide she wasn't done ged staff member, identified suspended pending nvestigative report dated NA-A had claimed she had The facility assigned NA-A to residents and assigend R17 on 4/20/22, 2:53 PM R17 and social worker (SW) had . R17 said the DON had eft any bruises, R5 said, "I bal abuse,' I don't know why r it!" on 4/22/22, 11:07 a.m. R17 her interactions with NA-A in w angry she felt about it, and abusive behavior and the ct her from being cared for by m. R17 stated she wanted to rience with NA-A again. R17 had reported the incident, and hgs about how she had been I felt like I was going to throw and the she came in, I say nasty things to me. It made me feel angry. When I in the past, it was like a power id, 'oh, [R17] get real!" R17	F	600			

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		AND HUMAN SERVICES				FORM	APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED
		245306	B. WING	i			C 27/2022
NAME OF	PROVIDER OR SUPPLIER	•		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
DOOLE				:	2215 HIGHWAY 52 NORTH		
ROCHE	STER HEALTH SERVI	CES WEST			ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From pa	ge 20	F	600			
	An anonymous staf complaint on 3/8/22 indicating NA-A was to residents and wo them. Another sepa member was also f was, "rough and run refuse to assist the if either of these sta concerns to the DC in the facility policy information. When interviewed of stated she had with poorly. RN-A stated residents and would couple months ago had complained ab concerns to the DC in R5's, R17's, or R not like how NA-A t because of schedu caring for those resists sometime in Decent in harsh tones to resist who, and RN-A hom supervision. RN-A sched told her the residen not send NA-A hom supervision. RN-A sched a conversation confronted RN-A. c slamming the door a problem with me, leadership involved RN-A had witnesse have to use the bat	f member had filed a 2, on behalf of all residents s providing, "rough treatment" buld often refuse to assist arate complaint from a staff iled on 3/8/22, identified NA-A de" to residents and would m with cares. It was unknown aff members had reported their PN or administrator as required as they did not leave contact on 4/20/22, at 8:00 a.m. RN-A tessed NA-A treat residents I NA-A was short with the d not listen to their needs. A two residents, R99 and R5 out NA-A and had reported the PN. NA-A was then not allowed 9's room, because they did reated them. However, ling NA-A was actually still idents. RN-A had witnessed nber of 2021, NA-A was talking esidents, she did not remember I confronted NA-A, but NA-A ts had behaviors. RN-A did he or provide continuous stated the executive director with NA-A. NA-A then ornering her in a room and and yelled at her, "if you have we don't need to get ." In the past couple weeks d NA-A tell R18, "You don't hroom, you can wait until it is A stated there had been					

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL		O	1	0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	` ′				PLETED
							C
		245306	B. WING			04/2	27/2022
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST			ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	multiple times NA-A DON. When interviewed of stated the facility ha made her aware of but they were not s December 2021, th she had a poor bed about communication NA-A denied being neglecting any resid honest, I feel it's a r was not supposed t sometimes she was for them, so she did residents were alleg rough/physically ab towards them beca efficient with her wo she has never refus bathroom, but remin been there or it was The administrator a of the facility were r 2:13 p.m. On 4/21/22, Betwee LPN-A, NA-B, MAIN	A had been reported to the on 4/20/22, at 8:53 a.m. NA-A ad called her yesterday and allegations pertaining to R9, pecific. NA-A stated back in e executive director told her side manner and talked to her on and not rushing residents. rough with, abusing or dent. NA-A stated, "if we are racist thing." NA-A stated she to care for R9 or R17, but is the only one available to care d. NA-A stated she felt multiple ging neglect of care, being use or verbally abusive use she, "speaks loud," is ork and "dictative." NA-A stated sed to take residents to the nds them when they had just on't time to go yet.	F 6	800	DEFICIENCY)		
	the abuse policy an starting their shift. H working had been e The immediate jeop	d not recieved education on d abuse reporting prior to dowever, by noon all staff educated. bardy that began on 4/20/22, 21/22, when the facility					

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			F		APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				E SURVEY IPLETED
			A. BUILL	JINC	<u> </u>		С
		245306	B. WING	;			27/2022
NAME OF	PROVIDER OR SUPPLIER	-		;	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	STER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH		
					ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600	removed NA-A from she subsequently re assessments were residents, investigat started to include in residents, staff were their next shift to into of abuse, investigat and audits of grievat none met the defini However, the nonce lower scope and se harm that is not imm and R24 both had af wellbeing. Actions t verified through inte MAINT, HSK-A, EV and review of psych documentation of s A facility policy date Prevention Program right to remain free Upon receiving an a member receiving t immediately notify t supervisor will imm administrator or des perpetrator will be a immediately and be necessary law enfo an employee, they y immediately pendin would have a full pf psychosocial suppo	n working with residents and esigned; psychosocial completed with affected tions into the allegations were iterviews with staff and other e educated prior to working clude reporting of allegations ting and on their abuse policy ances were reviewed to ensure tion of abuse for reporting. Ompliance remained at the everity level of a G, actual mediate jeopardy because R9 expressed they had lived in se not being addressed by the fected their psychosocial aken by the facility were erview of LPN-A, NA-B, 'S-A, SW, RN-A and NA-C, nosocial assessments and taff being trained on abuse. ed March 2018, titled Abuse n included, residents have the from abuse and neglect. allegation of abuse, the staff he allegation must he supervisor on duty. The ediately notify the signee. The alleged asked to leave the facility e escorted out of the facility. If rcement would be notified. If would be suspended ig investigation. The resident hysical assessment and	F	003			

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		& MEDICAID SERVICES	0.00			0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
						С
		245306	B. WING		04	/27/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH		
ROCHES	TER HEALTH SERVI	CES WEST		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 600	Continued From pa	ge 23	F 60			
		e inserviced on the abuse				
F 609 SS=D	prevention policy. Reporting of Allege CFR(s): 483.12(c)(F 60	09		6/2/22
		onse to allegations of abuse, n, or mistreatment, the facility				
	involving abuse, ne mistreatment, inclu source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not re the administrator of officials (including t adult protective ser for jurisdiction in lon	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events jation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established				
	designated represe accordance with St Survey Agency, with incident, and if the appropriate correct	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced				
	Based on interview facility failed to repo	/ and document review, the ort to the state agency ect, physical and verbal abuse		F 609 R5 and R9 allegations were rep 04/19/2022 and final reports sul		

Facility ID: 00941

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CENTEI STATEMENT AND PLAN C	RS FOR MEDICARE	AND HUMAN SERVICES AMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245306 CES WEST TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			OM	FORM / <u>IB NO.</u> X3) DATE COMF (04/2 BE	06/07/2022 APPROVED 0938-0391 SURVEY PLETED 27/2022
F 609	immediately and nor resident (R5 and R Findings include: R5's annual Minimu 4/19/22, R5 had ha cognitive score from in January, to being also exhibited mild indicated R5 did re- everyday living skill When interviewed of stated there was a would not respond clean up after a boy "she will say, 'I nee but then she will lea so." R5 stated the I she had not found a leave again. R5 felf hours for help. R5 s someone in leaders felt they did not res reported that he ha his care, feeling it v pain; R5 further rep him in a mocking to call the ombudsma stated he had calle to report his concer responding to his re On 4/19/22, 10:47 a information related director of nursing fu	a later than 2 hours, for 2 of 4 9) reviewed for abuse. a m Data Set (MDS) dated d a slight decline in his n being fully cognitively intact g moderately impaired, and depression. The MDS quire assistance with his s (ADLs). on 4/19/22, 9:30 a.m. R5 nursing assistant (NA)who to his request for assistance to wel movement. R5 stated, d to find someone to help me', ave and it will be an hour or NA might come back and say anyone to help and would the had waited up to four stated he had asked for ship to come talk with him, but pond to his requests. R5 also d complained to a NA about vas rough and caused him ported, the NA responded to one and said, "why don't you n or your caseworker?" R5 d his personal representative rns since he felt no-one was	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 sen at the facility have the potential to be impacted by the alleged practice. Au are completed five times weekly duri morning meeting to determine if any reported grievances need to be eleva- to abuse investigations. Abuse investigations are reviewed by the fa- interdisciplinary team and approved Director of Clinical Services or Vice President of Operations prior to subr the five-day report. Allegations that h the potential to be The leadership team was educated of an ad hoc Quality Assurance meeting regarding reporting requirements by clinical support team on April 20, 202 Education was presented by the Executive Director or designee begin April 20, 2022, to facility staff on the guidelines for reporting and investiga allegations of abuse. Post-tests to va understanding were completed begin April 20, 2022. Education was repeat the Director of Nursing or designee to direct care staff beginning May 18, 2 The Executive Director or designee to direct care staff beginning May 18, 2 The Executive Director or designee completes audits for compliance with reporting requirements three times w for twelve weeks or until substantial compliance is achieved. Audits were initiated April 20, 2022 and are ongoi this time. Results of audits will be forwarded to the facility quality comm	e idits ing atidits ing atid by the mitting have during g the 22. nning alidate nning ted by to 2022. h weekly e ing at	

Facility ID: 00941

		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED C		
		245306	B. WING				27/2022
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 609	director-administrati these people." On 4/19/22, 11:35 a and DON asked if t priority for the surve then stated they we talk to residents wh mistreatment and s On 4/19/22, 4:31 p. came to the survey yet spoken with R5 concern at 10:47 a. worked with R5's re worker-advocate (C "what he [R5] was of A review of a Griev 4/13/22 indicated fa from R5's CW. It in provided to the adm (SW). The grievand the NA turning off th requested assistan not return for four h a grievance that the bring a glass of ice told R5 to "hurry up leave soon as it wa	tor) right now and interview a.m. the facility administrator they had missed anything of ey. Administrator and DON ere going to go at that time and to had reported concerns with start investigating. .m. Administrator and DON team and stated they had not since receiving the reported .m. because the facility epresentative, a case CW) instead, saying that was comfortable with." ance/Complaint form dated acility had received a concern dicated the complaint was ninistrator and social worker ce outlined R5's concerns with he call-light after he had ce. Grievance indicated NA did nours. Also, the form included e same NA took two hours to , and also the same NA had " as NA was scheduled to is almost 10 p.m. on, 4/20/22, 8:54 a.m. CW,	F 6	09			
	similar concerns in so, R5 had stated a not providing care v for assistance after reported rude, moc	o R5, stated R5 had had the past. In the last week or a similar complaint of a person when he had turned his light on the had a BM; R5 had king and disrespectful W stated, "Last week we					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRO										
CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391									
					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
245306		B. WING	i		C 04/27/2022					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE						
ROCHES	TER HEALTH SERVIO	CES WEST			2215 HIGHWAY 52 NORTH					
Roomed				F	ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 609	grievance. I didn't k complaint." CW sai anyone in leadershi said no-one had res stated she assisted a grievance on 4/12 had occurred possi 4/9/22 during the ev attempted to advoc difficult as the facilit her and she felt the response to any cor When interviewed of stated that being lef talked to in a mocki feel, "so, soI felt you're not good end speaking this, turne eyes. In review of facility in 4/19/22, at 3:45 p.m potential abuse and two hours. R9's quarterly Minin 2/10/22, included co including cerebral p depressive disorder cares were noted. During an observati at 3:41 p.m. R9 stat	dministrator to file a now another way to file a d R5 had requested to talk to ip, the administrator, DON, but sponded to his request. CW R5 by calling the facility to file 2/22. CW stated the incident bly Friday 4/8/22 or Saturday vening shift. CW stated she ate for R5, but felt it was ty did not often reach out to re was little change in ncerns brought forward. On 4/25/22, 9:33 a.m. R5 ft in BM unattended, and being ing tone of voice, made him uncared for, like you're, like bugh." R5 had difficulty ed away and had tears in his reported incidences on n. the facility failed to report a neglect to state agency within mum Data Set (MDS) dated ognitively intact with diagnoses balsy and recurrent major r. No behaviors or rejection of	F	609						
	depressive disorder cares were noted. During an observati at 3:41 p.m. R9 stat	r. No behaviors or rejection of ion and interview on 4/18/22,								

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		AND HUMAN SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391
			LE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
245306		B. WING		C 04/27/2022		
NAME OF	PROVIDER OR SUPPLIER	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER HEALTH SERVICES WEST			2	2215 HIGHWAY 52 NORTH		
Roone			F	ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	what to do!" R9 state one minute she is r she will turn a cheer and activities aide (R9 asked ACT-B to from floor to bed. N 4/11/22 and yelled a resident's legs into you don't know what doing it right." R9 s and it hurt her legs NA-A treated her le not report the incide thought ACT-B wou stated this made her stated NA-A makes have a brain and m observed teary eye speaking to survey stated she felt NA-/ physically hurt her I own body, she has NA's how to do thei improperly trained a When interviewed of stated NA-A is "just she wished NA-A w resident gets very r her. R9 stated she psychosocial mistre being rough with her other NA's, activity nursing (DON) but it. R9 stated she fel at all to be honest."	ad NA-A told her, "don't tell me ted NA-A is two faced; stating eally sweet and the next time k on you. R9 disclosed NA-A ACT)-B were family members. assist her with elevating legs IA-A entered R9's room on at ACT-B for assisting bed, stating "you can't do that, at you're doing, and you're not tated NA-A threw legs into bed and hurt her pride. R9 felt gs roughly. R9 stated she did ent to management, but Ild have notified them. R9 er feel very frustrated. R9 sher feel like she does not akes me feel really bad. R9 d and saddened when or about the incident. R9 A verbally abused her and egs. R9 stated she knew her full cognition, and has to tell ir jobs as most of them are	F 609			

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		AND HUMAN SERVICES				FORM	: 06/07/2022 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245306	B. WING				C / 27/2022
NAME OF PROVI	DER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER	HEALTH SERVIO	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
obs reper- who active una ACT it to have (AD ACT active Who dire una ACT resi time pen was star and ago Surr and aga In re 4/19 pote two The Prov resi neg	eating incident. en interviewed of vities director (A ware of the situ- T-B as her activi- her. ACT-A cor- e been complet L's) such as ass T-A stated ACT vities with reside en interviewed of ctor of nursing (ware of incident T-B that included dent legs into be es facility was in ding internal inv going to notify t investigations NA-A had a cor- but there is no veyor notified D cringes at the s in NA-A would the eview of facility to 2/22, at 3:45 p.n ential abuse and hours. facility policy tif gram dated Mar dents have the lect, misapprop	and teary eyed again after on 4/19/22, at 8:56 a.m. ACT)-A stated she was ation involving R9, NA-A, and ities assistant did not mention offirmed ACT-B should not ing activities of daily living sisting legs into bed for R9. B should only be completing ents. on 4/19/22, at 9:25 a.m. (DON) stated she was t involving R9, NA-A, and d verbal abuse and tossing ed. DON stated numerous nediately suspending NA-A vestigation. DON stated she facility management team and right away. DON stated R9 ncern approximately one year o recent concerns noted. ON that R9 gets very tearful sight of NA-A. DON confirmed		\$09			

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	LE CONSTRUCTION	VIB NO. 0938-0391 (X3) DATE SURVEY	
		(X3) DATE SURVEY	
	i	(X3) DATE SURVEY COMPLETED	
245306 B. WING		C 04/27/2022	
NAME OF PROVIDER OR SUPPLIER S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH		
R	ROCHESTER, MN 55901		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 609 Continued From page 29 F 609 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. -The Administrator or designee -The Administrator or designee. -The Administrator or designee. -Results of the investigation will be reported to the state within 5 days of the initial allegation. F 690 SS=D CFR(s): 483.25(e)(1)-(3) F 690 SS=D CFR(s): 483.25(e)(1)-(3) F 690 Sk83.25(e)(1) The facility must ensure that resident who is continence. S 483.25(e)(1) The facility must ensure that resident who is 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		6/2/22	

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		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391			
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · ·	TIPLE CONSTRUCTION	COM	E SURVEY PLETED			
		245306	B. WING			C 27/2022			
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STAT	E, ZIP CODE				
ROCHESTER HEALTH SERVICES WEST				2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE			
F 690	and (iii) A resident who receives appropriat prevent urinary trac continence to the e §483.25(e)(3) For a incontinence, base comprehensive ass ensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat review, the facility f management and r catheter for 1 of 1 catheter care. Findings include: R19's quarterly Min 2/25/22, included c including type 2 dia diverticulosis, prost pacemaker, and ch R19 required exten transfer, dressing, f hygiene. R19's physician ord catheter (a urine co condom over the po as needed for cather vinegar two times a	is incontinent of bladder e treatment and services to at infections and to restore xtent possible.	F 6	F 690 R 19 has been free o symptoms. Orders ha and updated to includ cleansing urinary coll storing these to avoid contamination. Residents who chang systems from a urina to a urinary leg bag h be impacted by the a There are currently n facility population. The director of nursin provided education to certified nursing assis 18, 2022, on guideline urinary catheter colled including guidelines f	ave been reviewed le instructions for ection systems and l environmental ge their drainage ry collection system ave the potential to lleged practice. o like residents in the o licensed nurses and stants beginning May es for managing ction systems or sanitizing and s or system to reduce ental contamination. ng or designee will kly to validate				

Facility ID: 00941

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CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY IPLETED	
	245306	B. WING		C 04/27/2022		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHESTER HEALTH SERVIC	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
 condom catheter ne and history of prostawith goal to not hav urinary catheter use change urinary colle any changes in and and report to medic tract infection (UTI) fever, increased rescomplaints of pain a R19's medication are included, R19's conzero times in Decer January 2022, four times in March 2022 2022. R19's bladder/incor 2/18/22, indicated Fe but no other informat assessment record R19's hospital disch 2/5/22-2/8/22, indicated for infection so R19 2/6/22 for a urinary When interviewed of stated the facility do clean his catheter er a semi-private roor 	arting on 11/19/21. ed 11/19/21, included use of eeded due to disease process ate cancer and incontinence e acute complications of e. Staff were directed to ection bag as needed, report bunt and color or odor of urine, cal doctor (MD) signs of urinary such as blood, cloudy urine, stlessness, lethargy, or and burning. dministration record (MAR) ndom catheter was changed mber 2021, one time in times in February 2022, six 2, and three times in April			of May 23, for four		

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		AND HUMAN SERVICES					FORM	APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED C	
		245306	B. WING					27/2022
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	STER HEALTH SERVIC	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD	BE	(X5) COMPLETION DATE
F 690	finds his leg bag sit sometimes on the f R19 stated his equi and hung up to dry "passed out" in the months ago and the a UTI. R19 stated th facility for wrong do During an observati at 4:30 p.m. license stated R19 can ass catheter himself. R ⁻ to his catheter tubin stated a nurse hung earlier today; otherv the floor or in a bath place to dry. During an observati R19 was observed hanging over the be tip touching the bath condom catheter wa resident's homeman There was white dis bath basin on the floor During an observati R19's overnight gra sitting in a bath bas catheter tubing han uncapped. During an observati R19's overnight gra to a shared bathroor	ting on the floor and floor of the shared bathroom. ipment needs to be washed properly. R19 stated he, bathroom approximately two e hospital discovered he had he hospital, "got after the	F 6	90				

Facility ID: 00941

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DEPART CENTE	FORM	APPROVED 0938-0391					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245306	B. WING				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER HEALTH SERVICES WEST					215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 690	Continued From pa	ge 33	F6	690			
	R19's overnight gra	ion on 4/21/22, at 8:58 a.m. wity catheter tubing was ver the bed rail uncapped.					
	R19's overnight gra observed sitting in a	ion on 4/21/22, at 12:30 p.m. wity catheter bottle was a bath basin next to the bed bing draping from the bed rail					
		ion on 4/21/22, at 2:29 p.m. ng was observed hanging over m sink in bathroom.					
	overnight gravity bo	ion on 4/22/22, at 8:38 a.m. ottle was observed in a bath tubing hanging over bed rail esident's bed.					
	at 8:59 a.m. R19 of room with unbutton explained to nursing a new catheter as the wheeled R19 back transferred him to be roommate, and gra was ringing out of he NA-B was observed hygiene upon leavin NA-B was observed hand hygiene, but of	ion and interview on 4/22/22, oserved was wheeling back to ed, soiled pants. R19 g assistant (NA)-B he needed he other one fell off. NA-B to room, donned gloves, bed, pulled curtain divider to bbed residents phone that is left upper shirt pocket. d to not complete hand ng R19's room. At 9:02 a.m., d back in R19's room without donned new gloves and started nightstand for new condom					
	catheter. Overnight touching the outside 9:04 a.m., registere room to assist R19	catheter tubing observed e of bath basin uncapped. At ed nurse (RN)-A arrived to but had to leave to gather ral supply room at facility. At					

Facility ID: 00941

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		AND HUMAN SERVICES			FO	ED: 06/07/2022 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		DATE SURVEY COMPLETED
		245306	B. WING		C 04/27/2022	
NAME OF	PROVIDER OR SUPPLIER	-	\$	STREET ADDRESS, CITY, STATE, ZIP (CODE	
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH		
				ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 690	9:06 a.m. RN-A retu would take over fro and performed han observed assisting catheter and stated every three days or stated all catheter s cleaned daily with w hung to dry. RN-A s staff to not complet leg bag on most da when she arrives of dayshifts per week. drapes R19's leg ba drawer handle if it is catheter tubing sho bathroom floor. RN system change woo floor due to potentia which could lead to one UTI since adm When interviewed of RN-B stated she the changed once a mo stated she was una catheter supplies a done it on dayshift. know what R19's of or what they cleans stated catheter sup if found on floors as them."	urned and informed NA-B she m here. NA-B doffed gloves d hygiene upon exit. RN-A R19 place new condom catheter should be changed more often if needed. RN-A supplies and tubing are to be rinegar and water solution and stated she had noted other e this task daily for R19 as his ys is not clean in the morning n shift and she works five RN-A stated night staff ag over the locked nightstand s cleaned. RN-A verified uld never be placed on floor or -A stated a whole catheter uld be required if found on al contamination concerns UTI's. RN-A stated R19 had	F 690			

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TATEMEN	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED		
		245306	B. WING		04	C I/27/2022		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901	DDE	Ξ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETIC DATE		
F 690	RN-C stated cathe should never be plaincrease a residen When interviewed stated his leg bag vinegar and water gravity bottle and to over bed rail. When interviewed stated R19's overn getting cleaned by has not been comp stated she's obsern R19's bathroom to shifts as she will so black sharpie mark changes should be record (EMR). RN- have to bring facilit catheter system ar homemade. RN-A is changed approx falls off and it alwa RN-A stated facility catheter tubing end When interviewed director of nursing for R19's condom three days or more expectation for stated equipment with vin keep supplies sani to a potential infect R19 and family have	age 35 ter equipment and tubing aced on flooring as it would t's chance for infection. on 4/24/22, at 9:00 a.m. R19 was not cleaned out with again last night. Overnight ubing was observed draped on 4/25/22 at 10:32 a.m. RN-A ight catheter equipment is her; however, the night shift bleting leg bag cleaning. RN-A ved the vinegar solution in not decrease between her ometimes mark the level with a ker. RN-A stated catheter e charted in electronic medical A stated R19's family would ty new overnight gravity nd extension tubing as it is stated R19's condom catheter imately every two days as it ys gets completed on bath day. / does not use caps on ds when not being used. on 4/25/22, at 11:05 a.m. (DON) stated the expectation catheter is to be changed every e often if needed. DON stated ff nurses to clean catheter egar and water mixture daily tary which could possibly lead tion such as a UTI. DON stated ve been educated and e risks of using his homemade	F 69					

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	FORM	APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245306	B. WING _			C 27/2022
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHESTER HEALTH SERVIC	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
 properly every day. staff to replace cath ever accidentally play would be a potential leading to infection. When interviewed of practitioner (NP)-A not keeping R19's of daily. NP-A confirm catheter prior to add to maintain it without believed in her med to hospital on 2/6/22 to maintain a sanita ultimately lead to R The facility policy tit revised 2/22/21 indit the leg bag urine con- cleaned/disinfected manufacturer's guid was requested from provided upon requi- Use a dedicated un resident identifier and prevent contact of the nonsterile collecting drainage bag. F 695 Respiratory/Trached SS=D F 483.25(i) Respirati tracheostomy care The facility must en needs respiratory care 	the system is cleaned out DON stated expectation for neter bag and tubing if it was aced on the floor as there al for cross-contamination on 4/25/22, at 3:09 p.m. nurse expressed concern facility was catheter equipment cleaned ed R19 utilized a condom mission at home and was able ut difficulty. NP-A stated she dical opinion, R19's admission 2 was caused by facility failure ary catheter system which 19's UTI. tled Catheter Care, Indwelling icated, ensure, if applicable, if ollection device is and stored per policy and dance. The "stored per policy" in the facility, but never test. rine collection device with a nd date. Avoid splashing and he drainage spigot with the g container when emptying the ostomy Care and Suctioning	F 69			6/2/22

Facility ID: 00941

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		& MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
						C	2	
		245306	B. WING			04/2	27/2022	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	STER HEALTH SERVIO	CES WEST			ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC 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		F 69		F 695 R 24□s respiratory equipment was replaced on 4/25/2022 and storage provided for bedside storage of equ when not in use. R 24□s orders we updated on 4/25/2022 to include re equipment weekly, labeling, dating, storing equipment properly. Residents who use respiratory equi have the potential to be impacted b practice. Orders for like residents w reviewed and updated if needed. So were placed in like resident so room storage of respiratory equipment. The director of nursing or designee educated licensed nurses and certin nursing assistants on the care and storage of respiratory equipment beginning May 18, 2022. The director of nursing or designee complete audits weekly for four wea compliance with changing, dating, cleaning, and storing respiratory	ipment re placing and pment y this /ere upplies ns for fied will		
	from staff for bed m personal hygiene, a lift. R24's Order Summ included Ipratropiun that is used to treat worsening of COPE	 R24 required extensive assistance r bed mobility, dressing, toilet use, giene, and transfers with mechanical Summary Report dated 4/24/22, atropium-Albuterol Solution (medicine to treat air flow blockage and prevent f COPD, asthma or other lung 5-2.5 (3) mg/3ml 1 vial inhale orally 			equipment according to professiona standards. Audits will begin the wee May 23, 2022. Results of audits wil forwarded to the facility quality com for review and recommendations.	ek of II be		

TATEMENT ND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	Сом	E SURVEY PLETED	
		245306	B. WING				C 27/2022	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	DDE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH OCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) Completic Date	
F 695	four times a day for 5/25/21 and Saline 1 vial inhale orally	age 38 r shortness of breath started solution (Soft Lens Products) via nebulizer two times a day eath started 5/25/21. The	F 6	95				
	medication was to 12/15/21, four Liter ever shift for oxyge (MD). On 2/22/22,	be given via NMT. On rs oxygen with nasal cannula en ordered by medical doctor to wear bipap with four Liters ugh at bedtime for sleep apnea.						
	had risk for respira CHF, COPD, sleep Interventions includ and oxygen per ME infection or edema activities of daily liv energy, and evalua	dated 6/1/21, included R24 tory impairment related to apnea, and asthma. ded administer medications 0 orders, report signs of , provide assistance with <i>v</i> ing (ADL's) to conserve ate lung sounds and vital signs d report abnormalities to MD.						
	During an observat at 6:32 p.m. R24 st oxygen continuous times a day after ea R24 stated she nee equipment cleaned equipment was not Whole NMT equipr breathing mask, m observed not dated environment. NMT floor between resid Condensation obse Whole bipap equip the breathing mask	tion and interview on 4/18/22, tated she used four Liters ly and received NMT's four ach meal and before bedtime. eds to remind staff to keep her d regularly and confirmed NMT t cleaned after each use. ment set up, which included the edication cup and tubing, d and left exposed to the tubing end observed lying on lent bed and nightstand. erved in the medication cup. ment set up, which included k, humidified distilled water nd machine observed not						

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		AND HUMAN SERVICES				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
							С
		245306	B. WING	;		04/:	27/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				ROCHESTER, MN 55901		0.05
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From pa oxygen tubing obse however, tubing is to when it was last cha During an observat at 3:37 p.m. R24's I cleaned, dry, and tu nightstand. R24's N floor next to bed wit mask sitting on bed observed in the me nurses tell her to ho light when medicati medication chambe stated the NMT has staff changed the e tubing remained un During an observat condensation obsel water chamber. NM on nightstand with o Nasal cannula tubir unchanged. During an observat nursing assistant (N out of bed to motor portion of NMT tubi condensation in me continued to have o chamber. During an observat at 8:45 a.m. R24's I connected to nebul medication chamber	Ige 39 erved running at four Liters; undated and R24 uncertain anged. ion and interview on 4/19/22, bipap machine is appeared ubing was coiled up on IMT tubing observed lying on th medication chamber and lside table. Condensation dication cup. R24 stated staff old it in place and put on call on is done dispensing. NMT er dated with 4/19 now. R24 s not been cleaned out since quipment. Nasal cannula dated and unchanged. ion on 4/20/22, at 7:07 a.m. rved in R24's bipap humidified 1T dated 4/19 observed sitting condensation in chamber. ng remained undated and ion on 4/20/22, at 12:05 p.m. NA)-B observed getting R24 ized scooter. The distal ng observed lying on floor with edication chamber. Bipap condensation in water		695	DEFICIENCY)		
	continued to have of chamber. During an observat at 8:45 a.m. R24's l connected to nebul medication chamber running. Registered	ion and interview on 4/21/22, NMT dated 4/19 observed izer machine with full					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/07/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245306	B. WING			C 27/2022	
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	TER HEALTH SERVIO	CES WEST		215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
TAG F 695	Continued From par chamber and mask During an observat NMT dated 4/19 ob on nightstand. During an observat at 11:55 a.m. R24 of NMT in room without NMT had not been changing equipmer When interviewed of RN-B stated respirat out on nightshift; ho often this was compuncertainty if equippe electronic medical r task list, or just part confirmed it was ne equipment that has as it could potential could lead to an info left R24 unattended room. When interviewed of stated respiratory e weekly by nightshift and tubing should b NMT's should be of treatment and set of oxygen tubing lying	ige 40 ion on 4/21/22, at 12:54 p.m. served remained untouched ion and interview on 4/22/22, observed self-administering ut staff assistance. R24 stated cleansed all week other than	TAG F 695	DEFICIENCY)	RIATE	DATE	
	During an observat nasal cannula tubin	n and cross-contamination. ion on 4/22/22, at 1:30 p.m. ng, NMT tubing, and bipap ed unchanged and undated.					

Facility ID: 00941

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			,		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245306	B. WING				C 1 27/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROCHES	STER HEALTH SERVIC	CES WEST			215 HIGHWAY 52 NORTH COCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY DEFICIENCY		D BE	(X5) COMPLETION DATE			
F 695	Continued From pa	ige 41	F 69	95			
	NMT's dated 4/19 c machine on nightsta chamber of clear flu	ion on 4/24/22, at 8:40 a.m. observed placed on nebulizer and with a full medication uid. Tubing for nasal cannula, pap equipment remained					
	nasal cannula tubin	ion on 4/25/22, at 9:14 a.m. Ig labeled 4/25 and new 's are still enclosed in plastic					
	director of nursing (all respiratory equip changed, rinse/clea out to dry. DON sta on when to change R24 did not have ar immediately place of expectation if any re found on the dirty fle nursing staff to chan stated her concern the potential for bac	on 4/25/22, at 11:05 a.m. (DON) stated expectation for oment for staff to date when anse after each use, and left ited orders should be in EMR equipment. DON confirmed n order and she would one. DON expressed espiratory equipment was oors; she would expect nge it immediately. DON would be infection control and cterial growth which could lead y problems for residents.					
	dated June 2017 in date and time open tubing per facility po	tled Oxygen Administration dicated, label humidifier with led. Change humidifier and olicy. At regular intervals, sygen equipment, masks, a.					
	Respiratory Service	d a policy from Northwest es titled positive airway UIPMENT Care and Cleaning					

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		AND HUMAN SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT CON	TE SURVEY MPLETED
		245306	B. WING _			C /27/2022
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIF	, CODE	
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 758 SS=D	-Daily: Wipe off PA cloth, empty and se drain excess water refill water chambe chamber in the PAF -Weekly: Soak ma water chamber in w minutes, rinse well -Monthly: Change machine as needed -Replace tubing eve 6 months. Free from Unnec P CFR(s): 483.45(c)(§483.45(c)(3) A psy affects brain activiti processes and beh but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic Based on a compre- resident, the facility §483.45(e)(1) Resin psychotropic drugs unless the medicat specific condition a in the clinical record §483.45(e)(2) Resin drugs receive gradu	AP mask with a warm damp et out water chamber to dry, from tubing and hang dry, r nightly; do not fill with P device. sk, headgear, tubing, and varm soapy water for 30 and allow to dry. intake filter, wipe down d. ery 3 months, chamber every sychotropic Meds/PRN Use 3)(e)(1)-(5) tropic Drugs. vchotropic drug is any drug that es associated with mental avior. These drugs include, to, drugs in the following ; d ehensive assessment of a must ensure that dents who have not used are not given these drugs ion is necessary to treat a s diagnosed and documented	F 69			6/2/22

		AND HUMAN SERVICES				FORM	06/07/2022 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245306	B. WING				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	•	<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	contraindicated, in drugs; §483.45(e)(3) Resi psychotropic drugs unless that medica diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the beyond 14 days, he rationale in the resi indicate the duratio	an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F 7	/58			
	drugs are limited to renewed unless the prescribing practition the appropriateness This REQUIREMED by: Based on interview facility failed to ensime medication was evan addressed every 14 (R24) reviewed wh Findings include: R24's significant ch (MDS) dated 4/8/22 diagnoses of anxie The MDS indicated	 b 14 days and cannot be e attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced w and document review, the sure a as needed psychotropic aluated by a physician and 4 days for 1 of 2 residents o had as needed orders. 			F 758 R 24 is no longer enrolled in hospic services effective 5/19/2022 and is longer receiving PRN anti-anxiety medications. Residents who have been prescrib PRN antipsychotic or antianxiety medications have the potential to b impacted by the alleged practice. A residents with PRN psychotropic medication orders was completed 05/16/2022 by the consultant pharm	ed ee A list of on macist	
FORM CMS-24	The MDS indicated impairment, had no	R24 did not have cognitive o signs/symptoms of delirium, inations or delusions, and had	1	Fa		macist as ewed to	age 44 of

		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245306	B. WING			(04/2	C 2 7/2022
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	R24 was administer antidepressant, and R24's physician ord -Lorazepam (antiar (milligrams/milliliter four hours as need date was 4/5/22, th date. -Seroquel (antipsyon mouth at bedtime r disorder (start date R24's Psychotropic dated 2/10/22, iden antipsychotic, antid medications for dia disorder, anxiety di evaluation identified and did not have da indicated that R24's psychological stress treatable/reversable identify R24's target nonpharmacologica analysis of the effer medications. R24's behavior care "At risk for behavio illness. The only be was "Cares in pairs medication care pla was at risk for adve antidepressant medication included, evaluate	viors. The MDS also indicated ared antipsychotic, d antianxiety medications. ders included the following fixiety medication) 2 mg/ml (), give 0.5 mg by mouth every ed for anxiety. The order start e order did not include a stop chotic medication) 500 mg by elated to schizoaffective (9/14/21). Medication Use evaluation htified R24 was prescribed lepressant, and antidepressant gnoses of schizoaffective sorder, and chronic pain. The d R24 had duplicative therapy elirium. The evaluation also s environmental and sors could be e. The evaluation did not	F 7	758	determine if the resident was using the PRN medication and updates sent to medical provider based on reviews. plans were reviewed and updated were target behaviors and non-pharmacod approaches if indicated. Communicate was sent to contracted hospice age and medical providers regarding the federal regulations for PRN psychot use. The director of nursing or designee provided education to licensed nurse nursing assistants beginning May 18 2022, on regulations regarding the Fuse of psychotropic medications, the to identify target behaviors, and the to attempt non-pharmacological approaches to assist resident in mabehaviors. The director of nursing or designee complete audits of new and existing psychotropic medication orders were ensure stop dates are included on of for PRN psychotropic medication is reord The director of nursing or designee validate documentation of PRN psychotropic medications includes targeted behavior and non-pharmacological approaches with for four weeks. Audits will begin the of May 23, 2022. Results of audits with forwarded to the facility quality common for review and recommendations.	o Care vith logical ation ncies ropic es and 3, PRN e need naging will PRN ekly to orders nd ered. will eekly week vill be	

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		E SURVEY IPLETED
			A. BOILD	<u> </u>		С	
		245306	B. WING	IG			27/2022
NAME OF I	PROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			15 HIGHWAY 52 NORTH DCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 758	Continued From pa	age 45	 F7	58			
		, and Notify MD of decline in aily living] or mood/behavior hange.					
	behaviors for Seroc addition, the care p	cked identification of target quel and Lorazepam. In lan did not identify cal interventions for Seroquel					
F v C C iu 4 F s r	was reviewed betw combination with pr Care behavior/moo identified R24 was	administration record (MAR) een 4/5/22 and 4/19/22 in rogress notes and Point of od documentation. The MAR administered Lorazepam on					
	4/18/22 at 4:55 p.m R24's record did no symptoms/behavio	rs R24 had demonstrated, nor cal intervention attempted prior					
	3/22/2022 and 4/19 identified R24 had	cumentation between 0/22. The documentation seven occurrences of rejection ne morning. The dates/times .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.r -4/11/22 at 9:17 a.n -4/12/22 at 9:00 a.r	n. n. n.					
	for R24's rejections R24's progress not	n does not identify the reason s. es reviewed between 9/22, included behavior notes					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	E SURVEY PLETED
		245306	B. WING			C 27/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVIC	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	3/28/22, 3/29/22, ar indicated the depre- to pain, R24 was ch during those days, a outside social service During an observed R24 observed calm voice, no observed and her speech pat When interviewed of registered nurse (R utilized non-pharma R24's anxiety and n unaware if facility cl interventions in thei (EMR). RN-A indica non-pharmacologic attempted or offere be documented as When interviewed of director of nursing (non-pharmacologic attempted prior to g medications. DON of the EMR in a progra anti-anxiety medica and cannot be rene physician or prescri resident for the app medication. DON st was past 14 days a to the practitioner o Nutritive Value/App	had depressive symptoms on had 3/30/22. The record ssive symptoms were related becked on more frequently and a referral was made to ces for additional support. I on on 4/20/22, at 9:00 a.m. , not restless, even tone of hallucinations or delusions, terns were slow. on 4/25/22, at 10:39 a.m. N)-A stated uncertainty if staff acological interventions for nood. RN-A stated she was harted non-pharmacological r electronic medical record ted the EMR did not identify if al interventions were d and stated refusals should well. on 4/25/22, at 4:12 p.m. DON) stated expectation for al interventions should be iving pharmacological expected staff to document in tess note. DON stated prn tions are limited to 14 days wed unless the attending bing practitioner evaluates the ropriateness of that tated she knew R24's order s she handed the information n 4/21/22. ear, Palatable/Prefer Temp	F 75	8		6/2/22
F 804 SS=E	Nutritive Value/App	ear, Palatable/Prefer Temp	F 804	4		6/2/22

Facility ID: 00941

If continuation sheet Page 47 of 108

		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (COMF	E SURVEY PLETED
		245306	B. WING			04/2	27/2022
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From pa	age 47	F 8	04			
	§483.60(d) Food ai Each resident rece	nd drink ives and the facility provides-					
		l prepared by methods that value, flavor, and appearance;					
	attractive, and at a temperature.	l and drink that is palatable, safe and appetizing NT is not met as evidenced					
	Based on observation failed to provide me taste, texture, appertemperature for 11 R13, R17, R9, R24	tion and interview, the facility eals that were palatable in earance and at an appetizing residents (R18, R19, R26, , R5, R27) of the facility served for dining during the			F 804 R 27 no longer resides at facility. R 1 R19, R26, R13, R17, R9, R24, and F were interviewed regarding food serv since survey exit beginning May 23, to determine current level of satisfac and share plans for changes in meal delivery services.	R5 vice 2022, tion	
	were observed place doors to the front a element to maintain had been plated be cart. Plates were co When staff began t doors to the cart we open until all trays were observed on t to the dining area co served to residents small basket of sali	p.m. the evening meal trays bed on an upright cart with nd back, but no heating in temperature. All facility trays fore being brought out in the overed with a domed cover. to pass the meal tray, both ere opened and remained were delivered. No condiments the trays. Beverages had come on an open cart and had been prior to the trays arriving. A t and pepper were observed yay from the tray cart, and			Residents who receive meals from fa dietary department have the potential be impacted by the alleged practice. Dietary tray service delivery changes implemented on May 23, 2022, to increase the potential for meals bein delivered at appropriate temperature Condiments will be included on trays improve overall customer satisfaction machine was repaired, and ice coole are utilized to pass ice water. Cold d are delivered on ice to maintain palatability. The director of nursing or designee provided education to nursing staff of meal delivery expectations and custo	al to s were ng es. s to n. Ice ers Irinks	
	none were observe being served. R18	d being placed on any tray received a hamburger as the ain meal of fried fish, and			services expectations for meals begins May 18, 2022. The food service mar or designee provided education to di	inning nager	

Facility ID: 00941

If continuation sheet Page 48 of 108

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 245306 B. WING 04/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER HEALTH SERVICES WEST COMPLETED C (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION		0938-039 survey
245306 B. WING Odd/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE ROCHESTER HEALTH SERVICES WEST STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE (04) ID TYO SUMMARY STATEMENT OF DEPICIENCIES (Expendency Must be precised by FTULL REGULATORY OR LSC DENTIFYING INFORMATION) D PREYN (ECCOSS-REFERENCE) STREET ADDRESS, CITY, STATE, 2P CODE Concernence 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 kithen and came back with a handful of ketchup packets and also tarter sauce as this had not been provided for the fish meals. F 804 When interviewed on 4/18/22, at 2:07 p.m. R26 said, "The food is not there 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 atternative. 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 they cook it too much, the food gets tough to chew, the meats. Sometimes they cook it too much, the food gets tough to chew, the meats. Sometimes tor an be attilt charred and burnt on the egges." Stattilt the food is not the greatest. The food isn't								
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE ROCHESTER HEALTH SERVICES WEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRETRY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRETRY TAG PROVIDERS OF MAY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNETTE PROVIDERS OF MAY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNETTE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 804 F 804 Continued From page 48 yelled at shaff that she could not eat it, and asked shaff 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. F 804 When interviewed on 4/19/22, at 10:05 a.m. R19 said, "Thave 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." F 814 When interviewed on 4/18/22, at 2:11 p.m. R13 said, "The food is not that great, every none in a while we get sometting good. Sometimes they cook it too much; the food gets fought to chew, the meats. Somettimes it can be alittle charred and burnt on the edges." F 817 When interviewed on 4/18/22, at 2:12 p.m. R			0.45000					
215 HIGHWAY 52 NORTH RCOLESTER, NM. 3501 Organ D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAY DEFICIENCIES) REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OP COMPT THE BATE 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. F 804 F 804 When interviewed on 4/19/22, at 10:05 a.m. R19 said, "The tod isn't very good. The food is not hot by the time I get them." F 804 F 804 The interdisciplinary team weekly to determine if changes implemented to meal service. Audits will be analyzed by the itmel get them." F 813, "The food is not that great every note in a while we get something foo, you get tired of the alternative. There are very few fresh fruits and vegetables." F 813 When interviewed on 4/18/22, at 2:11 p.m. R13 said, "The food is not that great, every note 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." F When interviewed on 4/18/22, at 2:49 p.m. R17 stated the food was, "horrible. The eggs will come cold, like cold snot, the food is nuckerververververververververververververve			245306	B. WING			04/2	27/2022
ROCHESTER HEALTH SERVICES WEST ROCHESTER, MN 55901 (%1)D TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY PLL) (EACH DEFICIENCY OR LISC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPORTATE DEFICIENCY) (COM INSTEED REFORM SHOULD BE (CROSS-REFERENCED TO THE APPORTATE DEFICIENCY) 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. F 804 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." F 804 The interdisciplinary team members will complete audits three times weekly for four weeks regarding dustomer satisfaction of quality of meals and meal service. Audits will be gin 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. When interviewed on 4/18/22, at 2:14 p.m. R13 said, "The	NAME OF I	PROVIDER OR SUPPLIER						
PHĚETX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRĚTX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMHÝ TÍM IMTE 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. F 804 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 1 get them." The interdisciplinary team members will complete audits write breas 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." The interdisciplinary team weekky to determine if changes implemented to meal service have positively impacted customer satisfaction with meal quality qualite for review and recommendations. 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 isin't always hot. The meat is sometimes chewy.	ROCHES	TER HEALTH SERVI	CES WEST					
 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 wery 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 harm 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 lut kewarm-y." When interviewed on 4/18/22, at 2:40 p.m. R9 said, "Their food is not than greatest. The food oin't always hot. The meat is sometimes chewy. We 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETIC
we get it too often." When interviewed on 4/18/22, at 6:19 p.m. R24	F 804	yelled at staff that is staff if they would e meat on a bun and licensed practical n locate any condime came back with a h also tarter sauce as for the fish meals. When interviewed of said, "The food isn" hot by the time I ge When interviewed of said, "I have ham u is not for breakfast comes. You could g hamburger but that tired of the alternati fruits and vegetable When interviewed of said, "The food is n while we get somet cook it too much; th the meats. Sometir and burnt on the eo When interviewed of stated the food was cold, like cold snot, When interviewed of said, "Their food is always hot. The me get too much ham, we get it too often."	she could not eat it, and asked there were no condiments. A nurse (LPN)-A was unable to ents so went to the kitchen and handful of ketchup packets and is this had not been provided on 4/19/22, at 10:05 a.m. R19 t very good. The food is not it them." on 4/18/22, at 2:07 p.m. R26 up to three times per week. If it it is for supper. The menu just get a grilled cheese or 's the same thing too, you get ive. There are very few fresh es." on 4/18/22, at 2:11 p.m. R13 to that great, every once in a thing good. Sometimes they he food gets tough to chew, nes it can be a little charred dges." on 4/18/22, at 2:48 p.m. R17 s, "horrible. The eggs will come the food is lukewarm-y." on 4/18/22, at 4:02 p.m. R9 not the greatest. The food isn't eat is sometimes chewy. We now I'm beginning to hate it as		04	customer services expectations for beginning May 23, 2022. Staff train infection control practices in handli delivering foods was completed du survey in response to infection con citation. The interdisciplinary team member complete audits three times weekly four weeks regarding customer satisfaction of quality of meals and service. Audits will begin the week 23, 2022. Results of audits will be analyzed by the interdisciplinary tea weekly to determine if changes implemented to meal service have positively impacted customer satisf with meal quality and meal delivery Analysis of audits will be forwarded facility quality committee for review	r meals ing on ng and ring the trol s will / for meal of May am faction /.	

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		AND HUMAN SERVICES				FORM): 06/07/2022 /I APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245306	B. WING	i		04	C /27/2022
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP COD	•	
ROCHES	TER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 804	said, "the hot food if food isn't always co are cold." When interviewed of said, "the food is no dry or burned." When interviewed of said he didn't get its complained the food During an observat the beverage cart v of the dining area v milk or juice contain outside of the beve not cold to the touc During an observat R18 was seated in calling a family men food. R18 complain burned, and flipped then asked another (R20) to turn his eg observed to be bur During an observat the meal trays were transported out to t residents in the din taste test tray had t last, and when all tr p.m. the temperatu follows: meatloaf 10	isn't always hot and the cold old; most of the time the meals on 4/19/22, at 9:46 a.m. R5 ot good, some of the food is on 4/19/22, at 11:19 a.m. R27 ems he requested and id was often cold. ion on 4/19/22, at 11:56 a.m. vas observed sitting to the side with no ice under or around the ners to keep them cold. The rages were slightly cool, but h. ion on 4/21/22, at 9:02 a.m. the dining room and loudly mber (FM)-A to look at her ned that her omelet was I it over for FM-A to see. FM-A r resident seated at the table to solver, and they were	F	304			
		loaf was tender and with good ly warm in the mouth. The					Daga 50 of 10

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST		215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 804	potatoes were dry a significant seasonin The peas were not the other foods. A r tasted the food and warm, but thought t stated the food sho when served to the When interviewed of stated R18 had bee breakfast being bur often complain of th is to say the food is When interviewed of RD stated any cook but it should not be omelets were heate turned over before possible to acciden RD stated an expect for being properly of RD stated food that that might be burne unpalatable for any and steps taken to During an observat R5 had received bat breakfast. The eggs point that they were had called for some were overdone and but had not yet rece thought he had bee hour.	around the edges and lacked ng, and felt only slightly warm. seasoned but felt warmer than egistered dietician (RD) also indicated that it did not feel the flavor was pleasant. RD uld be appropriately warm residents. on, 4/21/22, at 2:04 p.m. FM-A en really upset about her rned. FM-A said R18 does not he food, but when she does, it cold. on 4/25/22, at 12:46 p.m. the k might accidentally burn food, served if it was burned. If ed in a large pan and not being served it would be tally serve a burnt portion, but ctation for food to be examined cooked before being served. t was not properly prepared,	F 804			

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		AND HUMAN SERVICES			FORM	: 06/07/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVIO	CES WEST	2	215 HIGHWAY 52 NORTH		
			R	ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 804	stated she did not g tray with oatmeal in conversation R17 n asked staff to get h food she had was n oatmeal was cold a was observed to be scoop. R17 did not to add to her cereal waiting for an exten alternative to arrive A facility policy titled dated May 2014 ind prepared by method value, flavor and ap attractive and serve Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food saft The facility must - §483.60(i)(1) - Proc approved or consid state or local author (i) This may include from local producer and local laws or re (ii) This provision d facilities from using gardens, subject to safe growing and fo (iii) This provision d from consuming foo	get her breakfast. She had a front of her. Later in the nade it clear that she had er something different as the not what she wanted, and the nd a solid lump. The oatmeal e in a mound, shaped like a have any milk, sugar or other l. R17 said she had been ided time for her requested d Food: Quality and Palatability dicated that food was to be ds that conserve "nutritive opearance. Food is palatable ed at the proper temperatures." Store/Prepare/Serve-Sanitary)(2) fety requirements.	F 804			6/2/22

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			COM	E SURVEY PLETED
		245306	B. WING			04/2	_ 27/2022
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHEST	ER HEALTH SERVIO	CES WEST		2	215 HIGHWAY 52 NORTH		
Recificor				R	COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	by: Based on observative review, facility failed were not stored bey of 2 kitchen refrig freezers, and failed were dated, labeled expiration dates for refrigerators. These affect all 28 residen Findings include: During observation Temperature logs for multiple blank entried that were above sat Fahrenheit (F) or lo F for freezer). The f evaluation and/or in temperatures were temperatures. On 2 the morning the free ajar. The temperature temperatures were temperatures were temperatures in the free ajar. The temperature to 1/24/2 55 degrees in the m During an initial brief following items were unlabeled, and expi- opened and undate opened bag of cole 4/14/22.	service safety. NT is not met as evidenced ion, interview and document d to ensure refrigerator items yond their expiration dates for erators and 2 of 2 kitchen to ensure refrigerator items l, and stored beyond their 1 of 1 dinette kitchen e failures had the potential to ts in the facility. on 4/18/22, at 11:50 a.m. or the cooler and freezer had es and identified temperatures fe zones (41 degrees wer for cooler and 0 degrees facility lacked evidence of terventions when above safe zone /13/22, freezer log indicated in ezer door was found to be ire recorded on the log was 30 2, the cooler temperature was	F8	312	F 812 No residents were directly identified Facility staff discarded outdated or unlabeled open food items from foo storage areas when they were made aware of the concerns during survey Forms for recording freezer, refriger and dishwasher temperatures per p were posted in kitchen upon survey Cleaning was completed upon survey and cleaning schedule posted. Tray 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 impacted by the alleged practice. Temperature logs, tray line checklist cleaning protocols were posted in ki and are monitored daily/weekly/ or monthly as appropriate for complete tasks. Hand hygiene competencies completed with staff during survey a audits are ongoing. A full review of storage areas was completed by the service manager and dietitian on Ma 2022, to ensure all outdated or oper food had been discarded The food service manager or design provided education beginning May 3 2022, to dietary staff on requiremen food storage, timelines for food use, infection control for dietary staff. The service manager or designee and the	d e of y. rator, olicy exit. ey exit line e be ts, and itchen on of were and e food ay 3, ned nee 3, ts for , and e food	
	cucumber in zip-loc				director of nursing or designee pres- information to the dietary staff and n	ented	

Facility ID: 00941

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 <i>' '</i>		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245306	B. WING			04/2	C 27/2022
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 812	Continued From pa 3/24/22; good for ty manager (CDM).	age 53 wo weeks per certified dietary	F 8	12	staff on food storage and sanitary environment for food services begi	nnina	
	-opened and undat mozzarella cheese -opened and undat cheddar cheese. -opened, undated, and peaches puree CDM. -opened container best if used by date days per CDM. -opened chopped g good for two weeks -opened sticky and liquid substance. C dietary aide (DA)-A personal coffee cree food does not below staff have a break personal items. -opened and undat barbeque sauce. -opened French's V 12/21; best if used	Unlabeled bottle with white DM confirmed this belongs to and white substance is staff's eamer. CDM confirmed staff ng in kitchen refrigerators and oom where they can store red Sweet Baby Ray's Worcestershire sauce dated			An environment for food services beginned for food services beginned for food services beginned food services beginned food services beginned food services and the service area to monitor compliance with cleanliness, hand hygiene, and food storage policies audits were initiated May 3, 2022 a continue through May 31, 2022. Reaudits will be analyzed weekly, and analysis forwarded to facility quality committee for review and recommendations. The director of or designee will complete audits dure meal tray delivery to ensure staff a compliant with customer service expectations and infection control measures in the delivery of meals.	nee These nd will esults of nursing uring	
	on 3/11/21; best if u -opened and undat -opened and undat -opened and undat best if used by 5/21 -unopened and und brown, mushy, and -undated and unlat brown and mushy. -ham that was undat	ed thickened dairy drink. ed liquid whole eggs. ed Hershey chocolate syrup; 1. dated lettuce that was wilted,					

Facility ID: 00941

If continuation sheet Page 54 of 108

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	`́сом	E SURVEY PLETED
		245306	B. WING				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER		_	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			15 HIGHWAY 52 NORTH OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 812		age 54 the bottom of the cooler. CDM	F٤	312			
	verified with cook (4/13/22; however, defrosted from free have to look back overify exact date it	C)-C that ham was sliced on C-C uncertain on date it was ezer. C-C stated she would on previous week's menus to was sliced and defrosted. C-C buld be labeled and dated upon					
	opening items in ki During an observat the following items	tchen. tion on 4/18/22, at 12:15 p.m. were noted to be undated,					
	-multiple open bag had a thick yellowis -opened undated b sausage patties, be						
	the following items expired in dry stora -opened and undat -dented diced toma storage rack and s and will have to be does all the facility foods with received						
	expired on 1/28/22 -opened and undat ground nutmeg, gro	and expired baking soda;					

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		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	E SURVEY IPLETED C
		245306	B. WING			27/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
ROCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 812	-opened and undat manufactures date -opened and undat manufactures date -opened and undat manufactures date -opened and undat 7/31/20. -opened and undat 11/24/20. -opened and undat -opened and undat uncertain on date m -opened and undat 9/19/19. -opened and undat 11/18/18. -opened and undat 11/18/18. -opened and undat 11/18/18. -opened and undat Uhen interviewed of stated her expectat label and date food dispose of expired concern could pote illnesses and unsar stated refrigerator a should be checked mornings and even temperatures were kitchen. CDM state should be checked to reeducate dietar	ed fajita seasoning; 2/27/20. ed whole sweet basil; 6/30/20. ed ground thyme; 12/24/20. ed lemon pepper; received on ed ground rosemary; received ed celery salt; received 7/9/20. ed ground ginger; CDM eceived as label has worn off. ed tarragon leaves; received ed allspice; manufactures date ed powdered sugar. ed vanilla. on 4/18/22, at 12:48 p.m. CDM tion for dietary staff was to is upon opening and to foods. CDM expressed ntially lead to food borne nitary temperatures. CDM and freezer temperatures and verified twice a day in the ings. CDM confirmed these not being completed in id dishwasher temperatures ed three times a day; however, ere not getting completed look at dishwasher log sheet ny times a day temperatures . CDM stated she would need	F 81			
	During an observat	ion of the kitchen on 4/18/22,				

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		AND HUMAN SERVICES				FORM	: 06/07/202 APPROVEI . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	CON	E SURVEY IPLETED
		245306	B. WING	i			C / 27/2022
NAME OF	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 812	at 1:00 p.m. the kite cooking equipment with dry food partic sink had dishes so food debris was sc areas, the grill had grease, the floor wa and floors were stic clean in appearance should be cleaned done in a very long During an observat the following items unlabeled, and exp opened and undat 5/4/20. -opened and undat cheesecake. -undated and unlat Sprite in white groo -undated and unlat meat with plastic w container; C-C stat was eating this on -opened and unlatb 4/18; the aluminum food exposed. -Chobani Greek str expired on 12/16/2 -opened, undated, peppers. -undated and unlatb discolored apple sli -undated, unlabeled and chicken.	chen was found to have dirty ; the microwave was soiled les, the three compartment aking from breakfast and dry attered throughout all three a very thick layer of black as soiled with dry potato peels, ky, counter tops were also not e. CDM confirmed grill grease daily and, "it had not been time." ion on 4/18/22, at 1:15 p.m. were noted to be undated, ired in the dinette refrigerator: ed tomato juice; best use by ed Member's Mark beled take out meal with can of tery bag. beled broccoli and unknown hite fork in Glad-wear ed a nurse with blonde hair 4/18/22 in the morning. eled bowl of sausage dated foil cover was torn open with rawberry banana yogurt; 1. and unlabeled crushed beled mushy and brownish	F	312			

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		AND HUMAN SERVICES				FORM	: 06/07/2022 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			` ´CON	E SURVEY IPLETED
		245306	B. WING				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	"ARTS". -opened and undat barbeque sauce lak -opened and undat labeled "ARTS". -opened Sara Lea countertop drawer bread was hardene -opened and unlab sliced bread found When interviewed of stated uncertainty if and freezer was for confirmed food in th use of personal foo C-C confirmed two temperature sliced were left on counte (ACT). C-C confirm temperature leftove countertop in Outba bag belonged to R of posted sign on o stated, "please man and dated - anythin is 7 days old or oldo otherwise specified please see Jamie, unidentified staff m facility tour to a fam stated "this refriger When interviewed of registered nurse (R refrigerator and free only. RN-B guessed with plastic fork wa	ed Sweet Baby Ray's beled "ARTS". ed Hershey's chocolate syrup classic white bread found in without twist tie; dated 2/23/22; ed but not moldy. eled Great Harvest Ambrosia on top of refrigerator. on 4/18/22, at 1:19 p.m. C-C f food in dinette refrigerator staff or residents. C-C his refrigerator was not for staff of items brought into facility.	Fε				

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	245306	B. WING				C 27/2022
	CES WEST		22	215 HIGHWAY 52 NORTH		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL) BE	(X5) COMPLETIC DATE
was used during re activities director w dating these items. into garbage as she belonged to. RN-B belonged to or how she placed it back if During an observat the following items opened above the L -opened ground cu -opened and undat celery seed, ground rosemary leaves, a When interviewed of activities director (A supposed to be che refrigerator and free everything is dated nursing or activities were the ones who items first. ACT cor be dated/labeled ar receiving. ACT stat labeled and dated. During an observat the refrigerator in th package of ham wr 4/12/22. One packa wrapped, leaving th the bottom of the re the refrigerator also defrosted ground b	sident activities and the as in charge of labeling and RN-B tossed leftover meal was not able to identify who it uncertain who cheesecake long it had been opened, but in refrigerator. ion on 4/19/22, at 8:40 a.m. were noted to be undated and kitchen stove: min; received 9/24/20. ed poultry seasoning, whole d sage, ground ginger, nd beef base. on 4/19/22, at 9:01 a.m. ACT) confirmed dietary is ecking temperatures on dinette ezer and making sure and labeled. ACT stated is staff will assist dietary if they obtained and opened the food firmed all food items should nd only kept for 72 hours after ed activities foods are to be ion on 4/19/22, at 11:15 a.m. he kitchen had 4 individual apped in saran wrap dated age of ham was not completely he ham exposed and touching erigerator. The bottom shelf of o had a metal pan with eef that was undated.	F 8	312			
	PROVIDER OR SUPPLIER STER HEALTH SERVIO SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa was used during re activities director w dating these items. into garbage as she belonged to. RN-B belonged to. RN-B belonged to or how she placed it back i During an observat the following items opened above the I -opened ground cu -opened ground cu -opened and undat celery seed, ground rosemary leaves, a When interviewed of activities director (A supposed to be che refrigerator and free everything is dated nursing or activities were the ones who items first. ACT cor be dated/labeled ar receiving. ACT stat labeled and dated. During an observat the refrigerator in th package of ham wr 4/12/22. One packa wrapped, leaving th the bottom of the re- the refrigerator also defrosted ground b	DF CORRECTION IDENTIFICATION NUMBER: 245306 PROVIDER OR SUPPLIER STER HEALTH SERVICES WEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 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 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.	COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL DP CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL DENTIFICATION NUMBER: 245306 B. WING PROVIDER OR SUPPLIER 3000000000000000000000000000000000000	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLIA DF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLIA DENTIFICATION NUMBER: 245306 B. WING PROVIDER OR SUPPLIER STER HEALTH SERVICES WEST STER HEALTH SERVICES WEST STER HEALTH SERVICES WEST STER HEALTH SERVICES WEST STER HEALTH SERVICES WEST ID Continued From page 58 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX 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. F 812 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 s	CP DEFICIENCIES (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STER HEALTH SERVICES WEST STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EXCH DEFICIENCY MS) HE PRECEDED Y FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFX TAG PREFX (EXCH CORRECTING ASTRONMERTOR) Continued From page 58 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 belorged to rhow long it had been opened, but she placed it back in refrigerator. F 812 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 poulity seasoning, whole celery seed, ground sage, ground ginger, rosemary leaves, and beef base. When interviewed on 4/19/22, at 0:1 a.m. activities director (ACT) confirmed diletary is supposed to be checking temperatures on dineite refrigerator and freezer and making sure everything is dated and labeled. ACT stated nursing or activities staff will assist dictary if they were the ones who obtained and opened the food items first. ACT confirmed all food items should be dated/ableed 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 warpped in saran wrap dated 4/1/222. One package of ham was not	COF DEFICIENCIES (X1) PROVIDERSUPPLIER(CLIA, DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATA A BUILDING A BUILDING (X1) PROVIDERSUPPLIER(X1, A BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATA PROVIDER OR SUPPLIER 245306 B. WING EXTERT ADDRESS, CITY, STATE, ZIP CODE (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATA STER HEALTH SERVICES WEST STEET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHWAY 52 NORTH RCCHESTER, MN 55901 (V4) STER HEALTH SERVICES WEST ID PROVIDERY NON STORECTION NUMBER: ID PROVIDERY NON STORECTION NUMDER: (X4) Continued From page 58 CONTINUE CONSTRUCTION NUMBER: ID PROVIDERY NON STORECTION NUMBER: ID PROVIDERY NON STORECTION NUMBER: CONSTRUCTION NUMBER: (X4) (X4) Continued From page 58 CONTINUE CONSTRUCTION NUMBER: ID PROVIDERY NON STORECTION NUMBER: CONSTRUCTION STORECTION NUMBER: ID PROVIDERY NON STORECTION NUMBER: CONSTRUCTION NUMBER: <

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · ·		E CONSTRUCTION	COM	E SURVEY IPLETED
		245306	B. WING				C 27/2022
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	STER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	'	age 59 en chili rice, and Mexican corn.	F 8	12			
	During an observat C-C was taking ten coming out of the o pans on the steam steam table was co to keep the water h touch. On top of the lettuce and a separ tomatoes and onion a.m.); there was not the lettuce cool. C temperatures of the steam table lid. During an observat an unidentified nurs kitchen from the sm a hairnet, opened t unknown item, and door. During an interview stated she had not "cold" food items, o stated "we don't ch stated they [kitcher because it was colo the refrigerator. Wh make sure those ite by stating because not able to articulat maintained a safe t removed from the r	tion on 4/19/22, at 11:25 a.m. hperatures of food that was oven and placing the metal table. An unused area of the overed with a metal lid in order not; the lid was warm to the e lid was metal pan of chopped rate pan with chopped ns (items noted there at 11:15 b barrier or a pan of ice to keep C was not observed to take e "cold" items that were on the ion on 4/19/22, at 11:39 a.m. sing assistant (NA) entered the nall dinning room door without he refrigerator, removed then exited through the same of a taken temperatures of the cold food items temperatures, eck temps of cold foods". C-C n staff] did not check cold items d when they pulled them out of hen C-C was asked how to you ems stay cold, C-C responded the food was cold. C-C was ie how cold food items temperature once items were					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED
						1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
					,		C
		245306	B. WING	;		1	27/2022
NAME OF I	PROVIDER OR SUPPLIER	•		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH		
					ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	sitting on the steam	ge 60 nato/cheese) that had been n table cover. At 11:53 a.m. nds, removed shredded	F٤	812			
	cheese from refrige placed the pan on t the lettuce, and with lettuce and cheese C-C with the same of the tray cart, turn without performing plates. When C-C p which time her thun the plate. With the placed taco shells of scoop for the chicke chicken on the first pieces rolled outsid up the chicken with back into the shell. During an observat beverage cart in the no ice under the mi assistant (NA)-F wa of a pitcher with ung	nds, removed shredded erator, put into a metal pan, he steam table cover next to h the same gloves on put onto the tacos. At 11:58 a.m. gloves on touched the outside hed the cart around, and hand hygiene picked up clean bicked up 5 more plates during nb was touching the inside of same gloves on, C-C then boto those plates, used a en however, when she put plate some of the chicken le the taco shell, C-C picked her gloved hand and placed it ion on 4/19/22, at 11:56 a.m. e hallway was observed with lk or juices. A nursing as observed grabbing ice out gloved un-sanitized hands. 21/22 resident freezer in the					
	that was used by m un-sanitized hands. During an observat the following items unlabeled, and exp -opened and undate beverage cup locate with.	ion on 4/19/22, at 12:00 p.m. were noted to be undated, ired in the dinette freezer: ed bag of ice with a facility ed on bottom shelf to grab ice weled Devour sweet and tangy					

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245306	B. WING				C 27/2022
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHE	STER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	 -undated, unlabeled crunch bars and ica -unlabeled and ope ice cream dated 2/ -undated and labele burrito. During an observat at 12:02 p.m. dieta asked by surveyor "cold" items that co steam table lid and checked since rem DA-A stated lettuce was 73 degrees, an Despite the warm t items, they continu table lid until all me to the residents at a During an observat "ACT" condiments prior were no longe female nurse grabt freezer with un-san Shasta soda can fo cup, touched whee then touched reside refrigerator and the using wall mounted During an observat the following items unlabeled, and exp located in dinette a -opened and undat seasoning. 	d, opened box of ice cream e cream sandwiches. ened container of rocky road 16. ed "CAT" Cilantro and Lime tion and interview on 4/19/22, ry assistance (DA)-A was to take temperatures of the ontinued to be on top of the had not been temperature oval from the refrigerator. e was 75.0 degrees, tomatoes nd cheese was 59 degrees. emperatures for these food ed to be on top of the steam eals were plated and delivered approximately 12:40 p.m. found in refrigerator the day er found. An unidentified bed ice cubes out of dinette hitized bare hands; poured or R11 into a covered sippy Ichair arms to adjust resident, ent cup, then went back to en completed hand hygiene d hand sanitizer.	F	312			

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		AND HUMAN SERVICES				FORM	: 06/07/2022 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	`´CON	E SURVEY IPLETED C
		245306	B. WING				27/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	 popcorn. -opened, unlabeled popcorn oil with art by 11/21. -opened, unlabeled artificial butter flavor -opened and undat -opened and undat -opened and undat crackers; best if us -opened bottle of D spray. -opened and unlabe cleaner. -opened bottle of O During an observat footlong Subway sa Armor beverage loor refrigerator. During an observat kitchen on 4/20/22, remained unchange observed on the gr 2/10. Left side of g soiled with half inch aluminum foils shoil C-C stated previous task as cooks and e enough time in thei current CDM does all. C-C stated she struggle to survive dishwasher and he kitchen on most da enough help. C-C stated	l, undated, and uncapped ificial butter flavor; best if used l, undated popcorn oil with or; best if used by 3/21. ed pure vegetable oil. ed Nestle hot chocolate ed Great Value honey graham	F 8	:12			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 06/07/2022 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) ´CON	E SURVEY IPLETED
		245306	B. WING				27/2022
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODI		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	1	ige 63 m at the very latest.	F 8	12			
	NA-B walked into k did not perform har	ion on 4/20/22, at 8:42 a.m. itchen without a hairnet on and nd hygiene, grabbed an om steam table, and walked tem.					
	saran wrapped plat pickle for R11 was refrigerator; howeve piece chicken tende and Body Armor wa next to refrigerator. practical nurse (LP resident freezer wit	ion on 4/20/22, at 3:06 p.m. a re with tomato, lettuce, and found in the resident dinette er, it was undated. A three ers package from Kwik Trip as placed on the counter top At 3:08 p.m., a licensed N)-D grabbed ice from h un-sanitized gloved hands to er from medication cart.					
	facility plastic bever	ion on 4/21/22, at 9:34 a.m. a rage glass was observed ed ice cube bag inside resident					
	at 9:36 a.m. CDM of have not been clear expectation for these or more often if new are to change these complete on 4/18/2 discussion. A clean taped to kitchen ref blanks last dated in confirmed she was kitchen to ensure c	ion and interview on 4/21/22, confirmed grill grease trays ned yet. CDM stated her se to be cleaned once a week eded. CDM stated the cooks e and she asked C-C to 2 afternoon via verbal ing schedule was observed frigerator door with numerous a February 2022. CDM the manager in charge in the leaning schedule gets CDM confirmed dietary staff					

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		AND HUMAN SERVICES				FORM	: 06/07/2022 APPROVED . 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G	CON	E SURVEY IPLETED
		245306	B. WING	÷			C 27/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROCHES	STER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	check temperatures refrigerator/freezer, and dated, and che foods have not exp task to complete ar completed routinely log was taped to th CDM confirmed she was not getting con expressed concern spoilage, thawed fr temperatures which illnesses for resider following items four refrigerator/freezer: -kitchen sausage la should be in the kite refrigerator. -2 liter bottle of Mt. uncertain who this -2 liter bottle of Pep stated this should be -opened tart cherry -opened, undated, CDM confirmed sea resident it was used -opened, undated, bars. -opened, undated, sandwiches; 2 boxe -opened, undated, confirmed these we them out. -undated but labeled she's unable to idea a resident's or emp -opened Sara Lea	s of resident dinette ensure everything is labeled ck once a week to ensure ired. CDM stated this is her ad it has not been getting 7. A March 2022 temperature e outside of dinette freezer. e did not post a new one and it npleted twice a day. CDM potentially leading to food ozen foods, improper food a could lead to food borne nts. CDM confirmed the nd in the dinette the beled 4/18; CDM stated this chen and not in the resident Dew dated 2/10; CDM belongs to. bsi dated 3/15 for R2; CDM be thrown out. juice dated 2/16 for R24. unlabeled bottle of ensure; al was broken and which d for. unlabeled crunch ice cream es. unlabeled ice cream es. unlabeled popsicles; CDM ere freezer burnt and threw d, frozen pulled pork and soup d "CAT" burrito; CDM stated ntify "CAT" and uncertain if it's	F	812	2		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		0. 0938-039 TE SURVEY MPLETED
		245306	B. WING_		04	C /27/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ROCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETIC DATE
F 812		age 65 't be served to anyone."	F 8′	12		
	stated the kitchen i up with facility need in the "coffee room nursing staff use the freezer. CDM confi a sealed container that is not left in the not labeled, dated, was. CDM threw the confirmed staff sho gloves, a clean sco scoop inside of bag confirmed ice shou cart container whice ensure they are ke	on 4/21/22, at 10:05 a.m. CDM ice machine is unable to keep ds and the ice machine located " is not functional currently so he ice placed in the dinette irmed all ice should be kept in with an appropriate ice scoop e bag. CDM confirmed ice was closed, or unsure how old it he bag out immediately. CDM buld use hand hygiene, clean bop or glass, and not place the g between using. CDM Ild be used in their beverage th holds milk and juices to pt at appropriate temperatures.				
	at 10:19 a.m. ACT dinette kitchen is s activities uses it on used the popcorn r however, it remains ACT stated she us items located in po the popcorns expir other day" had wor date. ACT stated s seasonings need d but stated they wer confirmed vegetab powder, and graha undated, and expir	tion and interview on 4/21/22, stated the popcorn machine in eldom used and confirmed ace a month. ACT stated she machine "just the other day," is soiled and unsanitary today. es the expiration dates of food opcorn cabinet. ACT confirmed ation date she used "just the in off and was unable to identify he does not think popcorn late opened labeled on them, re considered opened. ACT le oils, hot chocolate cocoa im crackers were opened, ed. ACT opened unidentified er, sniffed it, and stated it was				

Facility ID: 00941

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		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST		215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	however, confirmed used and never che cabinet. ACT expre- staff using outdated confirmed cleaning should not be with r When interviewed of stated ice machine broken for a very lo kitchen is unable to During an observat environmental serv observed entering F unwashed hands pr item off of steam ta During an observat director of nursing (then backed out, ar where the hairnets surveyor where she surveyor said the si DON then asked C kept and found one personal staff lunch counter in kitchen u located next to stea putting away the we Sysco and was not date. Food tempera dinner on 4/20/21. (soiled with great ye	d she only checks items she ecked the entire popcorn essed concern of other facility d and expired foods. ACT supplies with chemicals resident food items. on 4/21/22, at 10:54 a.m. RN-A in "coffee room" has been ong time and the one in the o keep up with demand. ion on 4/21/22, at 11:37 a.m. ices manager (EVS)-A kitchen without hairnet and rior to grabbing an unidentified able. ion on 4/21/22, at 11:59 a.m. (DON) entered kitchen door, nd then rummaged through should be kept. DON asked e retrieved hairnet from and urvey team brings their own. DM where the hairnets are e to don on her head. A n bag observed sitting on underneath the bananas am table. DA-A observed eekly shipment of foods from dating items with received atures were not tempted for Grill tray observed very heavily it.	F 812			

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	COM	E SURVEY PLETED
		245306	B. WING	_			C 2 7/2022
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) Completion Date
F 812	When interviewed or registered dietician part of facility qualit improvement (QAP correction since the confirms CDM is su at 40 hours per wee salaried and does r worked. During an observat at 4:20 p.m. NA-E or without a hairnet or NA-E stated she wa told me I'm not sup without a hairnet." I between NA-E and to interrupt to do eo going to immediate door telling all staff hairnet. DON obser when she realized a their main door. A s Please put on a hai Kitchen!!!" Hairnets outside of the kitcher the kitchen. When interviewed of confirmed she has kitchen without hair told any staff this w could be loose hair dishware. When interviewed of confirmed kitchen wa	ige 67 on 4/21/22, at 12:56 p.m. (RD) stated kitchen has been y assurance and performance I) and part of their plan of a last state survey. RD upposed to be working full-time ek. RD confirms CDM is not have to report hours ion and interview on 4/21/22, observed entering kitchen completing hand hygiene. as unaware as "nobody ever posed to walk into kitchen DON overheard conversation surveyor and quickly wanted lucation. DON stated she was ly put up a sign on the kitchen to not enter kitchen without a rved starring at kitchen door a sign was already posted on sign observed stated, "Stop! rnet before Entering the a were not observed on the en but inside the doorway to on 4/21/21, at 4:26 p.m. CDM noticed nursing staff enter nets. CDM stated she has not eek. CDM expressed concern getting into resident foods on on 4/21/21, at 4:28 p.m. RD was cleaned on 3/28/22, by nager from a sister facility. RD CDM did not know this	F	312			

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	0938-039 E SURVEY PLETED
		245306	B. WING				C 27/2022
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 812	information and wh (one in the kitchen downstairs in the b kitchen was unsam week. RD expected staff wore hairnets performed hand hy for the opportunity staff to easily touch could potentially leas stated expectation food temperatures concern would be p foods being in the of would expect my C When interviewed stated she felt fortu- facility this week. R out as my staff cha present in the facility expressed she did	and one in the CDM office asement). RD confirmed the itary when she arrived this d her CDM to ensure facility in kitchen at all times and rgiene. RD expressed concern for hair to get in food and for n their hair and faces which ad to cross contamination. RD for dietary staff to check cold before severing as her cotential food poisoning and danger zone. RD stated, "I CDM to know all of this."	F	312			
	coached on being j assisting staff with communicating wit "blatantly lies to you was without dietary as CDM did not con sister facility. RD si RD confirmed anot without dietary staff called, no showed" McDonald's by acti she was in contact	d previously been verbally present in the kitchen and dietary duties and h her team. RD stated CDM ur face." RD confirmed facility v staff on 4/17/22 for breakfast nfirm a back-up plan with a tated CDM "dropped the ball." ther instance when facility was f as a new employee "no and residents were served vities director. RD confirmed with North Shore corporate panish educational materials					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT COM	0938-039 E SURVEY IPLETED C
		245306	B. WING	;			27/2022
	PROVIDER OR SUPPLIER	CES WEST		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 812	for current staff as reads Spanish. RD quizzes on education when completed. Fe basement where an was located. CDM additional freezer an basement. Freezer since 3/18/22. During an observation sign is posted on re "Please make sure dated!!!! Anything re 7 days old or older otherwise specified please see Jamie, temperatures were 4/22/22. No temper refrigerator/freezer noticed lack of tem CDM never assists usually is located in when she is at facil not use a translator pamphlets with C-C and speak Spanish During an observation undated and unlabour were observed sitti with only one donut tempting resident of on March 2022 tem morning. The facility policy ti 9/2017 indicated, a accordance with th	half of dietary speaks and confirmed dietary staff takes on and signs off on materials RD brought surveyor to nother freezer and dry storage failed to show surveyor the and dry storage located in the clacked temperature checks tion on 4/24/22, at 8:09 a.m. a erigerator door stating, call items are labeled and not labeled and dated and/or is will be thrown away, unless d. Any questions or concerns dietary manager." Freezer not completed in evening on ratures were obtained for s until C-D noticed surveyor pting. C-C and C-D confirmed dietary staff in kitchen and n downstairs basement office lity. C-C confirmed CDM did r or use Spanish educational C or DA-A who primarily read h. tion on 4/24/22, at 8:20 a.m. eled Cream Dream donuts ng on top dinette refrigerator t leftover. C-D observed linette refrigerator and freezer operature log for 4/24/22 tled Food: Preparation revised ll foods are prepared in	F	812			

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	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT CON	. 0938-039 E SURVEY IPLETED
		245306	B. WING				C 1 27/2022
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			5 HIGHWAY 52 NORTH CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 812	techniques and glo -Dining Services st preparation proced by potentially physic contamination. -The Dining Service responsible for foo minimize the amount exposed to temper F and/or less than regulation. -All foods will be here temperatures, great state regulation react than 41 degrees F -All TCS foods that 24 hours at a temp less, will be labeled date: (Day 1) and a The facility policy to indicated, all cannel inspected for dents cans will be segreg return to vendor or -All food items will dated either throug staff notation. The facility policy to revised 4/2018 indi be maintained at a or below, except du preparation and se -Freezer temperatu- temperature of 0 du -A written record of recorded.	we use. aff will be responsible for food lures that avoid contamination cal, biological, and chemical es Director/Cook(s) will be d preparation techniques which int of time that food items are atures greater than 41 degrees 135 degrees F, or per state eld at appropriate ater than 135 degrees F (or as quires) for hot holding, and less for cold food holding. t are to be held for more than erature of 41 degrees F or d and dated with a "prepared a "use by date" (Day 7). tled Receiving revised 9/2017 ed goods will be appropriately s, rust or bulges. Damaged gated and clearly identified for disposal, as appropriate. be appropriately labeled and h manufacturer packaging or tled Food Storage: Cold Foods icated, all perishable foods will temperature of 41 degrees F uring necessary periods of rvice. ures will be maintained at a	F 8	12			

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245306	B. WING				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	The facility policy ti revised 9/2017 indi separate/secured a -All chemicals will b containers. If chem container, the holdi labeled with the nai Safety Data Sheet The facility policy ti indicated, ice will be safe and sanitary m -Ice scoops will be separate container and moisture reten -Staff will adhere to gloved hands for ha -In the event of a m be purchased from stored in a manner temperature and pu The facility policy ti indicated, all staff m the shoulders, conf facial hair properly The facility policy ti indicated, all foodse sanitary, and in pro -All good contact even -All non-food conta free of debris. The facility policy ti 9/2017 indicated, a service areas, and maintained in a cle	tled Storage: Chemicals cated, all chemicals will be in a area. be retained in their original nicals are not in original ng container will be clearly me corresponding with the (SDS). tled Ice revised on 9/2017 e prepared and distributed in a nanner. cleaned and stored in a that limits exposure to dust tion. b proper utensil usage or clean andling. hechanical malfunction, ice will an approved vendor and that maintains proper revents cross contamination. tled Staff Attire revised 9/2017 nembers will have their hair off ined in a hair net or cap, and restrained. tled Equipment revised 9/2017 ervice equipment will be clean, per working order. quipment will be cleaned and	Fε	312			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM): 06/07/2022 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245306	B. WING			04	C / 27/2022
NAME OF F	PROVIDER OR SUPPLIER	•	·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			15 HIGHWAY 52 NORTH DCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	routine cleaning sc cooking equipment surfaces. -All food contact su sanitized after each The facility policy ti Foods from Visitors when food items ar consumption, the re- member will: -Ensure that the food distinguishable fror -Ensure that the food sprevent cross conta -Label foods with th current date. -Refrigerator/freeze brought in by visito and have temperat refrigeration less th and freezer less or monitoring for refrig discard of any food for greater than or frozen foods and sl retained for 30 day Hospice Services CFR(s): 483.70(o)(§483.70(o) Hospice §483.70(o)(1) A lor do either of the folle (i) Arrange for the p through an agreem Medicare-certified (ii) Not arrange for	hedule is in place for all the food storage areas, and infaces will be cleaned and in use. teld Food: Safe Handling for since revised 7/2019 indicated, reintended for later esponsible facility staff od is stored separate or easily in the facility food. are in a sealed container to amination. The resident name and the ers for storage of foods rs will be properly maintained ure monitored daily for than or equal to 41 degrees F equal to 0 degrees F. Daily gerated storage duration and litems that have been stored equal to 7 days. (Storage of thelf stable items may be s.) Cleaned weekly. (1)-(4) e services. torvision of hospice services tent with one or more	F8				6/2/22
		Obsolato Event ID: C IZE1			ity ID: 00941 If contin	uction choot	

Facility ID: 00941

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMF	E SURVEY PLETED
		245306	B. WING			04/2	C 27/2022
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, Z	IP CODE		
ROCHES	TER HEALTH SERVIC	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD E THE APPROPR	BE	(X5) COMPLETION DATE
F 849	a Medicare-certified resident in transferr arrange for the prov when a resident red §483.70(0)(2) If hos LTC facility through paragraph (0)(1)(i) of the LTC facility must requirements: (i) Ensure that the h professional standa to individuals provide to the timeliness of (ii) Have a written a that is signed by an the hospice and an the LTC facility befor any resident. The v at least the following (A) The services the (B) The hospice's re the appropriate hos in §418.112 (d) of th (C) The services the provide based on ea (D) A communication communication will LTC facility and the that the needs of th met 24 hours per da (E) A provision that notifies the hospice (1) A significant cha mental, social, or er (2) Clinical complica alter the plan of car	d hospice and assist the ring to a facility that will vision of hospice services quests a transfer. spice care is furnished in an an agreement as specified in of this section with a hospice, at meet the following hospice services meet and principles that apply ding services in the facility, and the services. greement with the hospice authorized representative of authorized representative of ore hospice care is furnished to written agreement must set out g: e hospice will provide. esponsibilities for determining spice plan of care as specified his chapter. e LTC facility will continue to ach resident's plan of care. on process, including how the be documented between the hospice provider, to ensure e resident are addressed and ay. the LTC facility immediately about the following: ange in the resident's physical, motional status. ations that suggest a need to	F 849				

Facility ID: 00941

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		AND HUMAN SERVICES			FORM): 06/07/2022 // APPROVED). 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245306	B. WING		04	C /27/2022
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STAT	E, ZIP CODE	
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN IX (EACH CORRECTIVE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 849	for any condition. (4) The resident's of (F) A provision stati- responsibility for de- course of hospice of determination to ch- provided. (G) An agreement fr- responsibility to fur- care, meet the resid- nursing needs in co- representative, and provided is appropri- resident's needs. (H) A delineation of including but not lim- direction and mana- counseling (includin- bereavement); soci- supplies, durable m- necessary for the p- associated with the conditions; and all on- necessary for the c- illness and related of (I) A provision that personnel are resp- of prescribed thera- determined approp- delineated in the ho- facility personnel m- where permitted by the LTC facility. (J) A provision stat- report all alleged vi- mistreatment, negle- and physical abuse-	leath. Ing that the hospice assumes termining the appropriate care, including the ange the level of services that it is the LTC facility's hish 24-hour room and board dent's personal care and bordination with the hospice ensure that the level of care riately based on the individual f the hospice's responsibilities, hited to, providing medical gement of the patient; nursing; ng spiritual, dietary, and al work; providing medical nedical equipment, and drugs alliation of pain and symptoms terminal illness and related other hospice services that are are of the resident's terminal conditions. when the LTC facility possible for the administration pies, including those therapies riate by the hospice and ospice plan of care, the LTC ay administer the therapies of State law and as specified by ing that the LTC facility must	F 8	349		

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245306	B. WING			04	C /27/2022
NAME OF I	PROVIDER OR SUPPLIER	-		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			5 HIGHWAY 52 NORTH CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 849	Continued From pa	age 75	F 8	49			
	becomes aware of (K) A delineation of hospice and the LT	nel, to the hospice ediately when the LTC facility the alleged violation. If the responsibilities of the C facility to provide ces to LTC facility staff.					
	provision of hospic agreement must de facility's interdiscip for working with ho coordinate care to LTC facility staff an interdisciplinary tea clinical background scope of practice a assess the residen	n LTC facility arranging for the e care under a written esignate a member of the linary team who is responsible spice representatives to the resident provided by the ad hospice staff. The am member must have a d, function within their State act, and have the ability to t or have access to someone and capabilities to assess the					
	The designated int responsible for the (i) Collaborating w and coordinating L the hospice care p residents receiving (ii) Communicating and other healthca	ith hospice representatives TC facility staff participation in lanning process for those these services. with hospice representatives re providers participating in the					
	conditions, and oth of care for the patie (iii) Ensuring that t with the hospice m attending physiciar participating in the as needed to coord	or the terminal illness, related er conditions, to ensure quality ent and family. he LTC facility communicates edical director, the patient's n, and other practitioners provision of care to the patient dinate the hospice care with the ded by other physicians.					

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		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
		245306	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, 2	-	
ROCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 849	hospice: (A) The most rece to each patient. (B) Hospice election (C) Physician certing the terminal illness (D) Names and com- personnel involved patient. (E) Instructions on 24-hour on-call systems (F) Hospice medice each patient. (G) Hospice physice any) orders specified (v) Ensuring that the orientation in the per- facility, including para and record keeping furnishing care to L §483.70(o)(4) Each care under a writtener each resident's writtener the most recent hordes facility to attain or re- practicable physical well-being, as requiration This REQUIREMEN by: Based on observare review, the facility for the spin schedule for provides Second Second Seco	nt hospice plan of care specific on form. fication and recertification of specific to each patient. intact information for hospice in hospice care of each how to access the hospice's tem. ation information specific to cian and attending physician (if c to each patient. e LTC facility staff provides olicies and procedures of the atient rights, appropriate forms, g requirements, to hospice staff TC residents. h LTC facility providing hospice n agreement must ensure that then plan of care includes both spice plan of care and a ervices furnished by the LTC naintain the resident's highest al, mental, and psychosocial ired at §483.24. NT is not met as evidenced tion, interview, and document ailed to coordinate services of and the hospice agency by ce plan of care or the hospice ing services to ensure e for 1 of 1 resident (R24)	F 84	49 F 849 R 24 has discontinued s hospice effective 5/19/2 Residents who are rece services have the poten by the alleged practice. reviewed and updated if residents currently enro	022. iving hospice tial to be impacted Care plans were findicated for	
FORM CMS-24	567(02-99) Previous Versions	Obsolete Event ID:CJZE1		Facility ID: 00941	If continuation sheet P	

Facility ID: 00941

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245306				(
	PROVIDER OR SUPPLIER	245506	D. WING.		TREET ADDRESS, CITY, STATE, ZIP CODE	04/2	27/2022
	STER HEALTH SERVI	CES WEST		22	215 HIGHWAY 52 NORTH OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 849	Findings include: R24's significant ch (MDS) dated 4/8/22 with diagnoses incl anxiety disorder, co chronic obstructive acute and chronic r pulmonary embolis and chronic pain sy extensive assistant dressing, toilet use transfers with med R24's Order Summ indicated R24 adm 4/5/22. R24's hard medica hospice signed cor handwritten doctor ¹ R24's care plan da illness utilizing hos individualized interv to care for R24's te had not obtained th hospice schedule co During an observat at 5:35 p.m. R24 st scheduled for a vis notify her of resche hospice schedule co When interviewed of licensed practical m no idea if R24 had	hange Minimum Data Set 2, included cognitively intact uding schizoaffective disorder, ongested heart failure (CHF), pulmonary disease (COPD), respiratory failure, asthma, im, obstructive sleep apnea, yndrome. R24 required ce from staff for bed mobility, , personal hygiene, and hanical lift. hary Report dated 4/25/22, itted to hospice services on I chart only contained original hsent form on 4/1/22 and 's orders on 4/6/22. ted 4/1/22, identified terminal pice services. There were no ventions to direct staff on how erminal condition. The facility he hospice plan of care or of visits for continuity of care. tion and interview on 4/18/22, tated the hospice nurse was it today, but did not show up or eduling. R24's room lacked any	F8	49	services. The director of nursing or designed provided education to the interdisci team on the need to include care a services being provided by hospice 05/18/2022 and presented education the licensed nurses and nursing assistants on hospice services beg 05/18/22. The Director of Nursing or designed complete audits of hospice care plat facility care plans weekly for four we validate the documents contain continformation. Audits will be initiated week of May 23, 2022. Results of will be submitted to the facility qual committee for review and recommendations.	plinary nd on to pn to pinning e will ans and reeks to nsistent the audits	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245306	B. WING	_			C 27/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 849	a pool agency nurse When interviewed of stated R24 did not I binder (which is nor station and contains and any pertinent in need such as emer and the only hospic the hard medical ch on hospice the begi control. LPN-A state social worker, and r during the day but w they did for R24 oth When interviewed of LPN-C stated she w hospice binder. LPN come one to two tin was involved, and h when they were her would hope they ha When interviewed of registered nurse (R for pain manageme aide comes to facilii cares. RN-A was ur hospice aide compl were supposed to of During an observati at 2:37 a.m. LPN-A hospice binder. Bin correct spot in nurs	e so I don't need to know that." on 4/20/22, at 2:54 p.m. LPN-A have a hospice three ringed 'mally kept at the nurses is hospice care plan, schedule iformation the facility may gency contact for hospice) e information was located in hart. LPN-A stated R24 started inning of April 2022 for pain ed a nurse comes, licensed hursing assistants come vas unable to articulate what her than pain control. on 4/20/22, at 3:00 p.m. vas unsure if R24 had a N-C stated hospice nurses nes a week, music therapy hospice only let staff know re on site. LPN-C stated, "I ve a nursing assistant come." on 4/21/22, at 10:59 a.m. N)-A stated R24 has hospice ent. RN-A stated a hospice ty, but R24 sometimes refuses hable to articulate what eted for R24 or when they	F	349			

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DEPARTMENT OF HEALTH				FORM	06/07/2022 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
	245306	B. WING			C 27/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER HEALTH SERVIC	SES WEST		2215 HIGHWAY 52 NORTH		
Kooneoren neken oekois			ROCHESTER, MN 55901		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
 with resident name, home, or code statu blank, POLST is bla no aide plan of care not filled out, no doo no interdisciplinary on social worker (SW notes, no therapy no additional nursing no was first completed identifying she visite 4/22/22. The only nu 4/20/22. When interviewed o nursing assistant (N spend time with R24 does for R24, NA-B have to ask them yo specify when hospice aide comes shower R24. When interviewed o hospice RN-F stated control and anxiety f hospice SW came or motorized scooter. Fincreased nursing vito three times a wee music therapy. RN-F someone to be with and someone to do untangled. RN-F stated for the hospice three-rin initiated one on 4/22 informed her R24 does for R24 does 	basice patient (not filled out hospice diagnosis, funeral is), your hospice team is ink, no hospice plan of care, admission doctor's orders ctor's orders, no medications, group report, no aide notes, W) notes, no chaplain visit otes, and no continuous care otes. Hospice visit calendar on 4/20/22 by hospice nurse ed and will be back on urses notes found were from MA)-B stated hospice will 4. When asked what hospice stated, "I don't know; you will ourself." NA-B could not be comes other than stated a sonce or twice a week to an 4/22/22, at 1:30 p.m. d they are focusing on pain for R24. RN-F stated the but on 4/21/22 to address her RN-F stated hospice isits to twice a week, an aide ek, bathing once a week, and F stated R24 really just wants her to speak to, read to her,	F 84			

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
	245306	B. WING)			C 27/2022
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER HEALTH SERVIC	SES WEST		2	2215 HIGHWAY 52 NORTH		
Roonester nearth service				ROCHESTER, MN 55901		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 hospice binder to loc communication. When interviewed of stated that hospice of and herself. DON ex- nurses for not know plan of care for R24 the hospice binder winumbers to call in car plan of care, to proviand schedule for ear that planned on com- care to R24, and a co- binder so facility stat The facility policy title Requirements dated and the facility will co- when any changes a care. The hospice and the the other's responsi- plan of care. When a facility resi- Medicare hospice bo- nursing home must agree upon a coordi- providers which refe- and is based on an needs and unique life -The facility and the performing each of the have been agreed u- of care. The hospice 	 each visit and uses the ok at past notes for on 4/25/22, at 11:05 a.m. DON emails social worker (SW) emails at the social emails the social emails in the social emails the social emails in the social emails the social social emails in the social emails the social emails with each other are indicated to the plan of the emails in the social emails the social emails the social emails the social emails the social emails emails the social emails that upon and included in the plan emails the social emails to the emails the social emails the social emails to the social emails to the emails to the	F	849			

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		AND HUMAN SERVICES				FORM	APPROVED
	CARE MEDICARE	& MEDICAID SERVICES	(X2) MUI	TIP			0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
							C
		245306	B. WING			04/	27/2022
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVIO	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 880 SS=K	Infection Preventior CFR(s): 483.80(a)(F٤	380			6/2/22
	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es	tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable					
	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment og to §483.70(e) and following					
	procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pro-	eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; solation should be used for a					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245306	B. WING				C 2 7/2022
NAME OF I	PROVIDER OR SUPPLIER	-	_		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	 (A) The type and didepending upon the involved, and (B) A requirement to least restrictive post circumstances. (v) The circumstant ended isease or infected contact with resider contact with resider contact with resider contact will transmit (vi)The hand hygies by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual in The facility will contact the facility will contact with resider the corrective actions to infection. §483.80(f) Annual in The facility will contact for the facility will contact with resider the corrective actions to infection. §483.80(f) Annual in The facility factor and update the facility factor and spread of an unactive the factor and spread of	uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct t the disease; and he procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of	F	380	Attachments added F 880 R 82 and R27 recovered from GI i and have been discharged to hom survey exit. R1, R9, R13, R15, R1 R20, R21, and R26 were placed o transmission-based precautions a remained on precautions until pres treatment was completed if indicat when symptoms had resolved. Ide residents have since recovered.	e since 8, R19, n nd scribed red and	

Facility ID: 00941

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TATEMEN	OF DEFICIENCIES OF CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245306	B. WING			04/2) 27/2022
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 880	following care of sy this vulnerable pop care workers at risk the facility failed to passing ice water to and a cup inside wi the potential to affe residing in the facili The immediate jeop when the facility fai procedures were in and symptoms of G spread of unknown on 4/22/22. The ac nursing (DON) were at 1:31 p.m. The IJ 1:07 p.m. when the with symptoms of G transmission-based place. All residents illness, the physicia procedures were re educated, high touc tracking was starte audits of handwash the non-compliance and severity of an F severity level, which potential for more t immediate jeopardy Findings include: When interviewed of director of nursing s illness in the facility	mptomatic residents, placing ulation of residents and health c of serious illness. Further, use sanitary practices when o residents, using bare hands ith the ice to scoop, this had oct all 28 residents currently ity. pardy (IJ) began on 4/12/22 led to ensure infection control nplemented related to signs G illness to reduce the risk of GI illness and was identified dministrator and director of e notified of the IJ on 4/22/22, was removed on 4/27/22 at facility ensured all residents G illness were placed on d precautions with signage in s were screened for signs of GI an was notified, policies and eviewed, all staff were ch areas were disinfected, d for employee call in's, and ning were started. However, e remained at the lower scope - widespread scope and h indicated no actual harm with han minimal harm that is not	Fε	380	Residents who reside in the facility the potential to be impacted by the practices. Residents were monitore symptoms of GI illness once the out was identified. Residents who dever symptoms of GI illness were review the interdisciplinary team transmission-based precautions/co and isolation, environmental and she equipment management, hand hyg PPE use, and tracking and trending infections The facility has retained a consultation services of the corpora Director of Education, an RN who h infection preventionist certification. consultant will work with the facility infection control practices including transmission-based precautions/co and isolation, environmental and she equipment management, hand hyg PPE use, and tracking and trending infections. The consultant will assis leadership team in completing root analysis for the deficiencies cited. F of RCA will be shared with the Qua Assurance committee for review ar recommendations. The consultant RN, Infection Preventionist, will provide education Director of Nursing and interdiscipli team on infection control practices including transmission-based precautions/cohorting and isolation environmental and shared equipment management, hand hygiene, PPE us and tracking and trending of infection week of May 23, 2022. The Directon Nursing or designated certified Infe	alleged ed for tbreak loped ved by horting hared iene, g of the ate has The on horting hared iene, g of t the cause Results lity hd n to the nary	

Facility ID: 00941

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′			(X3) DATE	0938-039 SURVEY PLETED	
						C	2	
		245306	B. WING			04/2	27/2022	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	STER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH COCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) Completio Date	
F 880	Continued From pa	age 84	F 8	80				
	medical director. O R9, but canceled be and they determine constipation. Anoth pending. Some sta symptoms, but did symptoms were go which staff had bee they had a noroviru is highly contagious confirmation of that anyone who had or precautions and an immediately. Staff gloves in any symp they placed the res protection," which r supposed to use so hands after any car R82's admission M 4/13/22, identified r impairment, with di dementia. R82 requ toileting and was fr R82's care plan da gastro-intestinal illn Clostridium Difficile the colon caused b difficile, often result healthy bacteria in antibiotics. C. Diff of person to person b killed by hand sanit	t. The DON stated they put the to two loose stools on ayone who had an emesis were to wear gowns and tomatic resident room. Also, idents on, "enhanced barrier meant staff were also bap and water for washing res rather than hand sanitizer.			interdepartmental staff members wh enter resident rooms on transmission-based precautions/coh and isolation, environmental and sh equipment management, hand hygi and PPE use the week of May 23, 2 Competency audits will be repeated during this training and a posttest completed to validate staff understa of topics covered. Education and competencies were presented to the staff members during the extended as well and completed by April 27, 2 The Director of Nursing or a certifier Infection Preventionist or assigned licensed nurse will complete hand h and PPE compliance each shift for s days beginning May 20, 2022, and t three times weekly until full complian reached. The Director of Nursing or designee will complete audits of clear of environment and of shared equip four times a week on each shift beg May 20, 2022, and then three times weekly on various shifts until full compliance is reached. Audits of infections will be completed as per r during morning clinical meetings Monday-Friday. Audits of compliance surveillance measures will be comp twice weekly by a certified infection preventionist or the Director of Nurs until compliance is reached. Results audits will be submitted to the facility Quality Assurance Committee for re and recommendations.	norting ared ene, 2022. Inding ese survey 2022. d ygiene seven hen nce is aning ment inning routine se with leted s of y		

TATEMEN	FOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	0938-039 E SURVEY PLETED
		245306	B. WING				C 27/2022
	PROVIDER OR SUPPLIER			22	TREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHWAY 52 NORTH OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 880	signs of dehydratio staff on contact pre- soap and water for hand sanitizer and cleaning room or d the spread of infect R82's medication a 4/15/22, identified for cdiff." R82's bowel record loose stools, up to admission on 4/6/2 The facility GI illnes but did not identify indicated, "Ongoing had R82 listed as b During observation door was closed at indicating, "enhand instructed to staff to picture of a bottle of gloves and gown. / on top of the cart at During observation entered R82's room not put on gown or on R82's over-bed moved the table to on the tray table. No off and left the room hygiene. NA-B place	 an. The care plan did not direct ecautions or direct them to use hand washing rather than did not give any direction on edicating equipment to prevent tion. administration record dated "enhanced barrier precautions a showed she had frequent several times per day since 22. as tracking log identified R82, the start date of loose stool, it g," only. The map of GI illness being, "C. Diff." and 4/19/22, at 4:10 p.m. R82's not there was a sign on the door sed barrier precautions," and o clean hands and there was of hand sanitizer on it, use of A bottle of hand sanitizer was ind some disinfectant wipes. an on 4/20/22, at 8:20 a.m. NA-B n with a meal tray. NA-B did gloves. NA-B set the meal tray table and with bare hands wards R82 and arranged items IA-B then took the plate cover m without performing any hand ced the plate cover on the tray ed to move the cart down the 	Fε	880			

Facility ID: 00941

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						APPROVED
CENTERS FOR MEDICARE & ME	DICAID SERVICES	(X2) MUI	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	ENTIFICATION NUMBER:					PLETED
						C
	245306	B. WING			04/2	27/2022
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHWAY 52 NORTH		
ROCHESTER HEALTH SERVICES W	EST			ROCHESTER, MN 55901		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880 Continued From page 86 NA-B stated she had beer and gloves if she was wor and did not wash her hand hurry. NA-B stated she sh sanitizer and was unaward removed by using hand sa washing with soap and wa instead. When interviewed on 4/20 environmental services su hand sanitizer should be u resident room and after le case of C. dif, EVS-A state any difference, stating, "w sanitizer, it is quicker." EV control education had bee facility, but did not recall ro specific related to washing water in the case of C. dif When interviewed on 4/20 licensed practical nurse (I residents such as R82 wh resident should have sepa equipment, staff should us hands should be washed instead of hand sanitizer. should be using hand was water for any residents wi symptoms. LPN-A was no indicated hand sanitizer w During observation on 4/2 occupational therapist (O assisting R82 to the bathr incontinent loose stool and and gloves assisted R82 v completed OT-A placed th	rking with, "body fluids," ds due to being in a hould have used hand e C. Diff spores are not anitizer and hand ater should be used 0/22, at 9:38 a.m. the upervisor (EVS)-A stated used before going into a eaving the room. In the red she was not aware of <i>v</i> e typically use hand /S-A stated infection en provided at the receiving anything g hands with soap and f. or Rotavirus. 0/22, a 9:46 a.m. LPN)-A stated, for no had C. Diff, the arate dedicated se gown and gloves and with soap and water LPN-A stated staff shing with soap and ith vomiting or diarrhea of sure why the TBP sign vas to be used for R82. 21/22, at 10:50 a.m. T)-A was observed room, R82 had an d OT-A wearing gown with cleaning up, when	Fε	380			

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TATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245306	B. WING				C /27/2022	
	PROVIDER OR SUPPLIER	CES WEST		2215	EET ADDRESS, CITY, STATE, ZIP CODE 5 HIGHWAY 52 NORTH CHESTER, MN 55901	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 880	OT-A removed her room with a tablet, used hand sanitize stated R82 had an type of infection. O Diff and hand wash hand sanitizer. OT- after it had been in OT-A with contamin this time, R82 shar adjacent room. When interviewed registered nurse (F what type of transm (TBP) a resident re posted on their door should use soap an of alcohol based sa person with C. dif, information was por knew that. After ch finding such inform going to post a sign When interviewed director of nursing gastro-intestinal (G the past week, but it to be an outbreak cases of diarrhea in physicians and nur notified, but said th but DON stated in have been hyper-v received orders for had been unable to	gloves and gown and left the OT-A set the tablet down and r. When interviewed, OT-A infection, but was unsure what T-A did not know R82 had C. hing should be used instead of A had not sanitized her tablet R82's room and touched by nated hands. It was noted at red a bathroom with R15 in an on 4/21/22, 10:59 a.m. a RN)-C stated staff would know hission based precautions equired if infectious by the sign or. RN-C also said that staff ind water hand washing instead anitizer when working with a but was unsure it that usted on the door, or how staff ecking R82's door, and not hation, RN-C stated he was in immediately. on 4/21/22, 11:30 a.m. the stated there had been some an infections in the facility over normally they did not consider a until they had three or more in residents. DON said the se practitioners (NP) had been hey, "didn't think anything of it," her past experience they would igilant. Three residents had i testing, but DON said they o gather a sample for one rders for another had been	F 8	80				

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MUL		LE CONSTRUCTION		0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
							C
		245306	B. WING			04/2	27/2022
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST			ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	was positive for C. I GI outbreak, reside monitored, signs re and personal protect supplies would be p said she was unsur about using soap at sanitizer in the case not posted a sign, b between 9:30 a.m. go post the sign rigi going to start PPE a said R15 and R26 h GI illness, and she barrier precautions was going to talk wi "strongly encourage and any residents v DON said R15's FN shared with R82, bu sign on the door or R27's admission Mi cognitively intact an diabetes. R27 requi toileting and was co R27 was not shown tracking log. R27's medical reco watery stools and e been placed on TBI 4/14/22. When interviewed of	Dif. DON said in the case of a nts with symptoms would be garding TBP would be posted, clive equipment (PPE) blaced outside the room. DON e if there was a sign posted nd water instead of hand e of C. Dif. DON said she had but had started educating staff and 10:00 a.m. and she would ht away. DON said she was and handwashing audits. DON had developed symptoms of had placed them in "enhanced and droplet precautions" and th the medial providers and e" testing to be done on them, who developed GI symptoms. A should not use the bathroom ut was unsure if there was a in the bathroom. DS dated 3/28/22, identified id had heart disease and irred limited assistance with ontinent of bowel. a on the facility GI illness rd identified R27 had loose mesis on 4/12/22, and had P, which were removed on	F 8	880			
	4/14/22. When interviewed of stated he had gotte						

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUI	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(C
		245306	B. WING			04/2	27/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE		
		,			DEFICIENCY)		
F 000		22					
F 880	Continued From pa	ge 89	F8	80			
	When interviewed of	on 4/22/22, at 10:19 a.m. the					
	DON stated a stool	collection order was not					
		they only had vomiting and ON was not aware R27					
		se stools along with the					
	vomiting on 4/12/22	<u>)</u>					
	During an observat	ion and interview on 4/22/22,					
	at 10:31 a.m. RN-C	was observed leaving R27's					
		ed going from room to room on					
		ng vital signs on each resident. ng hand sanitizer outside each					
	resident room inste	ad of hand washing. RN-C					
		anitizing thermometer and					
		ipment between resident use. build have disinfected the					
	equipment betweer	each resident and used soap					
	and water for hand	washing.					
		ated 4/1/22, identified					
		th diagnosis of heart disease. ive assistance to toilet and					
	was frequently inco						
	D4la harrada a and i	den tit og det en					
		dentified loose stools as early iple daily loose stools starting					
	on 4/12/22.	ipie daily loose stoole starting					
	D1's care plan deta	d 1/22/22 identified a					
		d 4/22/22, identified a ess related to C. diff and					
	Rotavirus, staff wer	e to educate on signs and					
		tbreak, frequent handwashing					
		tay in room along with contact monitor for signs of					
	dehydration. The ca	are plan also directed to use					
	soap and water for	hand washing.					

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		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COM	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	infections as being GI illness symptom did not have a room was sent on 4/23/2 identified R1 as sta with the word, "aga been sent and was pathogen. R1's Clinical Comm identified they had u 4/23/22, and the sto Diff and directed fa and provide proper and a report was se Vancomycin (antibio ordered. R1's progress note included, "Call rece clinic with lab result tested and resulted Rotavirus and C-dif [physician] gave tel 125 mg to start with sending enough me to be started tomor When interviewed of stated R1 had deve previous evening, a private room. Testir immediately and re had Rotavirus and were to isolate the b	n the facility map of GI in one room but moved due to s to another room where she n mate and a stool specimen 2. The line listing of GI illness rting symptoms on 4/20/222, in." A stool specimen had back, with no information on nunication from Mayo Clinic lab received a stool specimen on bol contained Rotavirus and C. cility to place R1 on isolation infection control processes ent to community heath. otic used to treat C. Diff) was dated 4/23/22, at 10:42 p.m. tived from [physician] from ts for resident. Stool was with positive results for f. Pharmacy notified, as ephone order for Vancomycin nin 24 hrs. Pharmacy will be ed through back up pharmacy	F 88			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245306	B. WING	-			C 27/2022
NAME OF F	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 91	F٤	380			
	cognitively intact an bowel syndrome wir required extensive a was always contine R20's bowel and bla 2022 identified loos had two loose incor again on 4/21/22. R the DON had been R20 was placed on precautions (TBP). R20 was identified of tracking log as start The map of GI illne Rotavirus and GI sy R20's Clinical Com identified a stool sa the lab on 4/22/22, identified Rotavirus causes diarrhea, vo abdominal pain and even death). The co health would need to contagious virus. A	adder elimination log for April e stools starting on 4/14/22, ntinent stools on 4/15/22 and 20's progress notes identified notified of loose stools and transmission-based on the facility GI illness ting symptoms on 4/21/22. ss's identified R20 as having ymptoms. munication from Mayo Clinic mple had been obtained by and on 4/25/22 the specimen (a very contagious virus that omiting, fever and/or d can lead to dehydration or ommunication identified public to be notified of this nurse practitioner note dated fied R20's stool sample was					
	nursing assistant (N arranged items on t gloves and left the r NA-A touched R20's mechanical lift in th	on 4/22/22, at 9:50 a.m. NA)-B was in R20's room and the bedside stand, removed room without washing hands. s door handle, then went to a e hallway and brought it to the Iway. NA-A then went into R3's					

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245306	B. WING _		04	C I/27/2022
	PROVIDER OR SUPPLIER	CES WEST		STREET ADDRESS, CITY, STATE, ZIP 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 880	room and went into washed her hands door handle or the contaminated hand During observation medical doctor (MI assisted R20 with f room he used hand According to the C (CDC) updated 202 and water is most of Rotavirus from har MD-C used his per backpack then use shirt pocket and pr donned gloves with and water and assi interviewed on 4/22 stated staff had ins at door, but did not residents who were he would have use sanitizer. During observation attempted to bring R20 whose room is regional nurse con she could not take another without usi During observation health unit coordina door, donned perso (PPE) and entered	o the bathroom where she NA-A did not disinfect the lift after touching with		30		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
						С	
		245306	B. WING			04/	27/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHE	ROCHESTER HEALTH SERVICES WEST				ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	punched a code intrused the door hand then washed her ha code buttons or the touched with potent The facility provided R20 as having GI s tracking log identifie symptoms on 4/21// were noted prior to R18's significant ch identified cognitively multiple sclerosis. F assistance with toild incontinent of stool. R18's bowel record on 4/14/22. R18's m had been placed or removed on 4/18/22 A progress note ide R18's physician on loose stools again, started again. R18 was identified starting symptoms of During an observat new isolation cart w room. During an observat R18 was observed	o the utility room door and lle to open the door. The HUC ands, but did not disinfect the door handle that she had tially contaminated hands. d room tracking log identified ymptoms, and the GI illness ed R20 as beginning 22, even though loose stools that date. ange MDS dated 2/24/22, y intact with diagnosis of R18 required extensive eting and was frequently identified loose watery stools nedical record identified she n TBP on 4/16/22, but was 2. entified a note was sent to 4/22/22 indicating she had so isolation precautions were on the facility GI illness log as	F	380			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					1 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		245306	B. WING			C 04/27/2022	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BOOLES				2	2215 HIGHWAY 52 NORTH		
RUCHES	TER HEALTH SERVIC	JES WEST		F	ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG F 880	Continued From pa asked R18, "What's redirection to R18 to Family member (FM another resident roo redirected R18 to ge donned PPE and as During an observati R18 was observed help to get to the ba medication cart; wh to assist. FM-A requ however, DON told stated she couldn't R19's quarterly MD cognitively intact wit prostate cancer. R1 assistance for toilet of bowel. When interviewed of stated he had becom starting 4/16/22. R1 his diarrhea and ha his bedding as he w stools. R19 stated H 4/18/22 in the event much dinner. R19 s placed on any time out to eat Easter lur unable to eat as he R19's bowel elimina identified regularly f then had incontinen movements after 4/	Ige 94 s up?" and did not provide o go back into her room. M)-A was observed leaving om on north hallway and o back into her room. FM-A ssisted R18 back to room. ion on 4/24/22, at 8:54 a.m. back in hallway requesting athroom. LPN-A observed at ille FM-A ran down the hallway uested help from DON; FM-A to, "hold on." R18 wait. S dated 2/25/22, identified th diagnosis of diabetes and 19 required extensive ting and was always continent on 4/19/22, at 11:35 a.m. R19 me ill with severed diarrhea 19 stated staff were aware of d placed incontinent pads on vas unable to control the loose he had started to feel better on ing, but was still unable to eat stated he had never been of precautions and he went nch on 4/19/22, but was still felt ill. ation record for April 2022, formed stools until 4/16/22, it watery/diarrhea bowel /16/22.	F 8		DEFICIENCY)		
	movements after 4/						

Facility ID: 00941

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245306	B. WING				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH OCHESTER, MN 55901		
		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(1)(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	¢	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	Continue d Ereman	0E					
F 00U	Continued From pa	diarrhea, nor did R19's	F 88	80			
		w any evidence the physician					
		f the illness or any monitoring					
	When interviewed of	on 4/22/22, at 10:19 a.m. the					
		confirmed she was aware R19					
		6/22 as she worked an N failed to inform medical					
		testinal symptoms. DON					
		never placed on isolation					
		s symptoms still existed on sample had been sent to the					
	lab.						
	A facility provided n	nap of GI illness symptoms,					
		several residents who had GI					
		s not identified as having any					
		ting of residents who had been dated 4/24/22, also did not					
	identify R19.						
		S dated 3/26/22, identified					
		th diagnosis of heart failure.					
		sive assistance with toileting incontinent of bowel.					
	D26 was identified.	on the facility CL illnoop					
		on the facility GI illness inning GI symptoms on					
	4/21/22. The map of	of illness showed she had GI					
	symptoms.						
	R26 has 2 loose sto	ools on 4/19/22, 4/20 had one					
		4/21 had 7 loose stools, was					
	put on isolation the	21St.					
		ion on 4/21/22, 10:29 a.m. her door indicating the need					

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		AND HUMAN SERVICES			FOR	D: 06/07/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245306	B. WING		04	C /27/2022
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ROCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH		
Roonice				ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 880	open and R26 was obvious symptoms R26's bowel record on a regular basis, frequency on 4/21/2 R26's clinical commidentified R15's stor on 4/22/22, and wa and community hea R15's admission M cognitively intact, re- with toileting, and w bowel and had a dia Chrohn's disease of disease. R15's bowel record having loose stools orders dated 4/24/2 collect a stool spec The facility GI illness date of symptoms a infections identified During an observat was noted R15 sha had been placed or Family member (FM not wearing a gown overheard on the pl case of, "stomach f	 ions," but the door was wide sleeping without cough or of respiratory disease noted. I showed R26 had loose stools but had an increase in 22. nunication from Mayo clinic ol sample had been obtained s identified to be Rotavirus alth was to be advised. DS dated 2/24/22, identified equired extensive assistance vas frequently incontinent of agnosis of ulcerative colitis, r an inflammatory bowel I showed she had started on 4/16/22. R15's physician 22, identified staff were to imen for diarrhea over 7 days. as tracking log identified a start as 4/20/22. The map of her as having a GI illness. ion on 4/21/22, at 10:49 a.m. it ired a bathroom with R82 who in precautions for GI illness. M)-C was visiting R15, but was in gloves or mask. He was hone to not visit as R15 had a du." FM-C went into the shared 	F 88			
	overheard on the pl case of, "stomach f to the bathroom. FN	hone to not visit as R15 had a				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILL	JING	i	C	
		245306	B. WING			04/	27/2022
NAME OF	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHE	ROCHESTER HEALTH SERVICES WEST				2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	illness and also R83 should not enter wit gloves. FM-C stated way down the hall to unconsumed bever bathroom to dispos been told he should stated there was not bathroom regarding handwashing. R15's progress not identified R15 had of have been going ar R13's quarterly MD cognitively intact wi required extensive frequently incontine R13 was identified that he had develop on isolation on 4/21 R9's quarterly MDS cognitively intact wi cerebral palsy. R9 r with toileting and wa A progress note dat indicated R9 had for started at 7:15 a.m. documented R9 su and threw up withou small, hard bowel n enema at this time.	2's illness. FM-C said persons thout wearing a gown and d it was too far to walk all the o dump things such as ages, so he had gone in the e of them. He said he had d not use the bathroom. He o posted information in the g use of the toilet or e dated 4/22/22, at 8:45 a.m. developed, "GI symptoms that ound the facility." S dated 4/21/22, identified th diagnosis of a stroke. R13 assistance to toilet and was ent of stool. on the GI illness tracking log bed symptoms and was placed //22. G dated 2/10/22, included th diagnoses including required extensive assistance as always continent of bowel. ted 4/12/22, at 1:29 p.m. our episodes of emesis which . Registered nurse (RN)-A ddenly awoke this morning ut no warning. R9 had one novement but has refused RN-A documented there were idents with symptoms on	F	380			

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				<u> 2MB NO. 0938-0391</u>		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		LE CONSTRUCTION		E SURVEY PLETED	
			A. DOILL		,	с		
		245306	B. WING	;		04/27/2022		
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ROCHES	STER HEALTH SERVI	CES WEST			2215 HIGHWAY 52 NORTH			
					ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ge 98	F٤	880				
	indicated R9 request for evaluation as sh stated she felt weal discomfort. R9 refut 4:50 p.m., R9 return An emergency depa 1:47 p.m. indicated constipation; howev vomiting resolved w fleets enema offere since her abdomina A progress note dat indicated R9 had tw stools which was ref (DON). At 10:09 p.r diarrhea. On 4/17/2 practical nurse (LPI emesis or loose sto were resolved. When interviewed of stated she became gastrointestinal sign and diarrhea. R9 st coming out both en stated she requeste emergency departm other resident's dow similar gastrointesti was sick all week w diarrhea and could not feel well. R9 sta	artment note dated 4/13/22, at R9 was likely to have ver, abdominal pain and vithout further intervention. A d to R9, but she declined						
		outside R9's room was not and no door signs were						

Facility ID: 00941

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES						APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>SMB</u>	NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3	COM	E SURVEY PLETED
		245306	B. WING				(04/2	27/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	STER HEALTH SERVIC	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	Ē	(X5) COMPLETION DATE
F 880	posted. When interviewed of DON stated the nur canceled a stool sp issues with constipa maybe not part of th When interviewed of facility social worke received any new in When interviewed of RN-E stated she ha infection control trai When interviewed of DON stated it was i a bleach based clea had not switched ou with bleach. The DO right away. When interviewed of DON stated no stoo yet, they had receiv specimens in the wit they had been reject	on 4/22/22, at 10:19 a.m. the rse practitioner (NP)-A had becimen for R9 as she had ation not diarrhea and was he GI illness outbreak. on 4/21/22, at 12:27 p.m. the rr (SW) stated she had not effection control training today. on 4/21/22, at 12:31 p.m. ad not received any recent ining. on 4/22/22, at 11:18 a.m. the important for staff to be using aning solution for surfaces, but ut their standard disinfectant ON stated they would do that on 4/22/22, at 10:19 a.m. the ob samples had been obtained red orders, and sent rong type of specimen cup so cted by the lab on 4/21/22. on 4/24/22, 8:39 a.m. DON	F 8	80				
	stated one staff per symptoms 4/22/22 another had called	rson had developed GI and was sent home, and in sick overnight; R1 was otoms and confirmed GI						
	dietary aide had cor	ess outbreak log identified a me down with GI symptoms urse had on 4/24/22.						

If continuation sheet Page 100 of 108

		AND HUMAN SERVICES			P		APPROVED	
		& MEDICAID SERVICES				MB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245306	B. WING	÷		C 04/27/2022		
NAME OF F	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	ROCHESTER HEALTH SERVICES WEST				2215 HIGHWAY 52 NORTH			
					ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ge 100	F 8	880				
	stated one staff per symptoms 4/22/22 another had called moved due to symp infections. DON als develop some GI sy afternoon. DON said audits on PPE use facility IJ removal p at the facility. DON consultant (RNC)-B had been going thropolicies in the last the policies in the last the When interviewed of stated she was not products were out of to use, but then broot TB" wipes containing have the correct clean this, an observation bleach, peroxide or isolation carts or wi facility such as med During an observat NA-F walked across unbagged laundry ac lothes bin. NA-F the near the laundry reacher her potentially contain interviewed at 8:17 have bagged the la against her clothing During an observat	on 4/24/22, 8:59 a.m. RNC-B sure if the correct cleaning on the isolation carts for staff ought in a container of "Oxivir ng peroxide, and said they did eaning solution. Shortly after nevealed there were no Oxivir TB wipes on any th the shared equipment in the chanical lifts. ion on 4/25/22, at 8:14 a.m. s the north hallway carrying against her clothing to the dirty nen washed hands located ceptacle. NA-F did not change aminated clothing. When a.m. NA-F stated she should undry and not carried it g.						
		ion on 4/25/22, at 8:27 a.m. 20's door, donned appropriate						

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		AND HUMAN SERVICES				FORM	APPROVED
	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		1	0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	· /				PLETED
		245306	B. WING			C 04/27/2022	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	ROCHESTER HEALTH SERVICES WEST				2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	PPE, entered the ro set the breakfast tra moved R20's urinal removed gloves, sta R20's room, remov- utility room door, pu- door handle to oper washed her hands the room and walke the door handle. During an interview RNC-C indicated st contaminate the do indicated more infe needed to be comp When interviewed of registered dietician she had educated r from isolated reside the practice continu- mitigate this she ha practice was stopped When interviewed of RNC-B and the adr updated all residen disinfectant that wo They had placed sp for staff to use on e and R26 had come Rotavirus. When interviewed of stated even with all doors who are on is	oom with R20's breakfast tray, ay down the bed side table, off the bedside table, epped outside the threshold of ed her gloves, walked to the unched the code in, used the n the door, entered and with soap and water, exited ed away. HUC did not disinfect or on 4/25/22, at 8:39 a.m. he had seen the HUC or code and handle, and ction control audits of the staff leted. on 4/25/22, at 9:29 a.m. (RD) indicated even though hursing staff to not return trash ent trays back to the kitchen, ied. RD indicated in order to ad made signs so that this	F 8	380			

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		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245306	B. WING	i			C 27/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHEST	TER HEALTH SERVIO	CES WEST			2215 HIGHWAY 52 NORTH		
Roomeo				R	ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	One was tray was e countertop. During an observati R21 wheeled down bathroom in the hal room. R21's roomm illness. The toilet bo observed to have b bowel. At 11:57 a.m hallway with gloves protector up agains to a mechanical lift used the appropriat then washed her ha NA-B did not chang At 11:59 a.m. NA-B lift and put her on th bathroom, even tho toilet seat had not b During an interview NA-B confirmed sho communal bathroor TBP and was R21's had a formed bowe wiped down the toil the toilet bowel prio bowls were not cleat toilet had overflowe brown spots on the whole weekend, an cleaned it after it ow knew that brown stu Saturday, "that's wh	ion on 4/25/22, at 11:49 a.m. to use the communal llway and then returned to her nate remained on TBP for GI owel in the bathroom was rown spots all over the toilet n. NA-B walked down the on carrying a used mattress it her chest. NA-B then walked located down the hallway and te disinfectant to wipe it off, ands with soap and water. ge her contaminated clothing. assisted R9 onto mechanical ne toilet in the communal bugh the brown spots on the been cleaned off. on 4/25/22, at 12:04 a.m. e put R9 onto the toilet in the m and stated R10 who was on s roommate. NA-B stated R21 el movement, stated she had et seat however did not clean or. NA-B indicated the toilet aned between residents, the do over the weekend, the bowl had been there the d housekeeping had not verflowed. NA-B stated she uff has been there since	F	380			

Facility ID: 00941

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		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	2	2215 HIGHWAY 52 NORTH		
Rooned			F	ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	clean only the resid not clean the comm on Saturday. During an observat at 12:21 p.m. EVS- in the communal ba- longer observed in the condition of the EVS-A stated that w cleaned the bathroo had not cleaned it p had been busy. EV not disinfected after cleaned after break leaving at the end o had worked on Sun dirty toilet bowl. During an interview RNC-C was unawa being used until sur attention. RNC-C in would be expected between each use. would need more ti team meeting to reac correct the ongoing appropriate infectio When interviewed of medical doctor (MD informed of a coupl building quite some the date. He had be stool samples pend	age 103 cated she had been told to lent room bathrooms and did nunal bathrooms and/or toilets ion and interview on 4/25/22, A completed cleaning the toilet athroom, brown spots were not the toilet bowl. EVS-A verified toilet bowl prior to cleaning. was the first time she had om/toilet today. Indicated she prior because the bathroom S stated the toilet bowls were r each resident and were fast, after lunch, and before of the day. EVS-A stated she aday and did not notice the to a 4/25/22 at 12:39 p.m. re why commodes were not reyor brought it to her adicated in outbreak status it to be cleaning the toilet in RNC-C indicated the facility me to have an interdisciplinary evaluate the action plan to a lack of implementation of n prevention interventions.	F 880			

If continuation sheet Page 104 of 108

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	0938-039 E SURVEY PLETED
		245306	B. WING				C 27/2022
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			15 HIGHWAY 52 NORTH DCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 880	During an interview stated 5 isolation tr kitchen, three from 100 wing. RD state put directions on th bringing potentially kitchen increased to contamination, kitch handle dirty items w PPE on. When interviewed medical director (M had symptoms of M test first, then a test The immediate jeo 4/27/22, at 1:07 p.r facility completed to -Reviewed applical infection outbreak surveillance/prever designated infection logs completed. -All residents with 0 to be on transmissis signage in place in surveillance for east -Laboratory testing who demonstrated follow-up measures -Facility staff were education per depa practices such as a disinfecting of equi donning/doffing PP The education provi	v on 4/25/22, at 2:22 p.m. RD ray came back from the the 200 wing and two from the ed that was even after she had he trays. RD indicated by infectious items back to the the risk for cross then staff could inadvertently without having the appropriate on 4/25/22, at 3:35 p.m. the fD)-P stated If two residents oose stools would do a COVID st for norovirus. pardy was removed on m. after it was verified the he following actions: ble policies and procedures for and provided re-education on notion strategies to the m Preventionist. Surveillance GI symptoms were confirmed ion-based precautions with addition to ongoing rly detection. was completed for residents symptoms so appropriate s could be taken. provided with applicable artment on infection control appropriate hand hygiene, pment, disinfecting surfaces, PE, and meal service delivery. vided to department staff was uccessfully implemented.	F 8	80			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			F		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	Сом	E SURVEY PLETED
		245306	B. WING _				C 27/2022
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ROCHES	STER HEALTH SERVIC	CES WEST			215 HIGHWAY 52 NORTH		
	1			R	OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 105	F 88	80			
	This was verified by and residents and c	y observation, interview of staff document review.					
	beverage cart for the the dining area. A lawas located at the e assistant (NA)-F wai ice pitcher with her cup that had been so ice into another cup back into the ice pit poured juice into the the hall to deliver the immediately before pitcher was not com During an observation	ion 4/19/22, 12:03 p.m. a					
	reached in, took the touching the sides of into a large water m scooping cup back hygiene was not ob ice cup. RN-A then	N)-A opened the ice pitcher, e cup sitting in the ice, of the cup. RN-A scooped ice nug, and then dipped the into the pitcher of ice. Hand served prior to touching the proceeded down the hall and of ice to R5 in his room.					
	certified dietary mai not be touched with be applied after har	on, 4/21/22, 10:02 a.m. the nager (CDM) stated ice should a bare hand, gloves should nd hygiene. Ice should not be up to scoop, and such a cup g in the ice.					
	health unit coordina pitcher on the bever	ion 4/25/22, 12:44 p.m. a ator (HUC) reached into the ice rage cart with her bare hand, hand hygiene, remove a cup					

Facility ID: 00941

If continuation sheet Page 106 of 108

PRINTED: 06/07/2022

		AND HUMAN SERVICES			FORM	06/07/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	E SURVEY IPLETED
		245306	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	ice into another gla back into the ice pit When interviewed of registered dietician should be stored out was not aware the f with a cup from a p and leaving the cup [non-dietary staff] ju and RD was not away the ice left the kitch When interviewed of director of nursing (received training re- ice and ice scoops, from her training the in the ice container, that a cup was being beverage cart, nor was being touched in the ice. DON india and said, "I need to out to take care of t When interviewed of stated she had wor years and aside fro pass meal trays for an ice pitcher with a place for possibly s ever being aware the infection control pro- multiple people mig the environment pri- scooping, and then	her, fill it with ice, poured the ss and then drop the first cup icher. In 4/25/22, 12:46 p.m. a (RD) said a scoop for ice utside of the ice container. RD facility staff were scooping ice itcher on the beverage cart in the ice. RD said "they ust asked for a pitcher of ice" vare of what happened after ien area. In 4/25/22, 12:49 p.m. the (DON) stated she had lated to infection control with DON stated she was aware at an ice scoop should not sit . DON said she was unaware ing used to scoop ice on the was she aware that the cup by multiple staff and left sitting icated this was not appropriate take of this. I'm going right	F 880			

Facility ID: 00941

If continuation sheet Page 107 of 108

		AND HUMAN SERVICES				FORM	06/07/2022 APPROVED 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(COM	E SURVEY PLETED
		245306	B. WING			(04/2	27/2022
NAME OF F	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIF	, CODE		
ROCHES	TER HEALTH SERVI	CES WEST		215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	on Should B He Appropri		(X5) COMPLETION DATE
F 880	it might be an infect When interviewed of stated she had not issues. RD stated s CDM or DON at an the pitcher of ice we used to fill beverage covered steel conta located a small sco container on the be	tion control concern. on 4/25/22, 1:30 p.m. RD been made aware of the ice she had not been notified by y time. RD said she thought ould be filled with water and e glasses. RD brought in a siner and stated she had op that would be stored in the	F 880	DEFICIENCY)		

Facility ID: 00941

If continuation sheet Page 108 of 108



Protecting, Maintaining and Improving the Health of All Minnesotans

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.

Rochester Health Services West May 9, 2022 Page 2

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)

Rochester Health Services West May 9, 2022 Page 3

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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,

Mi Juin

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 Rochester Health Services West May 9, 2022 Page 4

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION 1		E SURVEY IPLETED
		245306	B. WING			04/	20/2022
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVIO	CES WEST			15 HIGHWAY 52 NORTH DCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	KC	000			
	FIRE SAFETY						
	conducted by the M Public Safety, State 04/20/2022. At the is ROCHESTER HEA found not in complia participation in Med Subpart 483.70(a), 2012 edition of NEPA) Chapter 19 Existing edition of NFPA 99, THE FACILITY'S PA ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	LTH SERVICES WEST was ance with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) 101, Life Safety Code (LSC),) Health Care and the 2012 Health Care and the 2012 Health Care Facilities Code. OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO: IN THE E-POC PROCESS, A THE PLAN OF CORRECTION					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						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.

		AND HUMAN SERVICES				FORM	06/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
245306						04/:	20/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVIC	CES WEST			215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Healthcare Fire Ins State Fire Marshall 445 Minnesota St., St. Paul, MN 55101 By email to: FM.HC.Inspections THE PLAN OF COP DEFICIENCY MUS FOLLOWING INFO 1. A detailed desc taken or planned to 2. Address the me place to ensure the 3. Indicate how th future performance sustained. 4. Identify who is n actions and monitor 5. The actual or p the remedy. ROCHESTER HEA one-story building w The original building determined to be of	pections Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: oription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. roposed date for completion of LTH SERVICES WEST is a with a partial basement. g was built in 1961 and was f Type II (111) construction.	K	000			
	system with smoke	system and has a fire alarm detection in corridors and corridors that is monitored for					

If continuation sheet Page 2 of 13

		AND HUMAN SERVICES			FORM	06/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG 01		E SURVEY IPLETED
		245306	B. WING		04/	20/2022
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 .	
ROCHES	TER HEALTH SERVIO	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	census of 28 at the	rtment notification. apacity of 48 beds and had a	K 0	00		
	NOT MET as evide Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting	nced by: 9 of at least 1-1/2-hour duration	K 29	91		5/20/22
	18.2.9.1, 19.2.9.1 This REQUIREMEN by: Based on a review and staff interview, operability of emerg NFPA 101 (2012 en sections 19.2.9.1 at	tically in accordance with 7.9. NT is not met as evidenced of available documentation the facility failed to test the gency lighting devices per dition), Life Safety Code, nd 7.9.3.1.1. This deficient a widespread impact on the facility.		The Maintenance Director compl 30-second monthly testing of eme light fixtures. The testing is on the preventive maintenance program been revised to list each emerger separately. The Maintenance Director is resp to ensure compliance.	ergency monthly and has acy light	
	it was revealed by a documentation that available or presen 30-second monthly fixtures was occurre	ween 08:00 AM to 11:00 AM, a review of available no documentation was ted for review to confirm that testing of emergency light ing or had been completed.				
		e Maintenance Director nt finding at the time of	K 3	24		5/20/22

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		AND HUMAN SERVICES				FORM	06/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245306	B. WING			04/2	20/2022
	PROVIDER OR SUPPLIER	CES WEST		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 324	Continued From pa	ge 3	K	324	L I I I I I I I I I I I I I I I I I I I		
	with NFPA 96, Stan and Fire Protection Operations, unless * residential cooking appliances such as toasters) are used cooking in accordat * cooking facilities of compartments with with the conditions or * cooking facilities i 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	g equipment (i.e., small microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with s comply with conditions under 6.4. rotected according to NFPA 96 quired to be enclosed as but shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through					
	by: Based on observat facility failed to prov hazards in accorda edition), Life Safet 19.3.2.5.3(9). This	NT is not met as evidenced tion and staff interview, the vide proper protection from nce with NFPA 101 (2012 y Code, sections 19.3.2.5 and deficient finding could have on the residents within the			The residential stove in the Occup Therapy Room, was inspected by the Maintenance Director and found to working lock. Staff were educated of need to lock the stove out when no use. An inspection of the residentia was added to the monthly preventa maintenance program. The Maintenance Director or design responsible to ensure compliance.	he have a on the t in I stove tive	

Facility ID: 00941

If continuation sheet Page 4 of 13

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E SURVEY
D PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G 01	COM	PLETED
		245306	B. WING		04/2	20/2022
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
K 324	On 04/20/2022, bet it was revealed by o Occupational Thera stove, which had a device, was found t functional state.	ween 08:00 AM to 11:00 AM,	K 32	4		
	discovery.	nt finding at the time of - Testing and Maintenance	K 34	5		5/20/22
	A fire alarm system accordance with ar with the requirement Electric Code, and and Signaling Code acceptance, mainter available. 9.6.1.3, 9.6.1.5, NF This REQUIREMENT	- Testing and Maintenance is tested and maintained in approved program complying hts of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily PA 70, NFPA 72 NT is not met as evidenced				
	facility failed to insp devices of the fire a with NFPA 101 (20 sections 19.3.4 and edition), National F sections 14.2.1.1.1	tion and staff interview, the bect and maintain initiating alarm system in accordance 12 edition), Life Safety Code, 4 9.6.2, and NFPA 72 (2010 ire Alarm and Signal Code, , 14.2.1.2.2, and 17.14.3. This uld have a patterned impact on the facility.		The Maintenance Director replace glass break rods in the manual fire pull stations located in the North a South corridors. Monitoring glass b rods was added to the facility s preventative maintenance program The Maintenance Director is respon to ensure compliance.	e alarm nd preak n.	
	Findings include:					
		ween 08:00 AM to 11:00 AM, observation that manual fire				

If continuation sheet Page 5 of 13

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TID	LE CONSTRUCTION	(X3) DATE SU	<u>38-039</u> RVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	
		245306	B. WING		04/20/2	2022
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE CO	(X5) MPLETIO DATE
K 345	alarm pull stations	age 5 were missing glass break rods ations in the facility: North and	K 345	5		
	verified this deficie discovery.	ne Maintenance Director nt finding at the time of Maintenance and Testing	K 353	3	6/1	/22
	Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, insp maintained in a set available.	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked				
	b) Who provided					
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by: Based on observa facility failed to insp system in accordant edition), Life Safety	KS information on coverage for r partial automatic sprinkler		The Maintenance Director remove storage in the 18 inches below a fi sprinkler head in rooms 209, 212 a The Maintenance Director inspector rooms, removed affected storage in	re and 219. ed all	

Facility ID: 00941

If continuation sheet Page 6 of 13

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	IPLE CONSTRUCTION		TE SURVEY MPLETED
	ST CONTRECTION		A. BUILDII	IG 01		
		245306	B. WING			/20/2022
	PROVIDER OR SUPPLIER	CES WEST		STREET ADDRESS, CIT 2215 HIGHWAY 52 NO ROCHESTER, MN	ORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
	 (2010 edition), Star Sprinkler Systems, deficient findings co on the residents with Findings include: On 04/20/2022, If AM, it was revealed closets of Rooms 2 stacked too high, w sprinkler heads 2. On 04/20/2022, If AM, it was revealed heads exhibited sig and Dish-washing A An interview with the verified these deficient discovery. Portable Fire Exting CFR(s): NFPA 101 Portable Fire Exting Portable fire exting inspected, and mai NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.12 This REQUIREMENT by: Based on document interview, the facilitit fire extinguishers deficient 	and and for the Installation of section 8.5.6.1. These build have a patterned impact thin the facility. between 08:00 AM to 11:00 d by observation that the 209, 212, 219 items were with less than 18 inches of between 08:00 AM to 11:00 d by observation that sprinkler ins of oxidation in the Kitchen Area. the Maintenance Director ient findings at the time of guishers ushers are selected, installed, ntained in accordance with I for Portable Fire	К 3	this requirement and address no Maintenance D the TELS syste inspection and The Maintenan the replacement the kitchen tha oxidation. The that the sprinkl the work will be arrive. The Maintenan responsible to	nt and asked to monitor oncompliance. The Director added this task to em for ensuring monthly	

Facility ID: 00941

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		(X3) DAT	E SURVEY
	U CORRECTION		A. BUILDING	G 01		IF LE I EV
		245306	B. WING		04/	20/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH		
ROCHES	STER HEALTH SERVI	CES WEST		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 355	Extinguishers, sect 7.2.4.5. This defici	age 7 ion 7.2.1.1, 7.2.4.3 and ent finding could have a on the residents within the	K 35	5 The Maintenance Director is respo to ensure compliance.	onsible	
	it was revealed by a documentation that available or presen the completion of n inspections. An interview with th verified this deficien discovery. HVAC CFR(s): NFPA 101 HVAC Heating, ventilation		K 52 ⁻	1		5/20/22
	This REQUIREME by: Based on observa and staff interview, corridors as an air accordance with NI Safety Code, sectio	NT is not met as evidenced tions, documentation review, the facility was using the plenum which is not in FPA 101 (2012 edition), Life on 19.5.2.1 and 9.2.1, and dition), Standard for the		The facility is requesting a waiver 521.	for K	

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	MB NO. 093 (X3) DATE SUF	RVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG 01	COMPLET	ED
		245306	B. WING		04/20/2	022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(X5) MPLETIO DATE
K 521	Continued From pa	-	K 52	21		
	Systems, section 4	onditioning and Ventilating .3.12.1.1. This deficient a widespread impact on the facility.				
	Findings include:					
	observations and d the ventilation syste	ween 08:00 AM to 11:00 AM, ocumentation review revealed em in the 1961 building utilized s as a return air plenum for the em.				
		e Maintenance Director nt finding at the time of	K 71	2	5/20	0/22
	signal and simulatic conditions. Fire dril unexpected times u least quarterly on e with procedures an established routine between 9:00 PM a announcement may alarms. 19.7.1.4 through 19 This REQUIREMEN by:	NT is not met as evidenced				
	Based on a review and staff interview, fire drills in accorda edition), Life Safety	of available documentation the facility failed to conduct ince with the NFPA 101 (2012 Code, sections 19.7.1.6 and at finding could have a		The Maintenance Director will utiliz TELS system for ensuring fire drills completed as required of one shift quarter. Documentation from the fin will be placed in the LSC binder for	are per e drill	

Facility ID: 00941

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STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G 01	COM	IPLETED
		245306	B. WING		04/	20/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 914	facility. Findings include: On 04/20/2022, bet it was revealed dur no documentation v confirm that a fire of shift in the 2nd and the 2nd and 4th qua 2nd, 3rd, and 4th qua 2nd, 3rd, and 4th qua An interview with the verified this deficient discovery. Electrical Systems CFR(s): NFPA 101 Electrical Systems Hospital-grade recellor locations and where anesthesia is admini- installation, replace testing is performed documented perfor- listed as hospital-grader tested at intervals r isolation monitors (intervals of less that actuating the LIM te which activates bott LIM circuits with au- manual test is performed equal to 12 months 6.3.3.3.2 after any re- electric distribution	on the residents within the tween 08:00 AM to 11:00 AM, ing documentation review that was presented for review to drill was conducted for the 1st 3rd quarters, the 2nd shift in arters, and 3rd shift staff in the	K 712	facility. Monthly fire drills will be reviewed QAPI meeting to evaluate complia The Maintenance Director and NH responsible to ensure compliance	nce.	5/20/22

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		AND HUMAN SERVICES			FORM	06/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		E SURVEY PLETED
		245306	B. WING _		04/	20/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	repairs or modificat area tested, and re 6.3.4 (NFPA 99) This REQUIREMEN by: Based on a review and staff interview, electrical receptacle NFPA 99 (2012 edit Code, sections 6.3. deficient finding con on the residents wit Findings include: On 04/20/2022, bet it was revealed by a documentation that for review did not in of the multi-point in individual outlets lo An interview with th verified this deficient discovery. Gas Equipment - C CFR(s): NFPA 101 Gas Equipment - C Greater than or equistor Storage locations a within an enclosed limited- combustible	tions, containing date, room or sults. NT is not met as evidenced of available documentation the facility failed to document e testing in resident rooms per tion), Health Care Facilities .3.2 and 6.3.4.2.1.2. This uld have a widespread impact thin the facility. tween 08:00 AM to 11:00 AM, a review of available the documentation presented adividually identify the results spection for each of the cated in resident rooms. The Maintenance Director the finding at the time of cylinder and Container Storage ual to 3,000 cubic feet the designed, constructed, and lance with 5.1.3.3.2 and	K 92	The inspection and testing of all non-hospital grade electrical recep was completed by Maintenance Di The electrical receptacle inspectio the annual preventative maintenan program and has been revised to l electrical receptacle separately. The Maintenance Director is respon to ensure compliance.	rector. n is on ice ist each	5/20/22

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G 01	(X3) DATE COMF	SURVEY
		245306	B. WING		04/2	20/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 923	Continued From pa	ige 11	K 92	3		
	separated from cor sprinklered) or encl noncombustible cor 1/2 hr. fire protection Less than or equal In a single smoke of cylinders available care areas with an or equal to 300 cub stored in an enclos handled with precar A precautionary sig each door or gate of where the sign inclu- minimum "CAUTIO STORED WITHIN Storage is planned of which they are re Empty cylinders are cylinders. When far integral pressure ga considered empty is are marked to avoid in the open are pro- 11.3.1, 11.3.2, 11.3 This REQUIREMEN	to 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than nic feet are not required to be ure. Cylinders must be utions as specified in 11.6.2. n readable from 5 feet is on of a cylinder storage room, udes the wording as a N: OXIDIZING GAS(ES)		The Maintenance Director has ch the lock on the Med Gas Storage I		
	Facilities Code, sec	99 (2012 edition), Health Care ction 11.3.2.1. This deficient an isolated impact on the facility.		one that remains in the locked pos and added a Keypad lock. The Maintenance Director will utilize th system for ensuring the Med Gas Room door is inspected weekly. The Maintenance Director or desig	e TELS Storage	

Facility ID: 00941

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		AND HUMAN SERVICES				FORM	06/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245306	B. WING	i		04/2	20/2022
NAME OF F	PROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST			215 HIGHWAY 52 NORTH OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 923	Storage Room was An interview with th	-	K	923			

Facility ID: 00941

If continuation sheet Page 13 of 13



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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

Rochester Health Services West May 13, 2022 Page 2 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.

Mighing

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00941	B. WING		04/2) 7/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST	HWAY 52 NC TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was conduct by surveyors from the Health (MDH). Your compliance with the following correction indicate in your elect	TS: 4/27/22, a standard licensing ted completed at your facility he Minnesota Department of r facility was found NOT in e MN State Licensure and the orders are issued. Please ctronic plan of correction you				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00941	B. WING			C 04/27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE			
		2215 HIG	HWAY 52 NO				
ROCHES	STER HEALTH SERVI	CES WEST	TER, MN 559				
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLET	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE	
2 000	Continued From pa	ige 1	2 000				
	have reviewed thes when they will be c	e orders and identify the date ompleted.					
		laint was found to be H5306078C(MN82516);					
	however NO deficie	encies were cited due to ed by the facility prior to survey					
		plaint was found to be ED: H5306077C(MN81831).					
		nent of Health is documenting					
		Correction Orders using ag numbers have been					
		sota state statutes/rules for					
		ne assigned tag number					
		eft column entitled "ID Prefix					
		tute/rule out of compliance is	,				
		ary Statement of Deficiencies' es the "To Comply" portion of					
		r. This column also includes					
	the findings which a	are in violation of the state					
		tement, "This Rule is not met					
		bllowing the surveyor 's					
		ggested Method of Correction					
	and Time Period fo	participate in the electronic					
		nsure orders consistent with					
	the Minnesota Dep						
	Informational Bullet	tin 14-01, available at					
		tate.mn.us/divs/fpc/profinfo/inf					
		e licensing orders are					
	delineated on the a	Ith orders being submitted to					
		Although no plan of correction					
		ate Statutes/Rules, please					
		RRECTED" in the box					
		ou must then indicate in the					
		ensure process, under the					
	heading completior	h date, the date your orders wil					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
	or contraction	DENTIFICATION NOMBER.	A. BUILDING:			
		00941	B. WING			C 27/2022
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	STER HEALTH SERVI	CES WEST	SHWAY 52 NO			
	1	ROCHES	STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
2 000	Continued From pa	age 2	2 000			
	the Minnesota Dep is enrolled in ePOC	o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			6/2/22
	have a continuous management to red unnecessary use of comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: tho enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as ler function as possible.				
	by: Based on observat review, the facility f management and r	ent is not met as evidenced ions, interview, and document ailed to ensure appropriate routine care of a condom resident (R19) reviewed for		Corrected		

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		с		
		00941	B. WING			04/27/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOI TER, MN 559				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 910	Continued From pa	age 3	2 910				
	catheter care.						
	Findings include:						
	2/25/22, included c including type 2 dia diverticulosis, pros pacemaker, and ch R19 required exter	nimum Data Set (MDS), dated cognitively intact with diagnosis abetes mellitus (DM2), tate cancer, cardiac nronic kidney disease (CKD). nsive assistance from staff for toilet use, and personal					
	catheter (a urine co condom over the p as needed for cath rinse out catheter to vinegar two times a on 2/24/22, and fol	ders included a condom ollection device that fits like a penis) change every 72 hours leter care starting on 12/15/21, bag that is removed with a day for catheter care starting ey output every shift for tarting on 11/19/21.					
	condom catheter n and history of pros with goal to not hav urinary catheter us change urinary coll any changes in am and report to media tract infection (UTI	ted 11/19/21, included use of needed due to disease process tate cancer and incontinence we acute complications of e. Staff were directed to lection bag as needed, report nount and color or odor of urine cal doctor (MD) signs of urinary) such as blood, cloudy urine, stlessness, lethargy, or and burning.	,				
anocoto D	included, R19's co zero times in Dece January 2022, four	administration record (MAR) ondom catheter was changed mber 2021, one time in times in February 2022, six 22, and three times in April					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						С
		00941	B. WING	04/2		27/2022
IAME OF F	PROVIDER OR SUPPLIER		TADDRESS, CITY, ST			
ROCHES	TER HEALTH SERVI	CES WEST	HIGHWAY 52 NOR ESTER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE
2 910	Continued From pa	age 4	2 910			
	2/18/22, indicated I	ntinence evaluation dated R19 used a condom cathete nation was filled out on the d.	r			
	2/5/22-2/8/22, indic was cloudy, had let cell count) and blac for infection so R19	harge summary dated cated R19's urine in catheter ukocytosis (high white blood dder wall thickening concern 9 was started on antibiotics r tract infection (UTI).				
	stated the facility de clean his catheter of a semi-private roor do not wash out the water nightly to pro- finds his leg bag sit sometimes on the f R19 stated his equ and hung up to dry "passed out" in the months ago and th	on 4/19/22, at 10:13 a.m. R1 oes not have the space to equipment properly as he is m. R19 stated most facility st e leg bag with vinegar and operly sanitize. R19 stated he tting on the floor and floor of the shared bathroom ipment needs to be washed properly. R19 stated he, bathroom approximately two e hospital discovered he ha the hospital, "got after the bing."	in taff			
	at 4:30 p.m. license stated R19 can ass catheter himself. R to his catheter tubin stated a nurse hun earlier today; other	tion and interview on 4/19/22 ed practical nurse (LPN)-C sist with putting on condom 19 stated the end piece cove ng is currently missing. R19 g it up over the bathroom sir wise, it is normally placed or h basin all curled up without	er Ik			
		tion on 4/20/22, at 7:24 a.m. sleeping in bed with leg bag				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00941			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		B. WING			C 04/27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	GHWAY 52 NOF STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 5	2 910			
	tip touching the bat condom catheter w resident's homema There was white di bath basin on the fl During an observat R19's overnight gra sitting in a bath bas catheter tubing har uncapped. During an observat R19's overnight gra to a shared bathroo	ed rail with the catheter tubing th basin on the floor. R19's vas observed hooked up to ide overnight gravity bottle. stilled vinegar and syringe in a loor next to the bathroom sink. tion on 4/20/22, at 9:00 a.m. avity bottle was observed sin on the floor with the nging over the bed rails tion on 4/20/22, at 12:09 p.m. avity bottle was observed next om toilet. The catheter tubing touching the dirty bathroom				
	R19's overnight gra	tion on 4/21/22, at 8:58 a.m. avity catheter tubing was ver the bed rail uncapped.				
	R19's overnight gra observed sitting in	tion on 4/21/22, at 12:30 p.m. avity catheter bottle was a bath basin next to the bed bing draping from the bed rail				
	R19's catheter tubi	tion on 4/21/22, at 2:29 p.m. ng was observed hanging ove m sink in bathroom.	r			
	overnight gravity bo	tion on 4/22/22, at 8:38 a.m. ottle was observed in a bath tubing hanging over bed rail resident's bed.				
		tion and interview on 4/22/22, bserved was wheeling back to				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
00941			A. BUILDING			С
		B. WING			04/27/2022	
AME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
OCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NOR STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pa	age 6	2 910		,	
	room with unbutton explained to nursin a new catheter as t wheeled R19 back transferred him to b roommate, and gra was ringing out of h NA-B was observed hygiene upon leavin NA-B was observed hand hygiene, but of looking in resident catheter. Overnight touching the outsid 9:04 a.m., registered room to assist R19 more supplies cent 9:06 a.m. RN-A retuing would take over from and performed han observed assisting catheter and stated every three days or stated all catheter as cleaned daily with w hung to dry. RN-As staff to not complet leg bag on most da when she arrives of dayshifts per week drapes R19's leg ba drawer handle if it i catheter tubing sho bathroom floor. RN system change woof floor due to potent which CUId lead to one UTI since adm	ied, soiled pants. R19 g assistant (NA)-B he needed the other one fell off. NA-B to room, donned gloves, bed, pulled curtain divider to abbed residents phone that nis left upper shirt pocket. d to not complete hand ng R19's room. At 9:02 a.m., d back in R19's room without donned new gloves and started nightstand for new condom t catheter tubing observed e of bath basin uncapped. At ed nurse (RN)-A arrived to but had to leave to gather rral supply room at facility. At urned and informed NA-B she m here. NA-B doffed gloves and hygiene upon exit. RN-A R19 place new condom t catheter should be changed more often if needed. RN-A supplies and tubing are to be vinegar and water solution and stated she had noted other te this task daily for R19 as his ays is not clean in the morning n shift and she works five . RN-A stated night staff ag over the locked nightstand s cleaned. RN-A verified ould never be placed on floor on I-A stated a whole catheter uld be required if found on al contamination concerns o UTI's. RN-A stated R19 had ission to facility.	4			
	When interviewed of partment of Health	on 4/22/22, at 12:32 p.m.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED		
	00941					С	
			B. WING		04/	27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOR STER, MN 5590				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 7	2 910				
	changed once a mo stated she was una catheter supplies a done it on dayshift. know what R19's o or what they cleans stated catheter sup	ought catheter supplies were onth by nightshift staff. RN-B aware of cleaning schedule for nd tubing as she's, "never " RN-B stated she did not rders for catheter cares were sed his equipment with. RN-B oplies should never be re-used s you, "never know what's on					
	RN-C stated cather month or as neede equipment is clean water solution and RN-C stated cather should never be pla	on 4/22/22, at 12:55 a.m. ters are changed out once a d. RN-C stated catheter ed out daily with a vinegar and set out to dry before re-use. ter equipment and tubing aced on flooring as it would t's chance for infection.					
	stated his leg bag winegar and water a	on 4/24/22, at 9:00 a.m. R19 was not cleaned out with again last night. Overnight ubing was observed draped					
	stated R19's overni getting cleaned by has not been comp stated she's observ R19's bathroom to shifts as she will so black sharpie mark changes should be record (EMR). RN- have to bring facilit catheter system an	on 4/25/22 at 10:32 a.m. RN-A ight catheter equipment is her; however, the night shift bleting leg bag cleaning. RN-A ved the vinegar solution in not decrease between her ometimes mark the level with a ter. RN-A stated catheter charted in electronic medical A stated R19's family would y new overnight gravity id extension tubing as it is stated R19's condom catheter					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	00941		B. WING		C 04/27/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NOF			
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pa	age 8	2 910			
	RN-A stated facility	ys gets completed on bath day does not use caps on ds when not being used.				
	director of nursing for R19's condom of three days or more expectation for stat equipment with vin- keep supplies san to a potential infect R19 and family hav informed about the gravity night system concern as long as properly every day, staff to replace cat ever accidentally pl	on 4/25/22, at 11:05 a.m. (DON) stated the expectation catheter is to be changed every often if needed. DON stated if nurses to clean catheter egar and water mixture daily tary which could possibly lead tion such as a UTI. DON stated ve been educated and risks of using his homemade n; but stated it should not be a the system is cleaned out DON stated expectation for heter bag and tubing if it was laced on the floor as there al for cross-contamination				
	practitioner (NP)-A not keeping R19's d daily. NP-A confirm catheter prior to ad to maintain it withou believed in her med to hospital on 2/6/2	on 4/25/22, at 3:09 p.m. nurse expressed concern facility was catheter equipment cleaned ned R19 utilized a condom Imission at home and was able ut difficulty. NP-A stated she dical opinion, R19's admission 22 was caused by facility failure ary catheter system which R19's UTI.				
	revised 2/22/21 ind the leg bag urine co cleaned/disinfected manufacturer's guid	d and stored per policy and dance. The "stored per policy" n the facility, but never				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
	00941		B. WING			C 04/27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE			
ROCHES	STER HEALTH SERVIO	CES WEST	HWAY 52 NO TER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE	
2 910	Continued From pa	ge 9	2 910				
	resident identifier a prevent contact of t	rine collection device with a nd date. Avoid splashing and he drainage spigot with the g container when emptying the					
	SUGGESTED MET	HOD OF CORRECTION:					
	re-educate licensed on the proper clean supplies, especially could provide educa urinary tract infection risks through appro- and resident care.	sing (DON) or designee could and unlicensed nursing care ing and storage of urinary catheter equipment, and ation on the complications of ons and how to reduce these priate cleaning of equipment DON or designee could initiate are: equipment and resident					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					
2 960	MN Rule 4658.0600 Food Quality	0 Subp. 1 Dietary Service -	2 960			6/2/22	
		uality. Food must have taste, ance that encourages resident d.					
	by: Based on observati failed to provide me taste, texture, appe temperature for 11 R13, R17, R9, R24	ent is not met as evidenced ion and interview, the facility eals that were palatable in parance and at an appetizing residents (R18, R19, R26, , R5, R27) of the facility served for dining during the		Corrected			

Minnesota Department of Health STATE FORM

6899

CJZE11

If continuation sheet 10 of 64

Minnesota Department of Health							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
00941		B. WING		C 04/27/2022			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ROCHESTER HEALTH SERVICES WEST 2215 HIGH			HWAY 52 NO TER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 960	Continued From pa	ige 10	2 960				
	survey.						
	Findings include:						
	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.						
		on 4/19/22, at 10:05 a.m. R19 t very good. The food is not t them."					
	said, "I have ham u is not for breakfast comes. You could g hamburger but that	on 4/18/22, at 2:07 p.m. R26 ip to three times per week. If it it is for supper. The menu just get a grilled cheese or 's the same thing too, you get ive. There are very few fresh					

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00941	B. WING		C 04/27/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	GHWAY 52 NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 960	Continued From pa	age 11	2 960			
	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."					
	stated the food was	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."				
	said, "Their food is always hot. The me	on 4/18/22, at 4:02 p.m. R9 not the greatest. The food isn' eat is sometimes chewy. We now I'm beginning to hate it as				
	said, "the hot food	on 4/18/22, at 6:19 p.m. R24 isn't always hot and the cold old; most of the time the meals				
		on 4/19/22, at 9:46 a.m. R5 ot good, some of the food is				
		on 4/19/22, at 11:19 a.m. R27 ems he requested and od was often cold.				
	the beverage cart of the dining area of the dining area of milk or juice contained area.	tion on 4/19/22, at 11:56 a.m. was observed sitting to the side with no ice under or around the ners to keep them cold. The erages were slightly cool, but ch.				
innesota D	of the dining area of milk or juice contain outside of the bever not cold to the touc	with no ice under or around the ners to keep them cold. The erages were slightly cool, but				

TATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00941	B. WING		04/27/2022	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	GHWAY 52 NOI STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 960	Continued From pa	age 12	2 960			
	calling a family me food. R18 complain burned, and flipped then asked another (R20) to turn his eg observed to be bur During an observat the meal trays were transported out to t residents in the din taste test tray had last, and when all t p.m. the temperatu follows: meatloaf 1 potatoes at 107 de degrees. The meat flavor, but felt bare potatoes were dry a significant seasonin The peas were not the other foods. An tasted the food and warm, but thought stated the food sho when served to the When interviewed stated R18 had be breakfast being bu often complain of th is to say the food is When interviewed RD stated any cool	tion on 4/21/22, at 12:20 p.m. e loaded on the cart and the dining area to be passed to ing room and on the units. A been requested to be served rays were passed, at 12:37 ures of the plated food were as 02.2 degrees, au gratin grees and peas were 105 tloaf was tender and with good Jy warm in the mouth. The around the edges and lacked ng, and felt only slightly warm. seasoned but felt warmer that registered dietician (RD) also d indicated that it did not feel the flavor was pleasant. RD puld be appropriately warm e residents.	n			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	OF SOUCEOHON	DENTIFICATION NOMBER.	A. BUILDING:				
		00941	B. WING			C 04/27/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
OCHES	TER HEALTH SERVI		HWAY 52 NOR TER, MN 5590				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 960	Continued From pa	age 13	2 960				
	 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. 						
s tu c a fr c v s t t v v s t v	stated she did not g tray with oatmeal in conversation R17 r asked staff to get h food she had was r oatmeal was cold a was observed to be scoop. R17 did not to add to her cerea	on 4/25/22, 9:40 a.m. R17 get her breakfast. She had a n front of her. Later in the made it clear that she had her something different as the not what she wanted, and the and a solid lump. The oatmeal e in a mound, shaped like a have any milk, sugar or other I. R17 said she had been nded time for her requested e.					
	dated May 2014 ind prepared by metho value, flavor and a	d Food: Quality and Palatability dicated that food was to be ds that conserve "nutritive opearance. Food is palatable ed at the proper temperatures.					
	SUGGESTED MET	THOD OF CORRECTION:					
	The facility Adminis	strator and contracted food					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI	ED.	E CONSTRUCTION		E SURVEY PLETED	
		00941	B. WING	B. WING		C 04/27/2022	
IAME OF I	PROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, S	STATE, ZIP CODE			
ROCHES	TER HEALTH SERVI	CES WEST	215 HIGHWAY 52 NO				
			OCHESTER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIC		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 960	Continued From pa	age 14	2 960				
	keeping food warm time of service, utili equipment or devis served so trays are period. Kitchen ma all foods for signs of problems, and tast serving temperatur educated on the cor related to temperatur flavor. All staff invo could be educated acceptable to resid each meal to ensur what they have rec alternatives and off as needed. Audits could be dor satisfactory in appe	ould develop a plan for on individual trays until izing either new warmin ing a change in how foo e not sitting for an exten- nager could be sure to o of burning, dryness or of e test food for palatabilit e. Dietary staff could be oncepts of food palatabilit ure and appearance as lved in serving residents in checking that the foo ents with each plate pas re residents are satisfied eived, offer condiments fer to warm food or exch me to ensure food is earance, taste and temp provided a regular metho- neir meals.	g od is ded check ther ty and ty well as s food d is ssed at d with , offer hange				
	TIME PERIOD FOI (21) days	R CORRECTION: Twen	ity one				
21100	MN Rule 4658.065 Storage of Perishal	0 Subp. 5 Food Supplie ble food	s; 21100			6/2/22	
	perishable food mu washable, corrosio	of perishable food. All ist be stored off the floo n-resistant shelving und , and at temperatures w spoilage.	ler				
	This MN Requirem by:	ent is not met as evide	nced				
	Based on observat	ion, interview and docur d to ensure refrigerator		Corrected			

STATE FORM

CJZE11

If continuation sheet 15 of 64

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00941	B. WING	B. WING		C 04/27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	-		
ROCHES	STER HEALTH SERVI	CES WEST	IGHWAY 52 NOI ESTER, MN 559				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET	
21100	Continued From pa	age 15	21100				
21100	2 of 2 kitchen refrig freezers, and failed were dated, labeled expiration dates for refrigerators. These affect all 28 resider Findings include: During observation Temperature logs f multiple blank entri that were above sa Fahrenheit (F) or lo F for freezer). The evaluation and/or in temperatures were temperatures. On 2 the morning the free	on 4/18/22, at 11:50 a.m. for the cooler and freezer had es and identified temperature fe zones (41 degrees ower for cooler and 0 degrees facility lacked evidence of nterventions when above safe zone 2/13/22, freezer log indicated ezer door was found to be	es in				
	degrees. On 1/24/2 55 degrees in the n During an initial brid 11:52 a.m. with the	ure recorded on the log was 3 22, the cooler temperature wa norning. ef kitchen tour on 4/18/22, at dietary manager (CDM) the re noted to be undated,					
	unlabeled, and exp -opened and undat -opened bag of colo 4/14/22.	ired in kitchen refrigerators: ed carrots, spinach. eslaw with use by date of					
	cucumber in zip-loc -opened bag of bag 3/24/22; good for ty manager (CDM).	g of parmesan cheese dated wo weeks per certified dietary	,				
	mozzarella cheese	ed bag of shredded ; three quarters used. ed bag of finely shredded					

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
						С
		00941	B. WING		04/2	27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DOOUTO		2215 HIG	HWAY 52 NO	RTH		
ROCHES	STER HEALTH SERVI	ROCHES	TER, MN 55	901		
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		COMPLETE DATE
				DEFICIENCY)	
21100	Continued From pa	ae 16	21100			
		-				
		and unlabeled cream of wheat d for an unknown resident per				
	CDM.	ed for an unknown resident per				
		of cottage cheese on 3/31/22;				
		e of 4/13/22; good for seven				
	days per CDM.					
		arlic in oil dated 2/24/22; only				
	good for two weeks					
		unlabeled bottle with white				
		DM confirmed this belongs to and white substance is staff's				
		amer. CDM confirmed staff				
		ng in kitchen refrigerators and				
		oom where they can store				
	personal items.	2				
		ed Sweet Baby Ray's				
	barbeque sauce.					
	12/21; best if used	Vorcestershire sauce dated				
		dated 12/8; best if used by				
	11/15/21.	dated 12/0, best in dised by				
		dated 2/6; delivered to facility				
	on 3/11/21; best if u					
		ed thickened dairy drink.				
		ed liquid whole eggs.				
		ed Hershey chocolate syrup;				
	best if used by 5/21					
	brown, mushy, and	lated lettuce that was wilted,				
		eled onion that was turning				
	brown and mushy.					
	-ham that was unda	ated wrapped in Saran wrap				
		n it was defrosted. One sliced				
		the bottom of the cooler. CDM				
		C)-C that ham was sliced on				
		C-C uncertain on date it was				
		zer. C-C stated she would on previous week's menus to				
		was sliced and defrosted. C-C				
		uld be labeled and dated upon				
/innesota D	epartment of Health		1	I		1

Minneso	ta Department of He	ealth			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMI	PLETED
		00941	B. WING		C 04/27/2022	
					1 04/	2112022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	SHWAY 52 NO STER, MN 559			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLET DATE
21100	Continued From pa	age 17	21100			
	opening items in kitchen.					
	During an observat	ion on 4/18/22, at 12:15 p.m.				
	the following items	were noted to be undated,				
	unlabeled, and expired in kitchen freezers:					
		s of cookie dough not dated sh layer of ice crystals.				
		ags of fish, breaded fish,				
		eef patties, and white turkey.				
	-opened undated b	ag of cinnamon rolls.				
	-opened undated b					
	-opened undated b	ag of peas.				
	the following items	ion on 4/18/22, at 12:30 p.m. were noted to be undated and				
	expired in dry stora					
	-opened and undat					
		atoes. CDM pulled them off of tated, "those cannot be used				
		tossed out." CDM stated she				
		ordering from Sysco, dates all				
		I date, and uses the "first in,				
	first out" method.					
	-opened and undat					
		and expired baking soda;				
	expired on 1/28/22	ed parsley, paprika, garlic salt				
		ound cloves, and oregano.	'			
		ed cinnamon; expired on				
	11/21/21.					
	-opened and undat date 7/20/20.	ed bay leaves; manufacturers				
		ed fajita seasoning;				
	manufactures date					
		ed whole sweet basil;				
	manufactures date					
	-opened and undat manufactures date	o				
		ed lemon pepper; received on				
	7/31/20.					
nesota D	epartment of Health					1

STATE FORM

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CJZE11

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Minnesc	ta Department of He	ealth				APPROVE
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	
		00044	B. WING			С
		00941			04/2	27/2022
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
21100	Continued From pa	age 18	21100			
	-opened and undat 11/24/20.	ed ground rosemary; received				
	-opened and undat	ed celery salt; received 7/9/20.				
	-opened and undat	ed ground ginger; CDM				
		eceived as label has worn off.				
	9/19/19.	ed tarragon leaves; received				
	11/18/18.	ed allspice; manufactures date				
	 opened and undat opened and undat 	ed powdered sugar. ed vanilla.				
	When interviewed (on 4/18/22, at 12:48 p.m. CDM				
		stated her expectation for dietary staff was to				
		ls upon opening and to				
		foods. CDM expressed				
		ntially lead to food borne				
		nitary temperatures. CDM				
		and freezer temperatures				
		and verified twice a day in the ings. CDM confirmed these				
		not being completed in				
		d dishwasher temperatures				
		ed three times a day; however,				
		ere not getting completed				
	either. CDM had to	look at dishwasher log sheet				
		ny times a day temperatures				
		. CDM stated she would need				
	to reeducate dietar	y staff right away.				
	During an observat	ion of the kitchen on 4/18/22,				
		chen was found to have dirty				
		; the microwave was soiled				
		les, the three compartment				
	sink had dishes soa	aking from breakfast and dry				
		attered throughout all three				
		a very thick layer of black				
		as soiled with dry potato peels,				
		cky, counter tops were also not				
	clean in appearanc	e. CDM confirmed grill grease				

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
					С	
		00941	B. WING			27/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
		2215 HIG	HWAY 52 NO			
ROCHES	STER HEALTH SERVI	CES WEST	TER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
21100	Continued From no	and 10	21100			
21100	Continued From pa	ige 19	21100			
		daily and, "it had not been				
	done in a very long	time."				
	During on choor of	ion on 4/19/22 of 1:15 nm				
		ion 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 undat	ed Member's Mark				
	cheesecake.					
		beled take out meal with can of				
	Sprite in white groc	ery bag. beled broccoli and unknown				
		hite fork in Glad-wear				
		ed a nurse with blonde hair				
		4/18/22 in the morning.				
		eled bowl of sausage dated				
		foil cover was torn open with				
	food exposed.					
		awberry banana yogurt;				
	expired on 12/16/2					
	peppers.	and unlabeled crushed				
		eled mushy and brownish				
	discolored apple sli					
		ed green top jar from R20;				
		t product inside jar included.				
		d, and opened jar of beans				
	and chicken.					
	-opened and undat	ed sweet relish labeled				
		ed Sweet Baby Ray's				
	barbeque sauce la					
		ed Hershey's chocolate syrup				
	labeled "ARTS".	,				
		classic white bread found in				
		without twist tie; dated 2/23/22;				
	bread was hardene					
		eled Great Harvest Ambrosia				
	epartment of Health	on top of refrigerator.				

Minnesota Department of Health STATE FORM

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00941	B. WING	B. WING		C 04/27/2022	
IAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	TATE, ZIP CODE			
OCHES	STER HEALTH SERVI	CES WEST	HIGHWAY 52 NOF HESTER, MN 559				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
21100	Continued From pa	age 20	21100				
	stated uncertainty i and freezer was for confirmed food in ti use of personal foo C-C confirmed two temperature sliced were left on counter (ACT). C-C confirm temperature leftowe countertop in Outba bag belonged to R ⁻ of posted sign on o stated, "please mai and dated - anythin is 7 days old or old otherwise specified please see Jamie, unidentified staff m facility tour to a fam stated "this refriger When interviewed or registered nurse (F refrigerator and fre only. RN-B guesse with plastic fork wa uncertain. RN-B sta was used during re activities director w dating these items. into garbage as sho belonged to. RN-B belonged to or how she placed it back	Hormel pepperoni package ertop area by activities direc- ned undated and room er steak and chicken found ack Steakhouse brown pap 19. C-C confirmed knowled outside of refrigerator door to rk sure all items are labeled ing not labeled and dated and er will be thrown away. Un d. Any questions or concern dietary manager." An nember who was giving a nily member walked by and rator is for resident food onl on 4/18/22, at 1:21 p.m. RN)-B confirmed dinette ezer were for resident food d leftover broccoli and mea is possibly a residents but v ated anything labeled "ACT esident activities and the vas in charge of labeling and RN-B tossed leftover mea e was not able to identify w uncertain who cheesecaked v long it had been opened, l	r staff /. es stor on er ge that d d/or less is y." t vas 'S" d l ho it e out				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00941	B. WING			C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NOF			
			TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE
21100	Continued From pa	ige 21	21100			
	-opened and undat	min; received 9/24/20. ed poultry seasoning, whole d sage, ground ginger, nd beef base.				
	activities director (A supposed to be che refrigerator and free everything is dated nursing or activities were the ones who items first. ACT cor be dated/labeled ar	on 4/19/22, at 9:01 a.m. ACT) confirmed dietary is ecking temperatures on dinette ezer and making sure and labeled. ACT stated s staff will assist dietary if they obtained and opened the food nfirmed all food items should nd only kept for 72 hours after ed activities foods are to be				
	the refrigerator in the package of ham wr 4/12/22. One packat wrapped, leaving the the bottom of the re- the refrigerator also	ion on 4/19/22, at 11:15 a.m. ne kitchen had 4 individual rapped in saran wrap dated age of ham was not completely ne ham exposed and touching efrigerator. The bottom shelf of b had a metal pan with eef that was undated.				
	refrigerator for 4/19	ved hanging on the side of the //22. Menu included chicken en chili rice, and Mexican corn.				
	C-C was taking ten coming out of the o pans on the steam steam table was co to keep the water h	ion on 4/19/22, at 11:25 a.m. operatures of food that was oven and placing the metal table. An unused area of the overed with a metal lid in order ot; the lid was warm to the e lid was metal pan of chopped				
	lettuce and a separ tomatoes and onior	rate pan with chopped ns (items noted there at 11:15 barrier or a pan of ice to keep				

					PLETED	
00044					<u> </u>	
00941		B. WING			C 04/27/2022	
ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
TER HEALTH SERVIO	CES WEST	HWAY 52 NOR TER, MN 5590				
	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
		PREFIX TAG	CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLET DATE	
Continued From pa	ge 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.						
stated she had not "cold" food items, c stated "we don't che stated they [kitchen because it was colo the refrigerator. Wh make sure those ite by stating because not able to articulate maintained a safe t	taken temperatures of the old food items temperatures, eck temps of cold foods". C-C staff] did not check cold items d when they pulled them out of nen C-C was asked how to you ems stay cold, C-C responded the food was cold. C-C was e how cold food items emperature once items were					
C-C set five plates menu items on the toppers (lettuce/ton sitting on the steam C-C with gloved has cheese from refrige placed the pan on t the lettuce, and with lettuce and cheese C-C with the same of the tray cart, turn without performing	on the make table and placed plates which included the nato/cheese) that had been in table cover. At 11:53 a.m. inds, removed shredded erator, put into a metal pan, he steam table cover next to in the same gloves on put onto the tacos. At 11:58 a.m. gloves on touched the outside ned the cart around, and hand hygiene picked up clean					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pat the lettuce cool. C-4 temperatures of the steam table lid. During an observat an unidentified nurs kitchen from the sm a hairnet, opened th unknown item, and door. During an interview stated she had not "cold" food items, o stated "we don't che stated they [kitchen because it was cold the refrigerator. Wh make sure those ite by stating because not able to articulat maintained a safe t removed from the r During an observat C-C set five plates menu items on the toppers (lettuce/ton sitting on the steam C-C with gloved ha cheese from refrige placed the pan on t the lettuce, and with lettuce and cheese C-C with the same of the tray cart, turr without performing plates. When C-C p	ROCHES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 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	ROCHESTER, MN 559 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG 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. 21100 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 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	ROCHESTER, MN 55901 RECOLDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAGE COLSPANE COLSPAN	ROCHESTER, MN 55901 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTLY AND THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTLY AND THE PROPORTIATE (EACH CORRECTLY ACTION NOT THE PROPORTIATE DEFICIENCY) Continued From page 22 21100 Continued From page 22 21100 Deficiency) Continued From page 22 21100 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 haimet, 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 with gloaved 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 11:53 a.m. C-C with the same gloves on touched the cutside of the tray cart, turned the cart around, and without performing hand hygiene picked up clean plates. When	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00941	B. WING			C 04/27/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21100	Continued From pa	age 23	21100				
	scoop for the chick chicken on the first pieces rolled outsic up the chicken with back into the shell. During an observat beverage cart in the no ice under the m assistant (NA)-F wa of a pitcher with un From 4/18/22 to 4/2 dining room had ar	onto those plates, used a en however, when she put plate some of the chicken de the taco shell, C-C picked in her gloved hand and placed it tion on 4/19/22, at 11:56 a.m. e hallway was observed with ilk or juices. A nursing as observed grabbing ice out gloved un-sanitized hands. 21/22 resident freezer in the in open bag of ice with a cup hultiple staff with ungloved					
	the following items unlabeled, and exp -opened and undat beverage cup locat with. -undated and unlab pulled pork. -undated beef soup -undated, unlabele crunch bars and icc -unlabeled and ope ice cream dated 2/ -undated and labele burrito.	d, opened box of ice cream e cream sandwiches. ened container of rocky road 16. ed "CAT" Cilantro and Lime					
	at 12:02 p.m. dieta asked by surveyor "cold" items that co steam table lid and checked since rem	tion and interview on 4/19/22, ry assistance (DA)-A was to take temperatures of the ontinued to be on top of the had not been temperature oval from the refrigerator. was 75.0 degrees, tomatoes					

STATE FORM

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CJZE11

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Minneso	ta Department of He	ealth			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMI	PLETED
		00941	B. WING		C 04/27/2022	
		1			04/.	2112022
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
21100	Continued From pa	ige 24	21100			
	was 73 degrees, ar Despite the warm to items, they continue table lid until all me to the residents at a During an observat "ACT" condiments prior were no longe female nurse grabb freezer with un-san Shasta soda can fo cup, touched whee then touched reside refrigerator and the using wall mounted During an observat the following items	nd cheese was 59 degrees. emperatures for these food ed to be on top of the steam als were plated and delivered approximately 12:40 p.m. found in refrigerator the day er found. An unidentified bed ice cubes out of dinette itized bare hands; poured or R11 into a covered sippy lchair arms to adjust resident, ent cup, then went back to en completed hand hygiene I hand sanitizer.				
	-opened and undate seasoning.	ed ranch popcorn seasoning. ed nacho cheddar popcorn ed whole yellow kernel				
	-opened, unlabeled popcorn oil with art by 11/21. -opened, unlabeled	l, undated, and uncapped ificial butter flavor; best if used l, undated popcorn oil with				
	-opened and undate	or; best if used by 3/21. ed pure vegetable oil. ed Nestle hot chocolate				
	crackers; best if us	ed Great Value honey graham ed by 10/2/20. awn platinum powerwash dish				
nnosota D		eled bottle of clear liquid				

STATE FORM

CJZE11

If continuation sheet 25 of 64

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
			A. BUILDING.		с	
C		00941	B. WING	B. WING		27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOI STER, MN 559			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21100	Continued From pa	age 25	21100			
	-opened bottle of C	Dxivir Tb spray cleaner.				
	footlong Subway sa	tion on 4/19/22, at 3:56 p.m. a andwich and opened Body cated inside resident dinette				
	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 betweer 10 or 11am until 4pm at the very latest.					
	NA-B walked into k did not perform ha	tion on 4/20/22, at 8:42 a.m. kitchen without a hairnet on and nd hygiene, grabbed an om steam table, and walked item.	t			
	saran wrapped pla pickle for R11 was refrigerator; howev piece chicken tend	tion on 4/20/22, at 3:06 p.m. a te with tomato, lettuce, and found in the resident dinette rer, it was undated. A three ers package from Kwik Trip as placed on the counter top				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						С
		00941	B. WING			27/2022
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
OCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21100	Continued From pa	age 26	21100			
	practical nurse (LP resident freezer wit	. At 3:08 p.m., a licensed N)-D grabbed ice from th un-sanitized gloved hands to her from medication cart.				
	facility plastic beve	tion on 4/21/22, at 9:34 a.m. a rage glass was observed ed ice cube bag inside resident				
	at 9:36 a.m. CDM of have not been clear expectation for the or more often if new are to change thes complete on 4/18/2 discussion. A clear taped to kitchen re blanks last dated in confirmed she was kitchen to ensure of completed on time.	tion and interview on 4/21/22, confirmed grill grease trays aned yet. CDM stated her se to be cleaned once a week eded. CDM stated the cooks e and she asked C-C to 22 afternoon via verbal hing schedule was observed frigerator door with numerous n February 2022. CDM the manager in charge in the cleaning schedule gets . CDM confirmed dietary staff s of resident dinette				
	refrigerator/freezer and dated, and che foods have not exp task to complete an completed routinely log was taped to th CDM confirmed sh	c, ensure everything is labeled eck once a week to ensure bired. CDM stated this is her nd it has not been getting y. A March 2022 temperature e outside of dinette freezer. e did not post a new one and it npleted twice a day. CDM				
	expressed concern spoilage, thawed fr temperatures which illnesses for reside following items four refrigerator/freezer	n potentially leading to food ozen foods, improper food h could lead to food borne nts. CDM confirmed the nd in the dinette : abeled 4/18; CDM stated this				

Minneso	ta Department of He	ealth			FORM	APPROVE
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
						С
		00941	B. WING			27/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
BOOLES		2215 HIG	HWAY 52 NO	RTH		
RUCHES		ROCHES	TER, MN 559	01		
(X4) ID			ID	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5) COMPLETI
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T		DATE
				DEFICIENC	()	
21100	Continued From pa	nge 27	21100			
	· · · · · · · · · · · · · · · · · ·					
	refrigerator.					
		Dew dated 2/10; CDM				
	uncertain who this					
	stated this should b	osi dated 3/15 for R2; CDM				
		juice dated 2/16 for R24.				
		unlabeled bottle of ensure;				
		al was broken and which				
	resident it was use					
		unlabeled crunch ice cream				
	bars.					
		unlabeled ice cream				
	sandwiches; 2 boxe					
		unlabeled popsicles; CDM				
		ere freezer burnt and threw				
	them out.					
	-undated, unlabeled	d, frozen pulled pork and soup				
		d "CAT" burrito; CDM stated				
	she's unable to ide	ntify "CAT" and uncertain if it's				
	a resident's or emp	loyee's food.				
	-opened Sara Lea I	Bread in drawer below				
	countertop; CDM s	tated, "this is very expired,				
	hardened, and can	t be served to anyone."				
	When interviewed (on 4/21/22, at 10:05 a.m. CDM				
		ce machine is unable to keep				
		is and the ice machine located				
		" is not functional currently so				
		e ice placed in the dinette				
		rmed all ice should be kept in				
		with an appropriate ice scoop				
		e bag. CDM confirmed ice was				
		closed, or unsure how old it				
		e bag out immediately. CDM				
		uld use hand hygiene, clean				
		op or glass, and not place the				
		between using. CDM				
		Id be used in their beverage				
	cart container whic	h holds milk and juices to				
	ensure they are ker	pt at appropriate temperatures				1

A. BUILDING:	STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
09941 B.WING 04/27/2022 AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 ADORESS, CITY, STATE, ZIP CODE COCHESTER HEALTH SERVICES WEST 2215 HIGHWAY 52 ADOREST, MAN 55901 DEPH CORRECTION GENERATION OF DEPICIENCE OF THE MODE OF THE MO				A. BUILDING:			
DUCKESTER HEALTH SERVICES WEST 2215 HIGHWAY 52 NORTH ROCHESTER, MX 65901 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IP PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY) (0) DEPICIENCY 21100 Continued From page 28 21100 Image: Construction of the propoorn activities uses it once a month. ACT stated the popcorn machine in dinette kitchen is scieldon used and confirmed activities uses it once a month. ACT stated she used the popcorn machine [1] 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 so todad them stated they were considered opened. ACT confirmed vegetable oils, hot chocolate cocco powder, and graham crackers were opened, undated, and expired. ACT opened unidentified spray bottle cleaner, sniffed it, and stated tive as whats inside the bottle. "ACT stated she was in charge of checking food items in popcorn carit; however, confirmed she only checks items she used and never checked the entire popcorn cabinet. ACT expressed concern of other facility staff using outbated and expired foods. ACT confirmed denaing supplies with chemicals should not be with resident food items. When interviewed on 4/21/22, at 10:54 atm. RN-A stated ice machine in "coffee room" has been troken 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 unwashe hands prior to grabing an unindentified			00941	B. WING	B. WING		
CACHESTER HEALTH SERVICES WEST ROCHESTER, MN 55901 (X4) ID TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED & FULL) REGULTIONY ON LSC IDENTIFYING INFORMATION) ID PREFIX TAG D PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTINE ACTION SHOULD BE CROSS-REFERENCY) (x6) (EACH CORRECTION SHOULD BE CROSS-REFERENCY) (x6) (EACH CORRECTINE ACTION SHOULD BE CROSS-REFERENCENCY) (x6) (EACH	IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
Display by the provided of the property of the propery of the propery of the property of the property of the property o	OCHES	TER HEALTH SERVI	CES WEST				
TAG REGULATORY OR LSC DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 21100 Continued From page 28 21100 21100 During an observation and interview on 4/21/22, at 10:19 a.m. ACT stated the popcorm machine in dinette kitchen is seldom used and confirmed activities uses it once a month. ACT stated she used the popcorm machine. Text the other day," however, it remains solied and unsanitary today. ACT stated she uses the expiration dates of food items located in popcon cabine. ACT confirmed the popcorms expiration dates she used "just the other day" had wom off and was unable to identify date. ACT stated she does not think popcorm seasonings need date opened labeled on them, but stated they were considered opened. ACT confirmed vegetable oils, hot chocolate cocca 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 "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 hainet and unwashed hands prior to grabbing an unidentified			ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		
During an observation and interview on 4/21/22, at 10:19 a.m. ACT stated the popcom machine in dinetite 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 solied 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 popcon cabinet. ACT expressed concern of other facility staff using outdated and expired foods. ACT confirmed leaning 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 haimet and unwashed hands prior to grabbing an unidentified					CROSS-REFERENCED TO	THE APPROPRIATE	DATE
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 dates 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	21100	Continued From pa	age 28	21100			
During an observation on 4/21/22, at 11:59 a.m.		at 10:19 a.m. ACT dinette kitchen is s activities uses it on used the popcorn r however, it remains ACT stated she us items located in po the popcorns expir other day" had wor date. ACT stated s seasonings need d but stated they wer confirmed vegetab powder, and graha undated, and expir spray bottle cleane vinegar and water is what's inside the bi- charge of checking however, confirme used and never ch- cabinet. ACT expre- staff using outdater confirmed cleaning should not be with When interviewed stated ice machine broken for a very lo kitchen is unable to During an observat environmental serv- observed entering unwashed hands p item off of steam ta	stated the popcorn machine in eldom used and confirmed ince a month. ACT stated she machine "just the other day," is soiled and unsanitary today. es the expiration dates of food poorn cabinet. ACT confirmed ation date she used "just the in off and was unable to identify the does not think popcorn late opened labeled on them, re considered opened. ACT le oils, hot chocolate cocoa im crackers were opened, ed. ACT opened unidentified er, sniffed it, and stated it was and "I guess it should state ottle." ACT stated she was in g food items in popcorn cart; d she only checks items she ecked the entire popcorn essed concern of other facility d and expired foods. ACT g supplies with chemicals resident food items. on 4/21/22, at 10:54 a.m. RN-A in "coffee room" has been ong time and the one in the p keep up with demand. tion on 4/21/22, at 11:37 a.m. vices manager (EVS)-A kitchen without hairnet and prior to grabbing an unidentified able.	y A			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00941	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21100	Continued From pa	ige 29	21100			
	director of nursing	(DON) entered kitchen door,				
	then backed out, ar	nd then rummaged through				
		should be kept. DON asked				
		e retrieved hairnet from and urvey team brings their own.				
		DM where the hairnets are				
		to don on her head. A				
	personal staff lunch	n bag observed sitting on				
		underneath the bananas				
		am table. DA-A observed				
		eekly shipment of foods from dating items with received				
		atures were not tempted for				
		Grill tray observed very heavily				
	soiled with great ye	it.				
	During an observation on 4/21/22, at 12:20 p.m.					
	beverage cart was	beverage cart was observed without ice				
	underneath milks a	nd juices.				
	When interviewed	on 4/21/22, at 12:56 p.m.				
	registered dietician	(RD) stated kitchen has been				
		y assurance and performance				
		(I) and part of their plan of				
		e last state survey. RD upposed to be working full-time				
		ek. RD confirms CDM is				
		not have to report hours				
	worked.					
	During an observat	ion and interview on 4/21/22,				
		observed entering kitchen				
	without a hairnet or	completing hand hygiene.				
		as unaware as "nobody ever				
		posed to walk into kitchen DON overheard conversation				
		surveyor and quickly wanted				
		ducation. DON stated she was				
	going to immediate	ly put up a sign on the kitchen				
	door telling all staff epartment of Health	to not enter kitchen without a				

		ealth (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		E CONSTRUCTION		E SURVEY PLETED
		00941	B. WING		04/	27/2022
IAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, S			
ROCHES	STER HEALTH SERVI	CES WEST	215 HIGHWAY 52 NO ROCHESTER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIC		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21100	Continued From pa	age 30	21100			
	when she realized their main door. As Please put on a ha Kitchen!!!" Hairnets	rved starring at kitchen a sign was already posi sign observed stated, "S irnet before Entering th s were not observed on en but inside the doorw	ted on Stop! e the			
	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.		nter has not concern			
	confirmed kitchen v another dietary ma was uncertain why information and wh (one in the kitchen downstairs in the b kitchen was unsam week. RD expected staff wore hairnets performed hand hy for the opportunity staff to easily touch could potentially leas stated expectation food temperatures concern would be p foods being in the opportunity	on 4/21/21, at 4:28 p.m was cleaned on 3/28/22 nager from a sister faci CDM did not know this by there are two differen and one in the CDM of asement). RD confirme itary when she arrived t d her CDM to ensure fa in kitchen at all times a giene. RD expressed c for hair to get in food ar their hair and faces wh ad to cross contaminati for dietary staff to chec before severing as her potential food poisoning danger zone. RD stated DM to know all of this."	2, by lity. RD at forms fice ed the his cility and oncern hich on. RD k cold g and d, "I			
	stated she felt fortu facility this week. R out as my staff cha	on 4/22/22, at 1:10 p.m Inate state survey walk ID stated, "I can't find a Inge how they act when ty." RD confirmed the	ed into Il of this			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00941	B. WING			C 27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE	•	
		2215 HIG	HWAY 52 NOR			
KUCHE	STER HEALTH SERVI	ROCHES	TER, MN 5590	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21100	Continued From pa	ige 31	21100			
	temperatures and o issue for this facility expressed she did unknowledgeable h confirmed CDM har coached on being p assisting staff with "blatantly lies to you was without dietary as CDM did not cor sister facility. RD st RD confirmed anot without dietary staff called, no showed" McDonald's by activ she was in contact training to obtain Sp for current staff as reads Spanish. RD quizzes on educatio when completed. R basement where ar was located. CDM additional freezer a basement. Freezer since 3/18/22. During an observat sign is posted on re "Please make sure dated!!!! Anything r 7 days old or older otherwise specified please see Jamie, o temperatures were 4/22/22. No temper refrigerator/freezers	dating foods have been an / for a very long time. RD not realize how her CDM really was. RD d previously been verbally present in the kitchen and dietary duties and h her team. RD stated CDM ur face." RD confirmed facility staff on 4/17/22 for breakfast nfirm a back-up plan with a rated CDM "dropped the ball." her instance when facility was f as a new employee "no and residents were served wities director. RD confirmed with North Shore corporate panish educational materials half of dietary speaks and confirmed dietary staff takes on and signs off on materials half of dietary speaks and confirmed dietary staff takes on and signs off on materials half of dietary speaks and confirmed dietary staff takes on on 4/24/22, at 8:09 a.m. a efrigerator door stating, all items are labeled and not labeled and dated and/or is will be thrown away, unless . Any questions or concerns dietary manager." Freezer not completed in evening on ratures were obtained for s until C-D noticed surveyor pting. C-C and C-D confirmed				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00941	B. WING		C 04/27/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21100	Continued From pa	age 32	21100			
	when she is at facil not use a translator	n downstairs basement office lity. C-C confirmed CDM did r or use Spanish educational C or DA-A who primarily read n.				
	undated and unlab were observed sitti with only one donut tempting resident d	tion on 4/24/22, at 8:20 a.m. eled Cream Dream donuts ng on top dinette refrigerator t leftover. C-D observed linette refrigerator and freezer operature log for 4/24/22				
	9/2017 indicated, a accordance with th -All staff will practic techniques and glo -Dining Services st preparation proced by potentially physi contamination.	e proper hand washing ve use. aff will be responsible for food ures that avoid contamination cal, biological, and chemical				
	responsible for foo minimize the amou exposed to temper	es Director/Cook(s) will be d preparation techniques which nt of time that food items are atures greater than 41 degrees 135 degrees F, or per state eld at appropriate				
	temperatures, grea state regulation red than 41 degrees F -All TCS foods that 24 hours at a temp less, will be labeled	ter than 135 degrees F (or as quires) for hot holding, and less for cold food holding. are to be held for more than erature of 41 degrees F or and dated with a "prepared				
	The facility policy ti indicated, all canne	a "use by date" (Day 7). tled Receiving revised 9/2017 ed goods will be appropriately s, rust or bulges. Damaged				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						С
		00941	B. WING		04/2	27/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S			
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
21100	Continued From pa	ige 33	21100			
	return to vendor or -All food items will I dated either throug staff notation. The facility policy ti revised 4/2018 indi be maintained at a or below, except du preparation and set -Freezer temperature temperature of 0 de -A written record of recorded. -All foods will be sta containers, labeled manner to prevent The facility policy ti revised 9/2017 indi separate/secured a -All chemicals will b containers. If chem container, the holdi labeled with the nat Safety Data Sheet The facility policy ti indicated, ice will be safe and sanitary m -Ice scoops will be separate container and moisture retem -Staff will adhere to gloved hands for ha -In the event of a m be purchased from stored in a manner temperature and pr	res will be maintained at a egrees F or below. daily temperatures will be ored wrapped or in covered and dated, and arranged in a cross contamination. tled Storage: Chemicals cated, all chemicals will be in a crea. be retained in their original nicals are not in original nicals are not in original ng container will be clearly me corresponding with the (SDS). tled Ice revised on 9/2017 e prepared and distributed in a nanner. cleaned and stored in a that limits exposure to dust tion. be proper utensil usage or clean andling. bechanical malfunction, ice will an approved vendor and that maintains proper revents cross contamination.				
nnesota D		tled Staff Attire revised 9/2017 nembers will have their hair off				

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Minnesc	ota Department of He	aalth			FORM	APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COM	PLETED
						С
		00941	B. WING			27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DRESS. CITY. S	STATE, ZIP CODE		
		2215 HIG	HWAY 52 NO			
ROCHES	STER HEALTH SERVI	CES WEST	TER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETE DATE
IAC		,		DEFICIENCY)		
21100	Continued From pa	age 34	21100			
		-				
	facial hair properly	fined in a hair net or cap, and				
		restrained.				
	The facility policy ti	tled Equipment revised 9/2017				
		ervice equipment will be clean,				
	sanitary, and in pro					
		quipment will be cleaned and				
	sanitized after ever	'y use. Ict equipment will be clean and				
	free of debris.	ict equipment will be clean and				
	The facility policy titled Environment revised					
	9/2017 indicated, all food preparation areas, food					
		dining areas will be				
		an and sanitary condition.				
		es Director will ensure that a hedule is in place for all				
		t, food storage areas, and				
	surfaces.					
	-All food contact su	Irfaces will be cleaned and				
	sanitized after each	n use.				
	The fact it for a line of the second					
		tled Food: Safe Handling for srevised 7/2019 indicated,				
		re intended for later				
		esponsible facility staff				
	member will:					
	-Ensure that the fo	od is stored separate or easily				
	distinguishable fror					
		are in a sealed container to				
	prevent cross conta					
	-Label foods with the current date.	ne resident name and the				
		ers for storage of foods				
		rs will be properly maintained				
		ure monitored daily for				
	refrigeration less th	nan or equal to 41 degrees F				
		equal to 0 degrees F. Daily				
		gerated storage duration and				
		l items that have been stored				
/linnesota D	epartment of Health					

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00941	B. WING		04/2	C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CESWESI	HWAY 52 NC TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
21100	Continued From pa	ge 35	21100			
	frozen foods and sh	equal to 7 days. (Storage of nelf stable items may be s.) Cleaned weekly.				
	The dietary manage the staff on why reg and proper sanitiza of perishable foods born illness. A meth are taken, documen if needed could be appropriate staff. Th designee could initia and food storage.	THOD OF CORRECTION: er or designee could educate gular temperature monitoring tion is important in the storage including the risk for food nod of ensuring temperatures nted, reviewed and acted upon developed and assigned to the he dietary manager or ate audits of temperature logs, R CORRECTION: Twenty one				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			6/2/22
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review the facility fa procedures were in and spread of an un illness in the facility (R82, R27, R1, R20 and R9) developing lacked any investig	ent is not met as evidenced ion, interview and document ailed to ensure infection control aplemented to reduce the risk anknown gastrointestinal (GI) resulting in 10 of 28 residents 0, R18, R19, R26, R15, R13, g GI symptoms and the facility ation of causal factors and or n. In addition, the facility failed		Corrected		

If continuation sheet 36 of 64

STATEMEN	It of Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00941		B. WING		C 04/27/2022	
	PROVIDER OR SUPPLIER		ADDRESS, CITY, S		04/.	2112022	
		2215 HI	GHWAY 52 NOF				
ROCHES	STER HEALTH SERVI	CES WEST	STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 36	21375				
	residents, and faile following care of sy this vulnerable pop care workers at risl the facility failed to passing ice water to and a cup inside wi	y isolation of symptomatic d to perform hand hygiene mptomatic residents, placing ulation of residents and health k of serious illness. Further, use sanitary practices when o residents, using bare hands ith the ice to scoop, this had ect all 28 residents currently ity.					
	director of nursing illness in the facility	on 4/20/22, at 2;39 p.m. the stated they had some GI / but it was resolved at this					
	outbreak and notified Health and notified medical director. O R9, but canceled b and they determine constipation. Anoth	ated they treated it as an ed Olmstead County Public the nurse practitioner and the one test had been ordered for ecause R9 went to the hospita ed her symptoms were from her specimen was ordered, bu ff had been ill with GI	al				
	symptoms, but did symptoms were go which staff had bee they had a noroviru is highly contagious confirmation of that	not come back to work until a ne. The DON had not tracked en ill. They were questioning if is (gastro-intestinal illness tha					
	precautions and an immediately. Staff gloves in any symp they placed the res protection," which r supposed to use so	ayone who had an emesis were to wear gowns and tomatic resident room. Also, idents on, "enhanced barrier meant staff were also bap and water for washing					
	-	res rather than hand sanitizer. linimum Data Set (MDS) dated					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _				
		00941	B. WING	B. WING		C 04/27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 37	21375				
	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.		N				
	gastro-intestinal illr Clostridium Difficile the colon caused b difficile, often resul healthy bacteria in antibiotics. C. Diff of person to person b killed by hand sanit with judicious hand water). Staff were of precaution as indic signs of dehydratio staff on contact pre- soap and water for hand sanitizer and	ted 4/15/22, identified a ness related to an outbreak of e Colitis, (an inflammation of by the bacteria Cloststridium ting from disruption of normal the colon, often from can also be transmitted from y spores and spores are not tizer, they can be washed off I washing with soap and directed to, "Maintain droplet ated for cdiff," and monitor for in. The care plan did not direct ecautions or direct them to use hand washing rather than did not give any direction on edicating equipment to prevent tion.					
	4/15/22, identified ' for cdiff."	administration record dated 'enhanced barrier precautions					
		d showed she had frequent several times per day since 2.					
	but did not identify	ss tracking log identified R82, the start date of loose stool, it g," only. The map of GI illness being, "C. Diff."					
	door was closed ar	on 4/19/22, at 4:10 p.m. R82's nd there was a sign on the door ed barrier precautions," and					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00941	B. WING			C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	IGHWAY 52 NOF ESTER, MN 559			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
21375	Continued From pa	age 38	21375			
	picture of a bottle of gloves and gown.	o clean hands and there was of hand sanitizer on it, use of A bottle of hand sanitizer was nd some disinfectant wipes.				
	entered R82's room not put on gown or on R82's over-bed moved the table to on the tray table. N off and left the room hygiene. NA-B place cart, then proceeded hall with her bare h time, NA-B stated F NA-B stated she has and gloves if she w and did not wash h hurry. NA-B stated sanitizer and was u removed by using h	on 4/20/22, at 8:20 a.m. NA- n with a meal tray. NA-B did gloves. NA-B set the meal tr table and with bare hands wards R82 and arranged iten IA-B then took the plate cover n without performing any han ed the plate cover on the tray ed to move the cart down the hands. When interviewed at the R82, "might have C. Diff." ad been told to wear a gown vas working with, "body fluids her hands due to being in a she should have used hand unaware C. Diff spores are no hand sanitizer and hand and water should be used	ay ns r nd y nis			
	environmental servi hand sanitizer shou resident room and case of C. dif, EVS any difference, stat sanitizer, it is quick control education h facility, but did not specific related to v	on 4/20/22, at 9:38 a.m. the vices supervisor (EVS)-A state uld be used before going into after leaving the room. In the A stated she was not aware ting, "we typically use hand er." EVS-A stated infection had been provided at the recall receiving anything washing hands with soap and of C. dif. or Rotavirus.	of			
	licensed practical n	on 4/20/22, a 9:46 a.m. hurse (LPN)-A stated, for R82 who had C. Diff, the				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00941	B. WING			C 27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST	HWAY 52 NOF TER, MN 559(
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	resident should hav equipment, staff shi hands should be wa instead of hand sar should be using har water for any reside symptoms. LPN-Av indicated hand san During observation occupational therap assisting R82 to the incontinent loose st and gloves assisted completed OT-A pla OT-A removed her room with a tablet, used hand sanitizer stated R82 had an type of infection. OT Diff and hand wash hand sanitizer. OT- after it had been in OT-A with contamir this time, R82 share adjacent room. When interviewed of registered nurse (R what type of transm (TBP) a resident re posted on their doo should use soap an of alcohol based sa person with C. dif, to information was pos knew that. After che	ve separate dedicated ould use gown and gloves and ashed with soap and water nitizer. LPN-A stated staff nd washing with soap and ents with vomiting or diarrhea was not sure why the TBP sign itizer was to be used for R82. on 4/21/22, at 10:50 a.m. bist (OT)-A was observed e bathroom, R82 had an ool and OT-A wearing gown d R82 with cleaning up, when aced the soiled items in a bag. gloves and gown and left the OT-A set the tablet down and . When interviewed, OT-A infection, but was unsure what T-A did not know R82 had C. ing should be used instead of A had not sanitized her tablet R82's room and touched by hated hands. It was noted at ed a bathroom with R15 in an on 4/21/22, 10:59 a.m. a N)-C stated staff would know hission based precautions quired if infectious by the sign r. RN-C also said that staff ind water hand washing instead unitizer when working with a out was unsure it that sted on the door, or how staff ecking R82's door, and not ation, RN-C stated he was				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00941	B. WING	B. WING		27/2022
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OCHES	TER HEALTH SERVI	CES WEST	3HWAY 52 NOF STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21375	Continued From pa	age 40	21375			
	director of nursing gastro-intestinal (G the past week, but it to be an outbreak cases of diarrhea in physicians and nur notified, but said th but DON stated in h have been hyper-vi received orders for had been unable to resident, and the of canceled. The test was positive for C. GI outbreak, reside monitored, signs re and personal prote supplies would be p said she was unsu about using soap a sanitizer in the case not posted a sign, B between 9:30 a.m. go post the sign rig going to start PPE said R15 and R26 GI illness, and she barrier precautions was going to talk w "strongly encourag and any residents v DON said R15's FN shared with R82, b sign on the door or	IDS dated 3/28/22, identified				
		nd had heart disease and ired limited assistance with				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00941	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	GHWAY 52 NO			
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET DATE
21375	Continued From pa	age 41	21375			
	toileting and was co	ontinent of bowel.				
	R27 was not shown tracking log.	n on the facility GI illness				
	watery stools and e	ord identified R27 had loose emesis on 4/12/22, and had P, which were removed on				
	stated he had gotte	on 4/22/22, at 9:00 a.m. R27 en ill about 10 days ago and Is off and on since then.				
	DON stated a stool obtained for R27 as no diarrhea. The D	on 4/22/22, at 10:19 a.m. the l collection order was not s they only had vomiting and ON was not aware R27 ose stools along with the 2.				
	at 10:31 a.m. RN-C room and proceede south hall completi RN-C observed usi resident room inste was observed not s pulse oximeter equ RN-C stated he sho	tion and interview on 4/22/22, C was observed leaving R27's ed going from room to room o ng vital signs on each residen ing hand sanitizer outside eac ead of hand washing. RN-C sanitizing thermometer and ipment between resident use ould have disinfected the n each resident and used soa washing.	n it. :h			
	cognitively intact w	lated 4/1/22, identified ith diagnosis of heart disease ive assistance to toilet and ontinent of stool.				
	R1's bowel record	identified loose stools as early	/			

STATEMEN	o <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
			A. BUILDING			С	
		00941	B. WING			27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLET	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE	
21375	Continued From pa	age 42	21375				
	as 4/9/22, with multiple daily loose stools starting on 4/12/22.						
	gastro-intestinal illn Rotavirus, staff wer symptoms of GI ou and encourage to s precautions, and to	ed 4/22/22, identified a less related to C. diff and re to educate on signs and tbreak, frequent handwashing stay in room along with contact o monitor for signs of are plan also directed to use hand washing.					
	infections as being GI illness symptom did not have a roon was sent on 4/23/2 identified R1 as sta with the word, "aga	n the facility map of GI in one room but moved due to s to another room where she n mate and a stool specimen 2. The line listing of GI illness rting symptoms on 4/20/222, in." A stool specimen had back, with no information on					
	identified they had a 4/23/22, and the sto Diff and directed fa and provide proper and a report was se	nunication from Mayo Clinic lab received a stool specimen on ool contained Rotavirus and C. cility to place R1 on isolation infection control processes ent to community heath. otic used to treat C. Diff) was					
	included, "Call rece clinic with lab result tested and resulted Rotavirus and C-dif [physician] gave tel 125 mg to start with	dated 4/23/22, at 10:42 p.m. sived from [physician] from ts for resident. Stool was with positive results for ff. Pharmacy notified, as ephone order for Vancomycin nin 24 hrs. Pharmacy will be ed through back up pharmacy row morning."					

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		СОМ	PLETED
		00941	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	GHWAY 52 NOF			
	SUMMARY STA		STER, MN 559	PROVIDER'S PLAN OF	CORRECTION	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 43	21375			
	stated R1 had deve previous evening, a private room. Testin immediately and re had Rotavirus and were to isolate the	on 4/24/22, 8:17 a.m. RN-C eloped GI symptoms the and had to be moved to a ng had been completed sturned results indicated R1 C. Diff. RN-C stated staff resident, wear PPE of gown, nd wash hands with soap and				
	cognitively intact ar bowel syndrome wi	OS dated 3/2/22, identified nd diagnoses including irritable ith diarrhea and a stroke. R20 assistance with toileting, but ent of bowel.				
	2022 identified loos had two loose income again on 4/21/22. F the DON had been	adder elimination log for April se stools starting on 4/14/22, ntinent stools on 4/15/22 and R20's progress notes identified notified of loose stools and a transmission-based				
	tracking log as star	on the facility GI illness ting symptoms on 4/21/22. ss's identified R20 as having ymptoms.				
	identified a stool sa the lab on 4/22/22, identified Rotavirus causes diarrhea, vo abdominal pain and even death). The c health would need	munication from Mayo Clinic ample had been obtained by and on 4/25/22 the specimen a (a very contagious virus that omiting, fever and/or d can lead to dehydration or ommunication identified public to be notified of this nurse practitioner note dated				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _	A. BUILDING:		С
		00941	B. WING			27/2022
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
OCHES	TER HEALTH SERVI	CES WEST	GHWAY 52 NOF STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 44	21375		,	
		ified R20's stool sample was				
	nursing assistant (arranged items on gloves and left the NA-A touched R20 mechanical lift in th communal bath ha room and went into washed her hands	n on 4/22/22, at 9:50 a.m. NA)-B was in R20's room and the bedside stand, removed room without washing hands. 's door handle, then went to a ne hallway and brought it to the Ilway. NA-A then went into R3's to the bathroom where she . NA-A did not disinfect the lift after touching with ds.				
	medical doctor (MI assisted R20 with a room he used hand According to the C (CDC) updated 200 and water is most of Rotavirus from har MD-C used his per backpack then use shirt pocket and pr donned gloves with and water and assi interviewed on 4/22 stated staff had insi at door, but did not residents who were	n on 4/22/22, at 9:58 a.m. D)-C was observed to have toenails, when MD-C exited the d sanitizer outside of the room. enter for Disease Control 21, hand washing with soap effective for removing nds versus hand sanitizer. rsonal laptop, touched a ed personal cell phone from occeeded to R30's room. MD-C nout washing hands with soap isted R30 with toenails. When 2/22, at 12:11 p.m. MD-C structed him to don/doff gloves is specify the type of illness the e on TBP had. If he had known ad soap and water versus hand	,			
	attempted to bring R20 whose room is regional nurse con	on 4/24/22, at 9:25 a.m. R18 a bottle of sparkling water to s directly across the hall. The sultant (RNC)-B instructed R18 items from one room to	3			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00941	B. WING			27/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	ICES WEST	HWAY 52 NOF STER, MN 559			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 45	21375			
	another without us	ing a bleach wipe on it.				
		n on 4/25/22, at 8:27 a.m. the				
	health unit coordinator (HUC) knocked on R20's door, donned personal protective equipment					
		the room with a meal tray. The	e			
	HUC set the tray o	n the bedside table, moved				
		e bedside table, removed d outside the room, where she				
		to the utility room door and				
		dle to open the door. The HUC				
		ands, but did not disinfect the edoor handle that she had				
		itially contaminated hands.				
	R20 as having GI s tracking log identifi	ed room tracking log identified symptoms, and the GI illness ied R20 as beginning /22, even though loose stools o that date.				
	identified cognitive multiple sclerosis.	hange MDS dated 2/24/22, ly intact with diagnosis of R18 required extensive leting and was frequently l.				
	on 4/14/22. R18's I	d identified loose watery stools medical record identified she n TBP on 4/16/22, but was 22.				
	R18's physician on	entified a note was sent to 4/22/22 indicating she had so isolation precautions were				
	R18 was identified starting symptoms	on the facility GI illness log as on 4/22/22.				

If continuation sheet 46 of 64

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00941	B. WING		04/2	27/2022
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	nge 46	21375			
	During an observation on 4/24/22, at 8:08 a.m. a new isolation cart was located outside R18's room.					
	R18 was observed room and into halw asked R18, "What's redirection to R18 t Family member (Fi another resident ro redirected R18 to g	ion on 4/24/22, at 8:47 a.m. coming outside of her isolatior vay. LPN-A glanced over and s up?" and did not provide o go back into her room. M)-A was observed leaving om on north hallway and lo back into her room. FM-A ssisted R18 back to room.				
	R18 was observed help to get to the ba medication cart; wh to assist. FM-A req	ion on 4/24/22, at 8:54 a.m. back in hallway requesting athroom. LPN-A observed at hile FM-A ran down the hallway uested help from DON; FM-A to, "hold on." R18 wait.				
	cognitively intact wi prostate cancer. R	S dated 2/25/22, identified ith diagnosis of diabetes and 19 required extensive ting and was always continent				
	stated he had beco starting 4/16/22. R ² his diarrhea and ha his bedding as he v stools. R19 stated I 4/18/22 in the even much dinner. R19 s placed on any time	on 4/19/22, at 11:35 a.m. R19 me ill with severed diarrhea 19 stated staff were aware of ad placed incontinent pads on was unable to control the loose he had started to feel better on ing, but was still unable to eat stated he had never been of precautions and he went nch on 4/19/22, but was				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00941	B. WING			C 04/27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ROCHES	STER HEALTH SERVI	CES WEST	GHWAY 52 NOF STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 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.						
	identification of the medical record sho	tes did not show any diarrhea, nor did R19's w any evidence the physician of the illness or any monitoring					
	DON stated . DON had diarrhea on 4/' overnight shift. DO provider of gastroir confirmed R19 was precautions and his	on 4/22/22, at 10:19 a.m. the confirmed she was aware R19 16/22 as she worked an N failed to inform medical ntestinal symptoms. DON s never placed on isolation s symptoms still existed on sample had been sent to the	9				
	undated, identified illness, but R19 wa GI illness. A line lis	nap of GI illness symptoms, several residents who had GI s not identified as having any ting of residents who had beer dated 4/24/22, also did not	1				
	cognitively intact w R26 required exter	OS dated 3/26/22, identified ith diagnosis of heart failure. asive assistance with toileting incontinent of bowel.					
	tracking log as beg	on the facility GI illness inning GI symptoms on of illness showed she had GI					

	ta Department of He			CONCEPTION		
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDING.			_
		00941	B. WING			C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
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		ROCHES	STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ige 48	21375			
		ools on 4/19/22, 4/20 had one 4/21 had 7 loose stools, was 21st.				
	R26 had a sign on for "droplet precaut open and R26 was	ion on 4/21/22, 10:29 a.m. her door indicating the need ions," but the door was wide sleeping without cough or of respiratory disease noted.				
		showed R26 had loose stools but had an increase in 22.	5			
	identified R15's sto on 4/22/22, and wa	nunication from Mayo clinic ol sample had been obtained s identified to be Rotavirus alth was to be advised.				
	cognitively intact, re with toileting, and w bowel and had a di	DS dated 2/24/22, identified equired extensive assistance /as frequently incontinent of agnosis of ulcerative colitis, or an inflammatory bowel				
	having loose stools orders dated 4/24/2	showed she had started on 4/16/22. R15's physician 22, identified staff were to imen for diarrhea over 7 days.				
	date of symptoms a	ss tracking log identified a star as 4/20/22. The map of her as having a GI illness.	t			
	was noted R15 sha had been placed or	ion on 4/21/22, at 10:49 a.m. i ired a bathroom with R82 who n precautions for GI illness. M)-C was visiting R15, but was				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00941	B. WING		C 04/27/2022	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OCHES	TER HEALTH SERVI	CES WEST	GHWAY 52 NOF STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
21375	Continued From pa	age 49	21375			
	overheard on the p case of, "stomach t to the bathroom. FI At 10:57 a.m. FM-C illness and also R8 should not enter wi gloves. FM-C state way down the hall t unconsumed bever bathroom to dispose been told he should stated there was no bathroom regarding handwashing.	h, gloves or mask. He was hone to not visit as R15 had a flu." FM-C went into the shared M-C came out of the bathroom C said he was aware of R15's '2's illness. FM-C said persons ithout wearing a gown and ed it was too far to walk all the to dump things such as rages, so he had gone in the se of them. He said he had d not use the bathroom. He o posted information in the g use of the toilet or the dated 4/22/22, at 8:45 a.m. developed, "GI symptoms that round the facility."	1			
	cognitively intact w	OS dated 4/21/22, identified ith diagnosis of a stroke. R13 assistance to toilet and was ent of stool.				
		on the GI illness tracking log ped symptoms and was placed 1/22.				
	cognitively intact w cerebral palsy. R9	6 dated 2/10/22, included ith diagnoses including required extensive assistance ras always continent of bowel.				
	indicated R9 had for started at 7:15 a.m documented R9 su	ted 4/12/22, at 1:29 p.m. our episodes of emesis which . Registered nurse (RN)-A iddenly awoke this morning out no warning. R9 had one				

NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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	00941	B. WING			27/2022
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STER HEALTH SERVI	CES WEST				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	nge 50	21375			
small, hard bowel n enema at this time. reports of other res	novement but has refused RN-A documented there were idents with symptoms on	2			
indicated R9 reques for evaluation as sh stated she felt weal discomfort. R9 refu	sted to go to emergency room he was not feeling well. R9 k and had abdominal ised enema at this time. At				
1:47 p.m. indicated constipation; howev vomiting resolved v fleets enema offere	R9 was likely to have ver, abdominal pain and vithout further intervention. A ed to R9, but she declined				
indicated R9 had tw stools which was re (DON). At 10:09 p.r diarrhea. On 4/17/2 practical nurse (LPI	vo emesis and two loose eported to director of nursing m., R9 had three emesis and 22, at 6:30 p.m. licensed N)-A indicated R9 had no				
stated she became gastrointestinal sign and diarrhea. R9 st coming out both en stated she requeste emergency departn other resident's dow similar gastrointest was sick all week w	violently ill on 4/12/22 with ns and symptoms of vomiting tated she was so ill that "it was ids at the same time." R9 ed to be transferred to the loca nent on 4/13/22. R9 stated wn the south hallway with inal symptoms. R9 stated she vith nausea, vomiting, and				
	PROVIDER OR SUPPLIER STER HEALTH SERVI (EACH DEFICIENCING) Continued From particular SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From particular Small, hard bowel r enema at this time. reports of other resist emesis at the skiller A progress note dar indicated R9 reque for evaluation as sh stated she felt weat discomfort. R9 refur An emergency dep 1:47 p.m. indicated constipation; hower vomiting resolved v fleets enema offere since her abdomina A progress note dar indicated R9 had tv stools which was refunded (DON). At 10:09 p.1 diarrhea. On 4/17/2 practical nurse (LP emesis or loose stor were resolved. When interviewed of stated she became gastrointestinal signand and diarrhea. R9 stor coming out both em- stated she requestor emergency departr other resident's dow similar gastrointest was sick all week v	AT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OO941 00941 PROVIDER OR SUPPLIER STREET AL 2215 HIG ROCHES STER HEALTH SERVICES WEST 2215 HIG ROCHES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 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	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D0941 (X2) MULTIPLE A. BUILDING: B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST STER HEALTH SERVICES WEST 2215 HIGHWAY 52 NOF ROCHESTER, MN 5599 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG 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. 21375 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 feit 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	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00941 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STER HEALTH SERVICES WEST 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRE/X TAG PROVIDER'S PLAN OF (EACH CORRECTIVE AC (EACH CORRECTIVE AC (EACH CORRECTIVE AC ROSS-REFERENCED TO DEFICIENCY TAG D PROVIDER'S PLAN OF (EACH CORRECTIVE AC (EACH CORRECTIVE	IT OF DEFICIENCIES (X1) PROVIDERSUPPLIERCLA Destriction NUMBER X2, MULTIPLE CONSTRUCTION A BUILDING:

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00941	B. WING		C 04/27/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	GHWAY 52 NOF STER, MN 559			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21375	Continued From pa	ige 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.					
	DON stated the nul canceled a stool sp issues with constip	on 4/22/22, at 10:19 a.m. the rse practitioner (NP)-A had becimen for R9 as she had ation not diarrhea and was he GI illness outbreak.				
	facility social worke	on 4/21/22, at 12:27 p.m. the er (SW) stated she had not infection control training today.				
		on 4/21/22, at 12:31 p.m. ad not received any recent ining.				
	DON stated it was a bleach based cle had not switched o	on 4/22/22, at 11:18 a.m. the important for staff to be using aning solution for surfaces, bu ut their standard disinfectant ON stated they would do that	t			
	DON stated no stor yet, they had receiv specimens in the w	on 4/22/22, at 10:19 a.m. the ol samples had been obtained ved orders, and sent rrong type of specimen cup so cted by the lab on 4/21/22.				
	stated one staff per symptoms 4/22/22 another had called	on 4/24/22, 8:39 a.m. DON rson had developed GI and was sent home, and in sick overnight; R1 was otoms and confirmed GI				
	The facilities GI illn	ess outbreak log identified a				

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00941	B. WING			C 27/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	GHWAY 52 NOF STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375		me down with GI symptoms	21375			
	When interviewed of stated one staff per symptoms 4/22/22 another had called moved due to symp infections. DON als develop some GI s afternoon. DON said audits on PPE use facility IJ removal p at the facility. DON consultant (RNC)-E had been going thre policies in the last to When interviewed of stated she was not products were out of to use, but then bro TB" wipes containing have the correct cleat this, an observation bleach, peroxide or isolation carts or wit facility such as med During an observat NA-F walked across unbagged laundry ac clothes bin. NA-F th near the laundry re- her potentially cont	on 4/24/22, 8:59 a.m. RNC-B sure if the correct cleaning on the isolation carts for staff ought in a container of "Oxivir ng peroxide, and said they did eaning solution. Shortly after n revealed there were no "Oxivir TB wipes on any th the shared equipment in the	y e /			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
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		00941	B. WING	B. WING		27/2022
NAME OF I	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	5 HIGHWAY 52 NO CHESTER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 53	21375			
	PPE, entered the reset the breakfast tr moved R20's urina removed gloves, st R20's room, removed utility room door, per door handle to ope washed her hands the room and walke the door handle. During an interview RNC-C indicated so contaminate the door	R20's door, donned approp oom with R20's breakfast t ay down the bed side table, repped outside the thresho red her gloves, walked to th unched the code in, used t n the door, entered and with soap and water, exite ed away. HUC did not disir of 0n 4/25/22, at 8:39 a.m. he had seen the HUC bor code and handle, and ection control audits of the obleted.	tray, e, Id of he he he id nfect			
	registered dietician she had educated of from isolated reside the practice continu- mitigate this she had practice was stopp		rash en,			
	RNC-B and the adr updated all residen disinfectant that wo They had placed sp for staff to use on e	on 4/24/22, at 10:01 a.m. ministrator stated they had t care plans and had order orks on Rotavirus and C. D oray bottles of bleach solut each wing. Lab results for f back and were positive for	red Diff. Lion R20			
	stated even with all doors who are on is nursing staff, nursi	on 4/25/22, at 11:28 a.m. F I the signs on the resident solation and again talking f ng brought back 5 trays fro h garbage back to the kitcl	to om			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _			С	
		00941	B. WING			27/2022	
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST				
ROCHES	TER HEALTH SERVI	CES WEST	IIGHWAY 52 NOF ESTER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21375	Continued From pa	age 54	21375				
	One was tray was even set on a kitchen countertop.						
	R21 wheeled down bathroom in the ha room. R21's room illness. The toilet b observed to have b bowel. At 11:57 a.m hallway with gloves protector up agains to a mechanical lift used the appropria then washed her ha NA-B did not chang At 11:59 a.m. NA-E lift and put her on t	tion on 4/25/22, at 11:49 a.m in to use the communal Ilway and then returned to he mate remained on TBP for G owel in the bathroom was prown spots all over the toilet in. NA-B walked down the son carrying a used mattress at her chest. NA-B then walke located down the hallway ar te disinfectant to wipe it off, ands with soap and water. ge her contaminated clothing assisted R9 onto mechanic he toilet in the communal ough the brown spots on the been cleaned off.	er I s ed nd				
	NA-B confirmed sh communal bathroo TBP and was R21's had a formed bowe wiped down the toil the toilet bowel price bowls were not clear toilet had overflowe brown spots on the whole weekend, and cleaned it after it ow	on 4/25/22, at 12:04 a.m. the put R9 onto the toilet in the m and stated R10 who was of s roommate. NA-B stated R2 el movement, stated she had let seat however did not clea or. NA-B indicated the toilet aned between residents, the ed over the weekend, the bowl had been there the nd housekeeping had not verflowed. NA-B stated she uff has been there since hen I noticed it"	on 21 n				
	HSK stated she ha Saturday. HSK indi	v on 4/25/22, at 12:13 p.m. d been the housekeeper on icated she had been told to dent room bathrooms and did					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			С
		00941	B. WING			27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF TER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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21375	Continued From pa	age 55	21375			
	not clean the comm on Saturday.	nunal bathrooms and/or toilets				
	at 12:21 p.m. EVS- in the communal ba- longer observed in the condition of the EVS-A stated that w cleaned the bathroo had not cleaned it p had been busy. EV not disinfected after cleaned after break leaving at the end of	ion and interview on 4/25/22, A completed cleaning the toilet athroom, brown spots were not the toilet bowl. EVS-A verified toilet bowl prior to cleaning. was the first time she had om/toilet today. Indicated she prior because the bathroom S stated the toilet bowls were r each resident and were cfast, after lunch, and before of the day. EVS-A stated she hday and did not notice the				
	RNC-C was unawa being used until sur attention. RNC-C ir	on 4/25/22 at 12:39 p.m. are why commodes were not rveyor brought it to her indicated in outbreak status it to be cleaning the toilet in				
	medical doctor (ME informed of a coupl building quite some the date. He had be stool samples pend	on 4/25/22, at 1:02 p.m. D)-D stated he had been le cases of diarrhea in the e time ago and could not recall een informed they had some ding by the NP. The NP would o results that are returned.				
	stated 5 isolation tra kitchen, three from 100 wing. RD state put directions on th	on 4/25/22, at 2:22 p.m. RD ay came back from the the 200 wing and two from the d that was even after she had e trays. RD indicated by infectious items back to the he risk for cross				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.		с	
		00941	B. WING	B. WING		27/2022
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
ROCHES	TER HEALTH SERVIO	CES WEST	HWAY 52 NO TER, MN 559			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 56	21375			
		nen staff could inadvertently vithout having the appropriate				
	medical director (M	on 4/25/22, at 3:35 p.m. the D)-P stated If two residents pose stools would do a COVID t for norovirus.				
	beverage cart for the the dining area. A la was located at the e assistant (NA)-F wa ice pitcher with her cup that had been s ice into another cup back into the ice pit poured juice into the the hall to deliver the	ion on 4/19/22, 11:56 a.m. the he noon meal was parked near arge pitcher that contained ice end of the cart. a nursing as observed to reach into the bare hand and lift ice with a sitting in the pitcher, pour the b, and then drop the other cup cher where it remained. NA-F e cup of ice and went down he juice. Hand hygiene touching the cup in the ice npleted.				
	registered nurse (R reached in, took the touching the sides of into a large water m scooping cup back hygiene was not ob ice cup. RN-A then	ion 4/19/22, 12:03 p.m. a N)-A opened the ice pitcher, e cup sitting in the ice, of the cup. RN-A scooped ice nug, and then dipped the into the pitcher of ice. Hand served prior to touching the proceeded down the hall and of ice to R5 in his room.				
	certified dietary ma not be touched with be applied after har	on, 4/21/22, 10:02 a.m. the nager (CDM) stated ice should a bare hand, gloves should nd hygiene. Ice should not be up to scoop, and such a cup g in the ice.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00941	B. WING	B. WING		C 27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST 2215 HIG	HWAY 52 NOF	RTH		
	STER HEALTH SERVI	ROCHES	TER, MN 559	01		-
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	nge 57	21375			
	health unit coordina pitcher on the beve without performing that was in the pitcl ice into another gla back into the ice pit When interviewed of registered dietician should be stored ou was not aware the with a cup from a p and leaving the cup [non-dietary staff] ju	on 4/25/22, 12:46 p.m. a (RD) said a scoop for ice utside of the ice container. RD facility staff were scooping ice itcher on the beverage cart o in the ice. RD said "they ust asked for a pitcher of ice" vare of what happened after				
	director of nursing received training re ice and ice scoops. from her training th in the ice container that a cup was bein beverage cart, nor was being touched in the ice. DON ind	on 4/25/22, 12:49 p.m. the (DON) stated she had lated to infection control with . DON stated she was aware at an ice scoop should not sit . DON said she was unaware ing used to scoop ice on the was she aware that the cup by multiple staff and left sitting icated this was not appropriate to take of this. I'm going right this."	I I			
	stated she had wor years and aside fro pass meal trays for an ice pitcher with a place for possibly s ever being aware th infection control pro	on, 4/25/22, 1:13 p.m. HUC ked at the facility for several m office duties, would help to residents. HUC felt the use of a cup for scooping had been in ix months. HUC did not recall hat the practice might be an oblem. After considering that ght be touching other things in				

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		ESURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
					С	
		00941	B. WING			27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVI	CES WEST	HWAY 52 NOF			
	1	ROCHES	TER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 58	21375			
	scooping, and then the ice for consum	ior to touching the cup used for multiple residents receiving ption, HUC stated she thought tion control concern.	r			
	stated she had not issues. RD stated s CDM or DON at an the pitcher of ice w used to fill beverag covered steel conta	on 4/25/22, 1:30 p.m. RD been made aware of the ice she had not been notified by by time. RD said she thought ould be filled with water and e glasses. RD brought in a ainer and stated she had bop that would be stored in the everage cart.				
	A facility policy was	requested, but not received.				
	The Director of Nur further develop pol delineate how the I program will meet a for infection surveil designee can desig guide nurses not of infections, but in th an informed respor infections, but to pr or designee could p infection identifical, including proper ha transmission based designee could des to utilize for investig control and preven The Administrator of assigned as the fac	THOD OF CORRECTION: rsing (DON) or designee could icies and procedures to clearly nfection Prevention (IP) state and federal regulations lance; additionally, the DON or gn or choose forms that will nly in data collection related to e analysis of the data to form nee to not only control current revent future issues. The DON provide on-going education on , reporting and response, and washing and the use of d precautions. The DON or sign an on-going audit system gation of facility practice for the tion of contagious disease. could ensure that the nurse cility Infection Preventionist training and time to oversee				

Minnesota Department of Health							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:				
		00941	B. WING			7/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NC				
	SUMMARY STA		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE	
21375	Continued From pa	ge 59	21375				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis htrol	21426			6/2/22	
	 (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. 						
	by: Based on interview facility failed to ens active tuberculin sy test (TST) and com screening was com	ent is not met as evidenced and document review the ure screening for possible mptoms with tuberculin skin plete a TB symptom pleted for 3 of 4 residents eviewed for the Tuberculosis		Corrected			

If continuation sheet 60 of 64

Minnesota Department of Health								
		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		00044		B. WING				
		00941		<u> </u>		04/2	7/2022	
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
ROCHES	STER HEALTH SERVI	CES WEST		HWAY 52 NO FER, MN 55				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21426	Continued From pa	age 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 MET The director of nurs revise policies and surveillance. The D	sing (DON) o procedures OON could ed	could review and for TB ducate all					
	appropriate staff on The DON could mo	n the policies	and procedures.					
Minnesota D	epartment of Health				l			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED C	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ROCHES	TER HEALTH SERVI	CES WEST	HWAY 52 NG TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLE ⁻ DATE
21426	Continued From pa	age 61	21426			
	TB screening to en	sure ongoing compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21565	MN Rule 4658.132 Medications Self Ad	5 Subp. 4 Administration of dmin	21565			6/2/22
	self-administer med resident assessme care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observat review, the facility f practice of self-adm	ent is not met as evidenced ion, interview, and document failed to determine if the ninistration of medications was dent (R24) observed to pulizer medications.		Corrected		
	Findings include:					
	(MDS) dated 4/8/22 with diagnoses incl anxiety disorder, co chronic obstructive acute and chronic r pulmonary embolis apnea. R24 require	hange Minimum Data Set 2, included cognitively intact uding schizoaffective disorder, ongested heart failure (CHF), pulmonary disease (COPD), respiratory failure, asthma, m, and obstructive sleep ed extensive assistance from nd personal hygiene.				
	included Ipratropiun that is used to treat	nary Report dated 4/24/22, m-Albuterol Solution (medicine t air flow blockage and prevent D, asthma or other lung				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:			С	
		B. WING			27/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	STER HEALTH SERVIO	CES WEST	HWAY 52 NOF STER, MN 559			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE
21565	Continued From pa	ge 62	21565			
	four times a day for	B) mg/3 ml 1 vial inhale orally shortness of breath. The cked self-administration of				
	risk for respiratory i COPD, sleep apnea	ed 6/1/21, included R24 had mpairment related to CHF, a, and asthma, but ot included self-administration				
	at 6:32 p.m. R24's i was set up on night chamber and moist facility staff have he					
	at 11:55 a.m. R24 v nebulizer equipmer present. R24 stated	ion and interview on 4/22/22, vas observed holding at up to face without a nurse I the nurse told her to press when medication was finished				
	registered nurse (R have a current self- order or an assess interdisciplinary tea	on 4/22/22, at 12:32 p.m. N)-B confirmed R24 did not administration of medications ment completed by the m from physician and stated histered the noon dose.				
	director of nursing (not self-administer	on 4/25/22, at 11:05 a.m. (DON) stated residents should nebulizer's without a nursing erve for safe administration cian's order.				

STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION (N1) PROVIDERSUPPLIENCIA DEVINITION NUMBER: 100941 (N2) MULTIPLE CONSTRUCTION A BULDING: (N3) DATE SURVEY C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE C 04/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE C 04/27/2022 IMUM SUMMARY STREMENT OF DEFICIENCIES PROCHESTER HEALTH SERVICES WEST TREET ADDRESS, CITY, STATE, ZIP CODE COMPLETE IMUM SUMMARY STREMENT OF DEFICIENCIES PROCHESTER, NM 55901 PROCHESTER, NM 55901 PROCHESTER, NM 55901 COMPLETE IMUM SUMMARY STREMENT OF DEFICIENCIES PROCHESTER, NM 55901 PROCHESTER, NM 55901 COMPLETE COMPLETE IMUM SUMMARY STREMENT OF DEFICIENCIES PROCHESTER, NM 55901 PROCHESTER, NM 55901 PROCHESTER, NM 55901 COMPLETE IMUM SUMMARY STREMENT OF DEFICIENCIES Continued From page 63 21565 PROCHESTER ADDRESS, CITY, STATE, ZIP CODE COMPLETE DEFICIENCY Imut and the dadminister or retain any medication in his or her room unlises their attending physician writes an order for self-administer nebulaed or other medications if not yet evaluated as completent to Self-administer medications. DON could provide training to all staff who administer. Imut and the Administer. Imut and the administer. TIME PERIOD FOR CORRECTION: Twenty one (21) days. TIME PERIOD FOR CORRECTION: Twenty one (21) days. Imut and the administer.	Minnesota Department of Health							
O0941 B.WM								
2215 HIGHWAY 52 NORTH ROCHESTER, NM 55901 CMULTINE Control of the protection of the p			00941	B. WING				
Image: Non-the standard state weeks in the state of t	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
Přěčív TAG IEACH DEPICIENCY MUST BE PRÉCEDED BY FULL TAG PŘĚTX TAG ILEA CHACH CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THA DAPROPRINTE COMPLETE DARE 21565 Continued From page 63 21565 21565 Image: Complete	ROCHES	STER HEALTH SERVI	CES WEST					
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 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.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	ULD BE COMPLET		
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	Continued From pa	age 63	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		- Y				