MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H3H8
Facility ID: 29822

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/08/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

X 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

- ___ 2. Technical Personnel
- ___ 3. 24 Hour RN
- ___ 4. 7-Day RN (Rural SNF)
- ___ 5. Life Safety Code
- ___ 6. Scope of Services Limit
- ___ 7. Medical Director
- ___ 8. Patient Room Size
- ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 10/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/26/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00160
(L31)

30. REMARKS

Posted 03/31/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

Certified Mail # 7013 3020 0001 8869 2217
CMS Certification Number (CCN): 245626

October 26, 2017

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

Dear Ms. Otto:

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

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

Effective May 8, 2017 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7013 3020 0001 8869 2217

October 26, 2017

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

RE: Project Number S5626002

Dear Ms. Otto:

On April 14, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 19, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on February 10, 2017, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 29, 2017. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 8, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 29, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 29, 2017, as of May 8, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 8, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of April 14, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 10, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 10, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 10, 2017, is to be rescinded.

In our letter of April 14, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 8, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

Certified Mail # 7013 3020 0001 8869 2217

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

October 26, 2017

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

RE: Project Number S5626002

Dear Ms. Otto:

On May 8, 2017, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on May 8, 2017, imposed a daily fine in the amount of $1000.00

On May 8, 2017, an acknowledgement was received by the Department stating that the violation(s) had been corrected. A reinspection was held on May 8, 2017 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $1000.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $98.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $1098.60 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

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

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H3H8
Facility ID: 29822

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/29/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 09/19/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
03/30/2017
(L32)

32. DETERMINATION OF APPROVAL DATE
03/30/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5626

A standard survey was completed at this facility on February 10, 2017. The most serious deficiencies were found at a S/S level of E.

A Post Certification Revisit (PCR) was completed on March 29, 2017. Three deficiencies were found uncorrected at a S/S level of D.

As a result of the PCR, State Monitoring was imposed effective April 21, 2017. In addition, we recommended the following to CMS and CMS concurred:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017

If mandatory denial of payment goes into effect, the facility would be subject to the loss of NATCEP for a two year period beginning May 10, 2017.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 14, 2017

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

RE: Project Number S5626002

Dear Ms. Otto:

On February 28, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 10, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 29, 2017, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 10, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 22, 2017. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on February 10, 2017. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.21(b)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0315 -- S/S: D -- 483.25(e)(1)-(3) -- No Catheter, Prevent Uti, Restore Bladder
F0329 -- S/S: D -- 483.45(d)(e)(1)-(2) -- Drug Regimen Is Free From Unnecessary Drugs

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective April 19, 2017. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 10, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 10, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 10, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Rochester Rehabilitation And Living Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 10, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

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 .

DEPARTMENT CONTACT

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 August 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING ________ B. WING ________	R-C 03/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on March 27, 28 & 29, 2017. There are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
{F 282} SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan to obtain weekly weights for 1 of 3 residents (R99) reviewed for nutritional status. Findings include:	{F 282}	It is the policy of Rochester Rehabilitation and Living Center to obtain weight upon admission and weekly for four weeks, monthly thereafter or as prescribed by physician. This policy was reviewed on 3/29/17. R99 was changed to monthly weights on	5/3/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/25/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING ______ B. WING ______	R-C 03/29/2017

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

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

{F 282}

Continued From page 1

R99's current care plan identified focus: nutrition, unintentional weight loss since admission related to cognitive decline/forgetfulness and lack of interest in food AEB (as evidenced by) weight loss and interventions included weigh resident every Wednesday.

R99's nursing assistant Kardex identified weigh resident every Wednesday.

On 3/28/17, at 9:18 a.m., R99 was observed to be in the dining room eating breakfast.

R99's record identified the last weight recorded under weights in the computer system was dated 3/10/17, at 2:51 p.m., 118.8 pounds.

R99's medication administration record (MAR) identified aides will weigh resident on every Wednesday, day shift. The last recorded weight was documented on 3/8/17 as 113.2 pounds.

On 3/28/17, at 9:09 a.m., licensed practical nurse (LPN)-A reviewed R99's care plan, MAR and weights in the computer system and confirmed the above. LPN-A confirmed R99 had not been weighed every Wednesday as care planned.

On 3/28/17, at 10:24 a.m., the interim director of nursing (IDON) confirmed weights for R99 had not been obtained every Wednesday as care planned.

The facility policy Weight Monitoring, dated 2006, indicated Policy 1. It is the policy of this facility to monitor residents' weights from the time of admission and to provide interdisciplinary support and/or intervention to avert adverse trends. Procedure 1. c. Residents will be weighed weekly

{F 282}

4/3/17. Her weight remains stable.
For all other residents who may have been affected by this; all long-term residents are weighed on their bath/shower day, the first week of the month. All new admissions are weighed upon admission, weekly for four weeks and then monthly, unless otherwise specified by the physician. A new corporate template was created for PointClickCare and implemented on 3/29/17 for new admission weights.
Daily weights are reviewed in morning meeting on Monday through Friday, not including holidays. If there are any missing weights during the morning meeting, the nurse managers ensure they are obtained after the meeting. The dietician continues to trend the daily weights and any weight changes. The Manager on Duty over the weekend audits to ensure the daily weights are obtained on the weekend.
Care plans and kardexs have been reviewed and revised as needed regarding weights and frequency of weights.
Education for obtaining weights per policy and physician order was completed with nursing staff April 5-7, and April 11-13.
Audits will be completed daily for two weeks, weekly for 3 months and randomly thereafter.
Director of Nursing or Designee will be responsible for compliance.
Date Certain: May 3, 2017.

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{F 282}	Continued From page 2 or more often based upon ongoing assessment of nutritional intake, fluid retention, and other medical factors.	{F 282}		
{F 315} SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is	{F 315}		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 315}	Continued From page 3 incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately complete and analyze data of the bowel and bladder assessments for 3 of 3 residents (R99, R49 and R50) reviewed for urinary incontinence. Findings include: R99's Admission Record, dated 3/28/17, included diagnoses of unspecified dementia without behavioral disturbance and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R99's quarterly Minimum Data Set (MDS) dated 3/10/17, identified no urinary or bowel toileting program, occasionally incontinent bladder, frequently incontinent of bowel, required one assist to toilet and had severe cognitive impairment. R99's current care plan identified focus: ADLS (activities of daily living)/Mobility: Needs help due to weakness and balance problems and interventions included Toileting: assist of one, do not leave alone in bathroom/on toilet and Transfers: assist of one with FWW (forward wheeled walker). Focus: Incontinence/altered elimination: revised 3/20/17. Has been incontinent of urine. Use of diuretic and bowel incontinence. Interventions included able to tell need or urge to void/defecate but does not always do so; offer to take to toilet when caring for resident/ when repositioning resident every two	{F 315}	It is the policy of Rochester Rehabilitation and Living Center to ensure that residents who are continent of bladder and bowel upon admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. For R99, R49 and R50, the bowel and bladder assessments were completed and care plans and Kardex's were updated by March 31, 2017. For all others who may have been affected by this, an audit was done to ensure all Bowel and Bladder assessments were completed and care plans and kardexs were updated with the assessment results. All new admissions have had 3-day data gathering and Bowel and Bladder assessments completed and analyzed per policy. Education on the Bowel and Bladder 3-day data gathering and Assessment was completed with nursing staff April 5-7, and April 11-13. Audits on the Bowel and Bladder assessments will be done weekly for 4 weeks, monthly for 3 months and submitted to QAPI team. The QAPI team will determine, based on the audit data, what further auditing is indicated The Director of Nursing or Designee will be responsible for compliance.	

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{F 315}	Continued From page 4 hours. Functional Incontinence (decreased mental awareness/decreased or loss of mobility or personal unwillingness) type incontinence. Provide frequent toileting and cares as needed. R99's nursing assistant Kardex identified bowel and bladder information able to tell need or urge to void/defecate but does not always do so; offer to take to toilet when caring for resident/ when repositioning resident every two hours. Functional Incontinence (decreased mental awareness/decreased or loss of mobility or personal unwillingness) type incontinence. Provide frequent toileting and cares as needed. Toileting assist of one, do not leave alone in bathroom/on toilet, toilet when repositioned every two hours. R99's Facility Bowel and Bladder 3-Day Screening Tool, dated 3/17/17 through 3/19/17, indicated when placed on toilet resident voided at times, urine stream strong, condition of pad wet at times and dry at times, resident asked to use toilet yes at times and no at times and bowel movement yes (no episodes of bowel incontinence). R99's facility Bowel and Bladder assessment, dated 3/27/17 (five days after the date certain of 3/22/17 per plan of correction) indicated short and long tern memory loss and the resident can sometimes identify the need or urge to void. Resident able to ask to use toilet - no, however the 3-Day Screening Tool identified the resident had asked to use the toilet at times. The resident had incontinent episodes, was frequently incontinent of urine and no restorative bladder program in use at this time. A toileting program was currently being used to manage the	{F 315}	Date Certain: May 3, 2017.	

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{F 315}	Continued From page 5 resident's bowel continence. Is resident incontinent of bowel or have incontinent episodes of bowel - no response marked. Normal bowel pattern - no regular times. Resident is not on a restorative bowel program. Symptoms affecting elimination patterns - functionally disabled and other. Requires assist with ambulation and transfers. One person physical assist to toilet. Elimination pattern shows patterns of urinary incontinence every two hours. The Analysis and Summary of Assessment Data had no documented information. On 3/28/17, at 8:23 a.m. observation revealed RN-E had stated to R99 let's go on the toilet and R99 replied I do not need to go. RN-E encouraged R99 to go into the bathroom to wash up and to change incontinent product. R99 agreed and was placed on the toilet. R99 had a soiled incontinent pad (with visible urine). On 3/28/17, at 10:09 a.m., RN-B sated she was the person who had completed R99's Bowel and Bladder Assessment on 3/27/17. RN-B confirmed the assessment had not been completed by the date certain of 3/22/17 per the facility plan of correction. RN-B stated she was a consultant for the facility and had come to help the facility complete the bowel and bladder assessments. RN-B confirmed the assessment had inaccurate documentation for resident able to ask to use toilet - no, should have been marked sometimes, according to the 3-Day Screening Tool. RN-B confirmed she had not documented any information on the assessment in regards to the analysis and summary of assessment data. RN-B stated I missed that. RN-B confirmed she had not revised the care plan based off the 3-Day Screening Tool and the Bowel and Bladder	{F 315}		

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{F 315}	Continued From page 6 Assessment, but RN-D may have revised the care plan. On 3/28/17, at 10:16 a.m., the IDON confirmed R99's Bowel and Bladder Assessment had not been completed by the date certain of 3/22/17 per the facility plan of correction. On 3/28/17, at 10:36 a.m., RN-D stated she had revised the care plan for toileting for R99 on 3/20/17. RN-D stated the revision for the care plan had not been based off of the facility 3-Day Screening Tool (dated 3/17/17 through 3/19/17), but was based from discussion at a meeting that although R99 could report needed to use the toilet R99 does not always do so. R99 could not get up safely by self, but at times does. R49's diagnosis included Alzheimer's dementia and urinary incontinence, according to facility Admission Record. Document review of facility Bowel and Bladder Quarterly Short, an assessment signed by the interim director of nursing (IDON) on 3/27/17, (five days after the date certain of 3/22/17 per plan of correction) revealed evaluation reviewed for changes since last assessment and indicated R49 required limited assistance of one staff for toileting related to occasional bladder incontinence, independent with ambulation and care plans reflect need for assist with toileting. The assessment identified R49 had no toileting program, occasional urinary incontinence and always continent of bowel. Document review of the significant change Minimum Data Set (MDS) dated 3/20/17, revealed R49 had no toileting program and was occasionally incontinent of bowel and bladder.	{F 315}		

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{F 315}	Continued From page 7 Document review of facility Bowel and Bladder 3 Day screening tool dated 3/16/17, 3/17/17, 3/18/17, revealed no summary or analysis of voiding data collection. The screening tool included instructions to individualize the resident's toileting plan from the data collected, utilize data for comprehensive assessment and note voiding patterns. The screening tool revealed R49 asked to use the toilet 28 times in three days, incontinent brief was wet 10 times in three days, voided on the toilet 27 times, and no bowel incontinence. Document review of R49's care plan target date of 2/27/17, revealed focus of activities of daily living needs hands on assist along with cueing related to unsteady gait, use of walker, Alzheimer's disease, history of falls, recent increase in overall weakness. Interventions include may need assist of one to cue to use the toilet, can be occasionally incontinent, and transfer with assist of one. R49's care plan target date of 2/27/17, revealed altered elimination, incontinent of bowel and bladder, may need guidance of limbs with toileting. Interventions included diuretics taken, potential for urinary frequency or urgency, offer toilet frequently through out the day, provide incontinent briefs as needed, encourage fluid intake, report signs and symptoms of urinary tract infection to physician. Document review of facility nursing assistant Kardex printed 3/29/17, revealed transfers with assist of one, may need assist of one to cue to use the toilet, occasionally incontinent of urine.	{F 315}		

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{F 315}	Continued From page 8 During interview on 3/29/17, at 8:30 a.m., nursing assistant (NA)-A stated R49 was continent of bowel and bladder, toileted self, and would put on call light for assistance to change incontinent brief. During interview on 3/29/17, at 8:32 a.m., licensed practical nurse (LPN)-B stated R49 toileted self and was occasionally incontinent. During interview on 3/29/17, at 8:50 a.m., IDON verified R49's bowel and bladder assessment was completed on 3/27/17, after the plan of correction date due to getting staff to work as a team, cooperation and education of staff. IDON stated she and registered nurse (RN)-A completed the bowel and bladder assessments themselves. IDON verified the assessment and care plan discrepancies. IDON stated was not aware R49 had bowel incontinence. IDON indicated analysis and summary of bowel and bladder assessment was the statement of evaluation reviewed for changes since last assessment and included limited assist of one for toileting, occasional incontinence, and independent ambulation. IDON verified the analysis and summary failed to include all the data gathered for bowel and bladder assessment including three day screening. IDON verified the facility did not develop a toilet schedule based on toileting data collected. R50 had diagnosis that included peripheral vascular and vascular dementia according to facility Admission Record. The facility identified R50 on the quarterly Minimum Data Set (MDS), as assessment dated	{F 315}		

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{F 315}	Continued From page 9 3/6/17, to be frequently incontinent of bowel and bladder, no bowel training program, no bladder retraining program. at risk of developing pressure ulcers and moderately impaired cognition. Document review of facility Bowel and Bladder Full assessment signed by the interim director of nursing (IDON) on 3/21/17, revealed analysis and summary of data included R50 was frequently incontinent of bowel and bladder, required mechanical lift and two staff for transfers, non-ambulatory, unable to detect need void, staff to offer toileting upon arising, before and after meals and bedtime and check and change every 2-3 hrs. Document review of facility Bowel and Bladder 3 Day screening tool dated 3/16/17, 3/17/17, 3/18/17, included instructions to individualize the resident's toileting plan from the data collected, utilize data for comprehensive assessment and note voiding patterns. The screening tool revealed R50 asked to use the toilet 4 times in three days, incontinent brief was wet 24 times in three days, voided on the toilet 20 times, and 2 bowel incontinence. Document review of R50's care plan target date of 6/17/17, revealed a focus of activities of daily living and mobility, generally weak with poor balance, has dementia and is forgetful, and anticipate needs. Interventions included toileting two assist with mechanical lift to transfer on and off commode, two assist to transfer on and off bedpan and one assist to use urinal. Transfers are two assist with mechanical lift. Document review of R50's care plan target date of 6/17/17, revealed a focus of incontinence and altered elimination, incontinent of urine more then	{F 315}		

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{F 315}	Continued From page 10 7 times a week, some bowel incontinence, is able to report need to use toilet but may not recognize in enough time to prevent incontinence. Interventions included able to tell need or urge to void, ok to offer to take him when caring for him or repositioning, alert appropriate staff to signs and symptoms of urinary tract infection, offer and encourage fluids. Document review of facility nursing assistant Kardex printed 3/28/17, revealed transfers with two assist and mechanical lift, able to tell need or urge to void or defecate but ok to offer to take R50 when caring for R50 or repositioning R50, as may not be able to report need and or tell soon enough to prevent incontinence, two assist and mechanical lift transfer on and off commode every morning, two assist to transfer on and off bedpan and one assist to use urinal. During interview on 3/28/17, at 11:17 a.m., nursing assistant (NA)-B stated R50 was a mechanical lift transfer with two staff, staff ask if wants to toilet, and R50 does tell staff mostly for bowel movements. NA-B verified the nursing assistant Kardex did not identify a toileting schedule. NA-B stated R50 was incontinent of urine most of the time. During interview on 3/28/17, at 12:45 p.m., NA-B stated had toileted R50 before lunch and would check for incontinence when laid down at this time. During interview on 3/28/17, at 1:30 p.m.,IDON verified the analysis and summary failed to include all the data gathered for bowel and bladder assessment including three day screening. IDON verified the facility did not	{F 315}		

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{F 315}	Continued From page 11 implement a toilet schedule based on toileting data collected. The facility policy Bowel and Bladder 3-Day Screening dated 2010, indicated a bowel and bladder screening will be completed on all new admissions, readmissions, annual and quarterly reviews or new incontinence. This 72 hour data collection tool will be used to assist in determining the resident's best toileting schedule to maintain or improve continence levels. Procedure indicated if the resident has been incontinent most of the time when toileted every two hours, change interval to every one and one-half hours. If more data is needed continue Bowel and Bladder screening until a toileting plan can be established. The facility policy Bowel and Bladder Data Collection dated 2010, indicated it is the policy of the facility that based on the resident's comprehensive assessment the facility will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder function as possible. Procedure: 2. Each resident will be assessed for 72 hours for bowel and bladder voiding patterns on admission, annually, quarterly, with discontinuation of catheterization and with a significant change in elimination patterns with evaluation for feasibility in retraining or toileting program/trial for bowel and /or bladder control. 5. Once the data is collected, the information a summary will be written to analyze the information collected.	{F 315}		
{F 329} SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	{F 329}		5/3/17

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{F 329}	Continued From page 12 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by:	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING ______ B. WING ______	R-C 03/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 13 Based on interview and document review, the facility failed to ensure a comprehensive sleep assessment was completed for 1 of 1 resident (R49), who received a medication for sleep. Findings include: R49's Admission Record dated 3/29/17, included diagnosis of Alzheimer's. R49's quarterly Minimum Data Set (MDS) dated 2/14/17, indicated had no trouble with falling asleep, staying asleep, or sleeping too much and had severe cognitive impairment. R49's physician orders dated 3/5/17, included an order for Melatonin (hormone to induce sleep) 3 mg (milligrams), two tablets by mouth every bedtime for insomnia. R49's medication administration record dated 3/17, identified R49 received the medication as ordered. Review of R49's record identified a comprehensive sleep assessment had not been completed for R49. On 3/28/17, at 4:06 p.m., registered nurse (RN)-B confirmed a comprehensive sleep assessment had not been completed for R49 before starting the melatonin medication. On 3/29/17, at 8:22 a.m. the interim director of nursing, when queried regarding a comprehensive sleep assessment had not been completed for R49, had no response. At the time RN-A verified a sleep assessment had not been completed for R49 and stated we have an action plan for the sleep assessments to be done.	{F 329}	It is the policy of Rochester Rehabilitation and Living Center to ensure all residents have a drug regimen free from unnecessary drugs. R49 had a comprehensive sleep assessment completed on 3/28/17. Her care plan and Kardex were updated. For all other residents that may be affected by this the policy regarding hypnotic medications was reviewed. All residents receiving a hypnotic medication for sleep were identified and a sleep study was completed by 4/1/17. All care plans and Kardex's were updated. Education for proper Hypnotic monitoring was completed with nursing staff April 5-7, and April 11-13. New orders are being audited to ensure new hypnotic medications have the appropriate monitoring, non-pharmacological interventions, and assessment completed. The audits will be completed weekly for 4 weeks, monthly for 3 months and submitted to QAPI team. The QAPI team will determine, based on the audit data, what further auditing is indicated. The Director of Nursing or Designee will be responsible for compliance. Date Certain: May 3, 2017	

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

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{F 329}	Continued From page 14 A sleep assessment policy was requested, but not provided.	{F 329}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245626 (Y1)	A. Building B. Wing (Y2)	3/29/2017 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) LSC	Correction Completed 03/22/2017	ID Prefix F0242 Reg. # 483.10(f)(1)-(3) LSC	Correction Completed 03/22/2017	ID Prefix F0314 Reg. # 483.25(b)(1) LSC	Correction Completed 03/22/2017
ID Prefix F0325 Reg. # 483.25(g)(1)(3) LSC	Correction Completed 03/22/2017	ID Prefix F0371 Reg. # 483.60(i)(1)-(3) LSC	Correction Completed 03/22/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/10/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on XXXX XXXX, 2017.
April 14, 2017

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

Re: Project # S5626002

Dear Ms. Otto:

On March 29, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 10, 2017 with orders received by you electronically on February 28, 2017.

State licensing orders issued pursuant to the last survey completed on February 9, 2017 and found corrected at the time of this March 29, 2017 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on February 10, 2017, found not corrected at the time of this March 29, 2017 revisit and subject to penalty assessment are as follows:

F0830 MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General $350.00
F0910 MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence $350.00
F1535 MN Rule 4658.1315 Subp.1 ABCD -- Unnecessary Drug Usage; General $300.00

The details of the violations noted at the time of this revisit completed on March 29, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $1000.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, PO Box 64900, St. Paul, MN 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

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

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: ______ B. WING ______	R-C **03/29/2017**

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

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{2 000}	Initial Comments	{2 000}		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
An onsite follow-up visit was completed on March 27, 28 & 29, 2017. During this onsite visit it was determined that the following corrections orders/s 0900, 0910 & 1535 were NOT corrected. These uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible

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{2 000}	Continued From page 1 penalty assessment/s.	{2 000}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan to obtain weekly weights for 1 of 3 residents (R99) reviewed for nutritional status. Findings include: R99's current care plan identified focus: nutrition, unintentional weight loss since admission related to cognitive decline/forgetfulness and lack of interest in food AEB (as evidenced by) weight loss and interventions included weigh resident every Wednesday. R99's nursing assistant Kardex identified weigh resident every Wednesday.	{2 830}	Corrected	5/3/17

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{2 830}	Continued From page 2 On 3/28/17, at 9:18 a.m., R99 was observed to be in the dining room eating breakfast. R99's record identified the last weight recorded under weights in the computer system was dated 3/10/17, at 2:51 p.m., 118.8 pounds. R99's medication administration record (MAR) identified aides will weigh resident on every Wednesday, day shift. The last recorded weight was documented on 3/8/17 as 113.2 pounds. On 3/28/17, at 9:09 a.m., licensed practical nurse (LPN)-A reviewed R99's care plan, MAR and weights in the computer system and confirmed the above. LPN-A confirmed R99 had not been weighed every Wednesday as care planned. On 3/28/17, at 10:24 a.m., the interim director of nursing (IDON) confirmed weights for R99 had not been obtained every Wednesday as care planned. The facility policy Weight Monitoring, dated 2006, indicated Policy 1. It is the policy of this facility to monitor residents' weights from the time of admission and to provide interdisciplinary support and/or intervention to avert adverse trends. Procedure 1. c. Residents will be weighed weekly or more often based upon ongoing assessment of nutritional intake, fluid retention, and other medical factors.	{2 830}		
{2 910}	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	{2 910}		5/3/17

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{2 910}	Continued From page 3	{2 910}		

unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:
A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and
B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to accurately complete and analyze data of the bowel and bladder assessments for 3 of 3 residents (R99, R49 and R50) reviewed for urinary incontinence.

Corrected

Findings include:

R99's Admission Record, dated 3/28/17, included diagnoses of unspecified dementia without behavioral disturbance and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.

R99's quarterly Minimum Data Set (MDS) dated 3/10/17, identified no urinary or bowel toileting program, occasionally incontinent bladder, frequently incontinent of bowel, required one assist to toilet and had severe cognitive impairment.

R99's current care plan identified focus: ADLS (activities of daily living)/Mobility: Needs help due

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{2 910}	Continued From page 4	{2 910}		

to weakness and balance problems and interventions included Toileting: assist of one, do not leave alone in bathroom/on toilet and Transfers: assist of one with FWW (forward wheeled walker). Focus: Incontinence/altered elimination: revised 3/20/17. Has been incontinent of urine. Use of diuretic and bowel incontinence. Interventions included able to tell need or urge to void/defecate but does not always do so; offer to take to toilet when caring for resident/ when repositioning resident every two hours. Functional Incontinence (decreased mental awareness/decreased or loss of mobility or personal unwillingness) type incontinence. Provide frequent toileting and cares as needed.

R99's nursing assistant Kardex identified bowel and bladder information able to tell need or urge to void/defecate but does not always do so; offer to take to toilet when caring for resident/ when repositioning resident every two hours. Functional Incontinence (decreased mental awareness/decreased or loss of mobility or personal unwillingness) type incontinence. Provide frequent toileting and cares as needed. Toileting assist of one, do not leave alone in bathroom/on toilet, toilet when repositioned every two hours.

R99's Facility Bowel and Bladder 3-Day Screening Tool, dated 3/17/17 through 3/19/17, indicated when placed on toilet resident voided at times, urine stream strong, condition of pad wet at times and dry at times, resident asked to use toilet yes at times and no at times and bowel movement yes (no episodes of bowel incontinence).

R99's facility Bowel and Bladder assessment, dated 3/27/17 (five days after the date certain of

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{2 910}	Continued From page 5	{2 910}		

3/22/17 per plan of correction) indicated short and long tern memory loss and the resident can sometimes identify the need or urge to void. Resident able to ask to use toilet - no, however the 3-Day Screening Tool identified the resident had asked to use the toilet at times. The resident had incontinent episodes, was frequently incontinent of urine and no restorative bladder program in use at this time. A toileting program was currently being used to manage the resident's bowel continence. Is resident incontinent of bowel or have incontinent episodes of bowel - no response marked. Normal bowel pattern - no regular times. Resident is not on a restorative bowel program. Symptoms affecting elimination patterns - functionally disabled and other. Requires assist with ambulation and transfers. One person physical assist to toilet. Elimination pattern shows patterns of urinary incontinence every two hours. The Analysis and Summary of Assessment Data had no documented information.

On 3/28/17, at 8:23 a.m. observation revealed RN-E had stated to R99 let's go on the toilet and R99 replied I do not need to go. RN-E encouraged R99 to go into the bathroom to wash up and to change incontinent product. R99 agreed and was placed on the toilet. R99 had a soiled incontinent pad (with visible urine).

On 3/28/17, at 10:09 a.m., RN-B sated she was the person who had completed R99's Bowel and Bladder Assessment on 3/27/17. RN-B confirmed the assessment had not been completed by the date certain of 3/22/17 per the facility plan of correction. RN-B stated she was a consultant for the facility and had come to help the facility complete the bowel and bladder assessments. RN-B confirmed the assessment had inaccurate

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{2 910}	Continued From page 6	{2 910}		

documentation for resident able to ask to use toilet - no, should have been marked sometimes, according to the 3-Day Screening Tool. RN-B confirmed she had not documented any information on the assessment in regards to the analysis and summary of assessment data. RN-B stated I missed that. RN-B confirmed she had not revised the care plan based off the 3-Day Screening Tool and the Bowel and Bladder Assessment, but RN-D may have revised the care plan.

On 3/28/17, at 10:16 a.m., the IDON confirmed R99's Bowel and Bladder Assessment had not been completed by the date certain of 3/22/17 per the facility plan of correction.

On 3/28/17, at 10:36 a.m., RN-D stated she had revised the care plan for toileting for R99 on 3/20/17. RN-D stated the revision for the care plan had not been based off of the facility 3-Day Screening Tool (dated 3/17/17 through 3/19/17), but was based from discussion at a meeting that although R99 could report needed to use the toilet R99 does not always do so. R99 could not get up safely by self, but at times does.
R49's diagnosis included Alzheimer's dementia and urinary incontinence, according to facility Admission Record.

Document review of facility Bowel and Bladder Quarterly Short, an assessment signed by the interim director of nursing (IDON) on 3/27/17, (five days after the date certain of 3/22/17 per plan of correction) revealed evaluation reviewed for changes since last assessment and indicated R49 required limited assistance of one staff for toileting related to occasional bladder incontinence, independent with ambulation and care plans reflect need for assist with toileting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 910}	Continued From page 7	{2 910}		

The assessment identified R49 had no toileting program, occasional urinary incontinence and always continent of bowel.

Document review of the significant change Minimum Data Set (MDS) dated 3/20/17, revealed R49 had no toileting program and was occasionally incontinent of bowel and bladder.

Document review of facility Bowel and Bladder 3 Day screening tool dated 3/16/17, 3/17/17, 3/18/17, revealed no summary or analysis of voiding data collection. The screening tool included instructions to individualize the resident's toileting plan from the data collected, utilize data for comprehensive assessment and note voiding patterns. The screening tool revealed R49 asked to use the toilet 28 times in three days, incontinent brief was wet 10 times in three days, voided on the toilet 27 times, and no bowel incontinence.

Document review of R49's care plan target date of 2/27/17, revealed focus of activities of daily living needs hands on assist along with cueing related to unsteady gait, use of walker, Alzheimer's disease, history of falls, recent increase in overall weakness. Interventions include may need assist of one to cue to use the toilet, can be occasionally incontinent, and transfer with assist of one.

R49's care plan target date of 2/27/17, revealed altered elimination, incontinent of bowel and bladder, may need guidance of limbs with toileting. Interventions included diuretics taken, potential for urinary frequency or urgency, offer toilet frequently through out the day, provide incontinent briefs as needed, encourage fluid intake, report signs and symptoms of urinary tract

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: ______ B. WING ______	R-C **03/29/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 910}	Continued From page 8	{2 910}		

infection to physician.

Document review of facility nursing assistant Kardex printed 3/29/17, revealed transfers with assist of one, may need assist of one to cue to use the toilet, occasionally incontinent of urine.

During interview on 3/29/17, at 8:30 a.m., nursing assistant (NA)-A stated R49 was continent of bowel and bladder, toileted self, and would put on call light for assistance to change incontinent brief.

During interview on 3/29/17, at 8:32 a.m., licensed practical nurse (LPN)-B stated R49 toileted self and was occasionally incontinent.

During interview on 3/29/17, at 8:50 a.m., IDON verified R49's bowel and bladder assessment was completed on 3/27/17, after the plan of correction date due to getting staff to work as a team, cooperation and education of staff. IDON stated she and registered nurse (RN)-A completed the bowel and bladder assessments themselves. IDON verified the assessment and care plan discrepancies. IDON stated was not aware R49 had bowel incontinence. IDON indicated analysis and summary of bowel and bladder assessment was the statement of evaluation reviewed for changes since last assessment and included limited assist of one for toileting, occasional incontinence, and independent ambulation. IDON verified the analysis and summary failed to include all the data gathered for bowel and bladder assessment including three day screening. IDON verified the facility did not develop a toilet schedule based on toileting data collected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 910}	Continued From page 9 R50 had diagnosis that included peripheral vascular and vascular dementia according to facility Admission Record. The facility identified R50 on the quarterly Minimum Data Set (MDS), as assessment dated 3/6/17, to be frequently incontinent of bowel and bladder, no bowel training program, no bladder retraining program. at risk of developing pressure ulcers and moderately impaired cognition. Document review of facility Bowel and Bladder Full assessment signed by the interim director of nursing (IDON) on 3/21/17, revealed analysis and summary of data included R50 was frequently incontinent of bowel and bladder, required mechanical lift and two staff for transfers, non-ambulatory, unable to detect need void, staff to offer toileting upon arising, before and after meals and bedtime and check and change every 2-3 hrs. Document review of facility Bowel and Bladder 3 Day screening tool dated 3/16/17, 3/17/17, 3/18/17, included instructions to individualize the resident's toileting plan from the data collected, utilize data for comprehensive assessment and note voiding patterns. The screening tool revealed R50 asked to use the toilet 4 times in three days, incontinent brief was wet 24 times in three days, voided on the toilet 20 times, and 2 bowel incontinence. Document review of R50's care plan target date of 6/17/17, revealed a focus of activities of daily living and mobility, generally weak with poor balance, has dementia and is forgetful, and anticipate needs. Interventions included toileting two assist with mechanical lift to transfer on and off commode, two assist to transfer on and off	{2 910}		

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ROCHESTER REHABILITATION AND LIVING CI	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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{2 910}	Continued From page 10	{2 910}		

Continued From page 10

bedpan and one assist to use urinal. Transfers are two assist with mechanical lift.
Document review of R50's care plan target date of 6/17/17, revealed a focus of incontinence and altered elimination, incontinent of urine more then 7 times a week, some bowel incontinence, is able to report need to use toilet but may not recognize in enough time to prevent incontinence.
Interventions included able to tell need or urge to void, ok to offer to take him when caring for him or repositioning, alert appropriate staff to signs and symptoms of urinary tract infection, offer and encourage fluids.

Document review of facility nursing assistant Kardex printed 3/28/17, revealed transfers with two assist and mechanical lift, able to tell need or urge to void or defecate but ok to offer to take R50 when caring for R50 or repositioning R50, as may not be able to report need and or tell soon enough to prevent incontinence, two assist and mechanical lift transfer on and off commode every morning, two assist to transfer on and off bedpan and one assist to use urinal.

During interview on 3/28/17, at 11:17 a.m., nursing assistant (NA)-B stated R50 was a mechanical lift transfer with two staff, staff ask if wants to toilet, and R50 does tell staff mostly for bowel movements. NA-B verified the nursing assistant Kardex did not identify a toileting schedule. NA-B stated R50 was incontinent of urine most of the time.

During interview on 3/28/17, at 12:45 p.m., NA-B stated had toileted R50 before lunch and would check for incontinence when laid down at this time.

During interview on 3/28/17, at 1:30 p.m.,IDON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 910}	Continued From page 11 verified the analysis and summary failed to include all the data gathered for bowel and bladder assessment including three day screening. IDON verified the facility did not implement a toilet schedule based on toileting data collected. The facility policy Bowel and Bladder 3-Day Screening dated 2010, indicated a bowel and bladder screening will be completed on all new admissions, readmissions, annual and quarterly reviews or new incontinence. This 72 hour data collection tool will be used to assist in determining the resident's best toileting schedule to maintain or improve continence levels. Procedure indicated if the resident has been incontinent most of the time when toileted every two hours, change interval to every one and one-half hours. If more data is needed continue Bowel and Bladder screening until a toileting plan can be established. The facility policy Bowel and Bladder Data Collection dated 2010, indicated it is the policy of the facility that based on the resident's comprehensive assessment the facility will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder function as possible. Procedure: 2. Each resident will be assessed for 72 hours for bowel and bladder voiding patterns on admission, annually, quarterly, with discontinuation of catheterization and with a significant change in elimination patterns with evaluation for feasibility in retraining or toileting program/trial for bowel and /or bladder control. 5. Once the data is collected, the information a summary will be written to analyze the information collected.	{2 910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21535}	Continued From page 12	{21535}		
{21535}	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive sleep assessment was completed for 1 of 1 resident (R49), who received a medication for sleep. Findings include: R49's Admission Record dated 3/29/17, included diagnosis of Alzheimer's. R49's quarterly	{21535}	Corrected	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CI	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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{21535}	Continued From page 13	{21535}		

Minimum Data Set (MDS) dated 2/14/17, indicated had no trouble with falling asleep, staying asleep, or sleeping too much and had severe cognitive impairment.

R49's physician orders dated 3/5/17, included an order for Melatonin (hormone to induce sleep) 3 mg (milligrams), two tablets by mouth every bedtime for insomnia.

R49's medication administration record dated 3/17, identified R49 received the medication as ordered.

Review of R49's record identified a comprehensive sleep assessment had not been completed for R49.

On 3/28/17, at 4:06 p.m., registered nurse (RN)-B confirmed a comprehensive sleep assessment had not been completed for R49 before starting the melatonin medication.

On 3/29/17, at 8:22 a.m. the interim director of nursing, when queried regarding a comprehensive sleep assessment had not been completed for R49, had no response. At the time RN-A verified a sleep assessment had not been completed for R49 and stated we have an action plan for the sleep assessments to be done.

A sleep assessment policy was requested, but not provided.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
29822		3/29/2017

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 03/22/2017	ID Prefix 20965 Reg. # MN Rule 4658.0600 Subp. 2 LSC	Correction Completed 03/22/2017	ID Prefix 21015 Reg. # MN Rule 4658.0610 Subp. 7 LSC	Correction Completed 03/22/2017
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 03/28/2017	ID Prefix 21800 Reg. # MN St. Statute144.651 Subd. 4 LSC	Correction Completed 03/22/2017	ID Prefix 21830 Reg. # MN St. Statute 144.651 Subd. 10 LSC	Correction Completed 03/22/2017
ID Prefix 21915 Reg. # MN St. Statute 144.651 Subd. 27 LSC	Correction Completed 03/22/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/10/2017	

 EVENT ID: H3H812

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H3H8
Facility ID: 29822

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/10/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA
02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF
03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC
04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 03/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/30/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00160
(L31)

30. REMARKS

Posted 03/31/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

February 28, 2017

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

RE: Project Number S5626002

Dear Ms. Otto:

On February 10, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 22, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 10, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING ______ B. WING ______	02/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=E	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		3/22/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 03/09/2017

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

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personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42

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F 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

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F 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident’s stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 156		

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regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of Medicare Part A skilled services for of 4 of 4 residents (R113, R35,	F 156	Residents 113, 120 and 40 have been discharged from the facility. ABN 10055 has been provided to resident 35. All residents who have a Medicare Part A stay or equivalent who reside longer than	

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F 156	Continued From page 6 R40, R120), reviewed for liability and beneficiary rights. Findings Include: R113 was discharged from Medicare Part A on 10/22/16, used 8 days and remained in the facility. The facility did not provide R113 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R35 was discharged from Medicare Part A on 10/27/16, used 6 days and remained in the facility. The facility did not provide R35 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R40 was discharged from Medicare Part A on 12/8/16, used 35 days and remained in the facility. The facility did not provide R40 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R120 was discharged from Medicare Part A on 8/27/16 used 43 days and remained in the facility. The facility did not provide R120 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to	F 156	what Medicare part A or equivalent covers will have an ABN form CMS 10055 provided to them. The facility has provided training/education to the MDS coordinators regarding proper notices for each type of service discontinuation. The MDS coordinators will provide ABN notices appropriately to all residents staying longer than their rehabilitation service letting them know they may be responsible for payment. MDS coordinators or trained designee will be responsible for giving proper notices according to facility protocol. The administrator will monitor compliance of ABN notices using weekly audit tools based on who will be discharging from rehabilitation services. The administrator will monitor weekly for 3 months as the process is integrated into the IDT process. The results of the monitoring/audits will be reviewed by the QAPI committee on an ongoing basis. System revisions and/or staff education will be implemented as indicated based on the audits and/or QAPI committee recommendations. The facility alleges that it will be in substantial compliance with the standard indicated by March 22, 2017.	

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F 156	Continued From page 7 Medicare. On Wednesday 2/8/17, at 4:10 p.m. Administrator stated in response to a question regarding when they provide the SNFABN form to the residents, "We have not been giving these out. We will change our practice and will be starting to give them in the future." Asked for but did not receive the facility's policy and procedure for Medicare Denials.	F 156		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine preferences for bathing for 3 of 3 residents (R188, R81, R173) reviewed for choices. Findings include:	F 242	Resident 188 and 173 are discharged. Resident 81 has been given choices in regard to “awake at will” and bathing. Care plan and kardex have been updated. All residents will be interviewed upon admission for choice in bathing and waking schedules. This will be reflected	3/22/17

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F 242	Continued From page 8 R188 was admitted to the facility on 2/3/17 per the facility admission record. On 2/07/17, 2:06 p.m. R188 stated she had a shower today. R188 stated she had been asking for a shower since admission on 2/3/17. R188 stated she had been unware of when her next shower would be and stated she was not asked if she would like a shower or a bath today when she was given a shower. R188's Nursing Day 1 of Admission/Readmission assessment dated 2/3/16 included, "REQUIRED QUESTION: Ask the resident their preferences for bathing and past routine mark answers here for their plan of care." The questions that addressed bathing frequency or preferences were not answered and were left blank. R188's progress note dated 2/10/17, indicated, "Resident would prefer a bath x2 [two times] a week and on day shift." On 2/09/17, at 7:35 a.m., nursing assistant (NA)-A stated baths were scheduled once a week and as requested. NA-A stated residents are assigned their bath day based on their room assignment. NA-A stated if a resident requested a different bath day staff can make a schedule change to reflect a resident's preference in the computer and update the bath sheet. On 2/09/17, 11:32 a.m. the director of nursing (DON) stated she expected the nurse to complete the bathing preference questions on the nursing admission assessment and verified this portion of the assessment had not been completed for R188. The DON stated at the time the assessment was completed nursing should be	F 242	in their care plans. All current residents are being interviewed for their preferences in regard to bathing and waking schedules and care plans/kardex are being updated. The DON will implement measures to ensure this deficient practice does not recur including: all nurses will be educated on the admission process in terms of obtaining resident preferences and entering them into the care plans/kardex. The CNAs will be educated on accessing the care plan information through the kardex in PCC, as well as making sure to ask before doing each task (i.e. waking time and bathing preferences) and reporting any requests for changes to the nurses to update the care plans. The DON or designee will monitor the corrective actions to ensure the effectiveness of these actions including: auditing all new admission paperwork for resident choices and integration into the care plans for 2 weeks followed by random weekly audits. Upon completion of these audits, education will be completed timely. Failure to adhere to these protocols will result in re-education and/or corrective counseling. The results of the audits and compliance rates (track, trend, analysis) will be reported to the facility QAPI Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility DON will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the	

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F 242	Continued From page 9 explaining the normal routine was a weekly bath/shower and if a resident had a specific bathing request we would work with them on the day of week and time of day to try to accommodate bathing their bathing preferences. The DON stated nursing should have reviewed with R188 her bathing schedule, frequency of bathing and preference for type of bathing upon admission. On 2/10/17, at 10:19 a.m. the DON stated she had assigned a staff member to speak to R188 about her bathing preferences today and stated she would provide this writer a copy of the assessment once the nurse had completed it. On 2/10/2017, at 10:48 a.m., the DON stated today was the first time R188 was interviewed by staff regarding her bathing preferences. R188 had requested a bath two times a week on the day shift. A bathing choices and preferences policy was requested and not provided. R81's quarterly Minimum Data Set (MDS) dated 10/25/16; identified R81 had severe cognitive impairment and needed extensive assistance for dressing and bed mobility. During the initial interview on 2/7/17 at 3:37 p.m., R81 was asked about her choice to get up in the morning. R81 had said, when girls come in they tell us when to get up, we cannot sleep in, staff tell us we need to get up to go get breakfast. During an interview with R81 on 2/08/17 at 12:40 p.m. R81 had been asked when she got up this morning she stated that she got up in time for breakfast. Surveyor asked if ready to get up she	F 242	standard indicated by March 22, 2017.	

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stated with a laugh, turned her head up, and stated, "O, no I was not ready."

At 2/9/17 at 7:46 a.m. R81 observed to be rising to the edge of bed. Surveyor asked if getting up for the day, R81 stated, "I guess so."

Interview on 2/9/17 at 7:52 a.m. with nursing assistant (NA)-B when asked if R81 gets woke up or if she usually gets up on own. NA-B stated R81 is woke up, does not know R81 time to get up NA-B stated that R81 has not told staff what time she wants to get up in the morning. Surveyor asked how staff know the residents preferences. NA-B stated that they look in the kardex (a reference tool for staff for resident's information). NA-B went to computer to review kardex and was not able to find any wake times for R81.

Interview on 2/9/17 at 12:12 p.m. with licensed practical nurse (LPN)-B asked if she knew R81 wake time LPN-B stated R81 is not an early riser and varies between 7:45 a..m-8:20 a.m. R81 is sometimes woke up by staff and other times she gets up on her own. LPN-B was asked about where to find the preferences residents would like. LPN-B stated, "We do not have a lot of float staff here on this unit and the staff just know their preferences."

Interview on 2/9/17 at 1:27 p.m. with LPN-B had been asked who completes the admission paper when residents was admitted to the facility. LPN-B stated that the floor nurses complete the admission papers with each resident that comes on the unit. LPN-B asked when the preferences or choices were asked of the residents LPN-B stated they do not ask their preferences or

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F 242	Continued From page 11 choices on admission. Interview on 2/9/17 at 2:50 p.m. with director of nursing (DON) updated the nurse on the floor completes the admission on the residents then information is placed in the computer that auto populates to other areas. Questions on wake and bedtime are asked on admission. Facility also has a program in place to wake at will. DON expectation would be not wake up R81 if she prefers to sleep. R173 admitted to the facility on 12/26/16. A nursing day one admission/readmission assessment form was completed indicating that resident prefer showers and one time per week. R173 (per nursing notes) admitted back to hospital on 1/9/17 and readmitted to facility on 1/13/17. Progress note dated 1/13/17, title: nursing day 1 admission/readmission note, there is no indication of bathing preferences. During interviews with R173 on 2/7/17, at 3:45 p.m. R173 had indicated that she takes a shower at home every day but would be ok with every other day because they are so busy. On 2/8/17 at 12:36 p.m. R173 stated she had asked everyday if she could get a shower and then is told by staff they would look into it but it never happens. On 2/9/17 at 1:14 a.m. R173 she stated that she will ask the nursing assistant and they will tell her they will get back to her. 2/9/17, at 12:09 p.m. NA-A stated I do not recall if R173 asked for any extra showers. However, R173 added, frankly, if I was scheduled a shower one time a week I would want more.	F 242		

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

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F 242	Continued From page 12 On 2/9/17, at 2:05 p.m. Interview with RN-B and RN-D, regarding resident preferences regarding addition showers, neither RN-B nor RN-D indicated that they were aware of R173 preference or that she had been requesting to have an additional shower during the week. Both nurses stated, "Everyone is guaranteed one shower weekly, but with only having one aide and one nurse here most times it is sometimes difficult to give them an extra shower. On 2/10/17, at 9:15 a.m. during interview with DON, she stated that if resident requests to have an extra shower that staff should make every attempt to accommodate the request. On 2/10/17, at 10:16 a.m. R173 said that someone (staff) had come in to talk with her regarding her bathing preferences. Document titled Sleep Program Cornerstones not dated reads; Open breakfast is served to facilitate wake-at-will and residents and family are informed about the importance of sleep and reviewed at care conferences.	F 242		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		3/22/17

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F 282	Continued From page 13 by: Based on observation, interview and document review, the facility failed to follow the care plan to obtain weekly weights, which resulted in significant weight loss for 2 of 3 residents (R22, R67) who had been reviewed for nutritional status and failed to follow current pressure ulcer care plan interventions for 1 of 1 resident (R61) who had a pressure ulcer. Findings Include: LACK OF TAKING WEIGHTS AS ORDERED AND TIMELY NOTIFICATION OF WEIGHT LOSS: R22's admission Minimum Data Set (MDS) dated 12-13-16, identified diagnoses of Alzheimer's disease and dementia. R22 needed assistance of one staff member for eating and had severely impaired cognition. R22 was a closed record review as he died on 1/24/17. R22's nutritional care plan included, "Potential nutrition risk related to dementia AEB [as evidenced by] periods of somnolence, forgetfulness and confusion." Interventions included: "Weigh resident every Wednesday." Review of the medical record revealed R22 did not have any weights taken from 12/28/16 to 1/24/17 when he expired. Review of R22's weights was documented as follows in pounds: 12/2/16: 179 12/14/16: 180 12/21/16: 168 12/28/16: 168	F 282	All residents cited in this tag have been discharged from the facility. Weights: Facility staff will obtain weights for all residents currently residing here. Nursing and the Registered Dietitian will review weights weekly ongoing to identify weight changes and report them to the attending physician/NP/PA. All new admissions will have weights obtained within the first 3 days. Pressure ulcers: Licensed nurses will complete a body audit for all skin conditions/impairments for all residents currently residing in the facility. The IDT will review the body audits and reassess all resident with pressure ulcers (and/or other skin impairments). The care plans will be updated as indicated by the findings. All new admissions will thorough body audits upon admission and ongoing as determined by their assessment and/or facility protocol. Residents with potential for pressure ulcers will have care planned interventions to prevent pressure ulcers as indicated by their individual assessment. The DON will implement measures to ensure this deficient practice does not recur including: all nurses will be educated on ensuring weights are obtained according to individual resident's care plan and/or facility protocol. The licensed nurse will notify the dietitian and providers of any significant weight changes; all nurses will be educated on	

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F 282	Continued From page 14 R22 had an 11 lbs. weight loss in the first 16 days since admission; this was a 6 % weight loss. The initial dietary/nutritional data collection dated 12/19/16, included, "Diet order of Regular, regular textures, thin liquids ... Meal tray to room is preferred dining location. Limited assistance for eating self-performance Setup help only ... Summary: R22 admitted for rehab following a hospital stay for a hip fracture and urinary tract infection. He has a PMH [personal medical history] of Alzheimer's dementia and multiple strokes. His wife is his historian as he is unable reply to questions appropriately r/t [related to] cognitive status. He appears normal weight, alert with periods of somnolence and well nourished. He eats with assistance in the dining room or his room. His wife is his primary care giver. He has no trouble chewing or swallowing and eats well with intake of >75% each meal daily. Fluid intake ~1500 ml/day per nursing task records. Weight has remained stable...Continue with Regular diet ...Monitor intake/fluids daily and weights weekly ..." Registered Dietitian 30 Day review notes dated 1/18/17, included, Diet: Regular, Regular textures, thin liquids, Intake: declined to ~50% on average at each meal daily x 1 week. Fluids: Declined to ~1100 ml .Weights: Admit wt. 179# [pounds], last recorded wt [weight]12/21/16 167.8# -11# (6%) since admission. No weight recorded this month. R22 has had a decrease in intake over the past week. Most currently the last few days he has had issues with swallowing. Nursing has ordered a 3-day trial of mech [mechanical soft] soft/pureed textures. This writer notified DON/SLP/therapy	F 282	monitoring pressure ulcers and other skin impairments, ensuring care plans are updated for interventions and ensuring the interventions provided are prescribed by the care plans. All CNAs will be educated on accurate and timely weights as directed by the licensed nurse; all CNAs will be educated on following care planned interventions for pressure ulcers and other skin impairments and notifying nurses if there is a discrepancy in the care plan or refusal of an intervention by the resident. The DON or designee will monitor the corrective actions to ensure the effectiveness of these actions including: auditing all weight records to ensure all weights are obtained according to resident care plan 3 times per week for 2 weeks, weekly for 3 weeks, followed by random weekly audits. The DON or designee will audit every resident with pressure ulcers twice daily for 2 weeks to see that the pressure ulcer interventions are in place. Based on the outcome of the audits, education/training will be completed timely. Failure to adhere to these protocols will result in retraining and/or corrective counseling. The results of the audits and compliance rates (track, trend, analysis) will be reported to the facility QAPI Committee monthly for the first 3 months, then quarterly ongoing. Upon this review, system revisions and/or staff education will be implemented as by the outcomes. Facility DON and/or designee will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the	

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F 282	Continued From page 15 [director of nursing and speech therapist] for a screening of his swallowing ability and recommendations. Weight loss of 6% since admission noted. Recommend weights be done 3 times per week given decline in intake for closer monitoring. Following up for SLP [speech] recommendations." On 2/8/17, at 2:36 p.m., registered dietician (RD)-A stated when a resident displayed weight loss, she expected staff to alert her to complete a consult for weight loss. RD-A stated weights are to be completed every Wednesday and stated she checked the weights and vital reports under clinical tab. RD-A stated since staff had not weighed R22, he did not trigger for a weight loss. RD-A stated she was unaware of R22's weight loss until she completed the nutritional 30-day review and noticed R22 was not being weighed. RD-A stated every resident in the building was to be weighed on Wednesdays, unless they had a different order for more frequent weights. RD-A stated staff obtaining weights weekly had been a problem and that was why she would sometimes order daily weights or weights three times a week for residents to help ensure weights would be taken. RD-A verified this was why she indicated R22 should have weights taken three times a week as a part of her 30-day nutritional review. RD-A stated her expectation was staff to follow the care plan and weigh residents on Wednesday. On 2/9/17, 7:40 a.m. nursing assistant (NA)-A stated staff try to get all resident weights on Wednesdays. NA-A stated sometimes based upon acuity and workload weights do not always get done.	F 282	standard indicated by March 22, 2017.	

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F 282	Continued From page 16 On 2/9/17, at 11:32 a.m., during an interview with the DON, stated she was not aware of R22's weight loss. The DON stated she was aware of the trial mechanical soft and recommendations for swallowing evaluation. The DON stated when weights are recorded under the weights and vitals section in the computer, there is an alert if there was a weight change. The DON stated the dietician monitored the weights alerts and residents weights in the computer. The DON stated she was aware weights were not being done weekly prior to the identification by corporate during an audit on 2/2/17. The DON stated she expected weekly weights to be completed on weight day and entered into the computer system. The Weight Monitoring - Nursing Services policy dated 2006, included, "Each resident will be weighed and measured within 24 hours of admission. Each resident will be weighed weekly for the first four weeks of her/his stay, monthly thereafter unless an adverse trend has been identified. Residents will be weighed weekly or more often based upon ongoing assessment of nutritional intake, fluid retention, and other medical factors." R67 was admitted to the facility on 12/19/16 according to the face sheet. R67 diagnosis found on the Diagnosis Report identified Alzheimer's Disease, unspecified Dementia without behavioral disturbance and weakness all dated 12/19/16. Order Listing Report dated 12/19/16, identifies R67 received a regular diet, regular texture, thin fluid consistency, for General diet.	F 282		

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Order Summary Report dated 12/19/16, indicates R67 to be weighed every Wednesday.

Care plan dated 1/8/17, identifies potential nutrition risk related to Alzheimer's dementia, recent cognitive and functional decline and low BMI (body mass index). Interventions include: monitor intake, offer bedtime snack, offer substitutes for uneaten foods, and provide diet as ordered, regular. Observe changes in weight, notify physician, and weigh resident every Wednesday.

Weights and Vitals Summary identified R67 weight on 12/19/16, was 125.6 pounds. 1/11/17, 120.8 pounds. 1/18/17, 115.8 pounds a 9.2 pound weight loss and a 9 percent decline in one month (significant weight loss). No other weights were done.

Interview on 2/9/17, at 7:10 a.m. with licensed practical nurse (LPN)-A stated everyone gets weighed on Wednesday's unless they have an order to complete more often. If we enter a weight and it is a 3 pound difference in a day or a 5 pound difference in a week the computer will prompt a message that indicates a weight loss and then nursing is to notify the provider.

Interview on 2/9/17, at 7:26 a.m. with nursing assistant (NA)-C stated residents are weighed weekly. When entering weights into the computer system they are able to see the previously entered weight and are to alert the nurse if there is a change.

Interview on 2/9/17, at 10:43 a.m. with director of nursing (DON) stated weights are to be completed at least once weekly unless ordered

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otherwise. DON stated when a decline in weight is identified the inner disciplinary team (IDT) meets to try and determine the cause of the weight loss. DON stated the dietician talks with the resident to determine appropriate interventions. DON verified R67 had only 3 documented weights during her stay in the facility. DON stated she was aware weight loss was a problem within the facility, including weights being completed as ordered.
LACK OF FOLLOWING CARE PLAN IN REGARDS TO INTERVENTIONS TO PROMOTE HEALING OF PRESSURE ULCERS:

R61's 14 day schedule assessment Minimum Data Set (MDS) dated 11/29/16 identifies R61's moderately impaired and requires extensive assistance with two persons for bed mobility, dressing and personal hygiene.

R61's care plan with a target date of 12/6/16, reviewed at risk for skin breakdown as skin in generally thin and fragile, R61 has history of pressure ulcers both heels. Interventions reposition in chair every two hours, offload (to remove pressure) heels, administer treatments as orders.

During observations on 2/8/17 from 12:50 p.m. to 3:07 p.m. observed R61 to have her heels resting on the end of her recliner no cushion or pillow placed properly to float (offload) her heels as an intervention in R61 care plan and had been in place for two hours and 17 minutes.

During constant observation on 2/9/17 between 7:11 a.m. and 8:48 a.m. heels not floated (offload) while resting in bed. Feet resting directly on bed surface.

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F 282	Continued From page 19 Observed 2/9/17 10:52 a.m. sitting in recliner, pillow under legs and again heels not floated. 11:08 a.m. Observation 2/10/17 at 8:16 a.m. R61 found lying in bed and again her heels not floated. LPN-B was notified and observed R61 in bed with surveyor verified at 8:21 a.m. her heels were not floated. Interview with nursing assistant (NA)-F on 2/09/17 at 12:02 p.m. regarding R61 intervention in place to help promote healing of pressure ulcer. NA-F stated that staff place a pillow underneath feet in chair and bed, a bar on bed to keep blankets off feet and do not place shoes, but socks only. NA-F gave a demonstration using the pillow on how it should look when R61's heels are floated. Interview on 2/9/17 12:06 p.m. LPN-B was asked about the intervention in place to promote healing to R61 left foot. LPN-B stated dressing changes are completed in the evening, bath day are Mondays, feet elevated on pillow when in chair and in bed, no shoes, but wears socks liked heavy blankets on to keep warm and has lift in bed to keep blankets off feet. Interview with DON on 2/9/17 at 2:59 p.m. had reviewed of current care plan for R61 and verified it includes to be repositioned every 2 hours and to float heels at all times. Policy titled, "Care Plan Policy and Procedure" dated 11/2016, doesn't address following the care plan to provide the highest level of care for each resident.	F 282		

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F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide pressure ulcer services to promote healing and prevent further pressure ulcers from developing for 1 of 1 resident (R61) with a current heel pressure ulcer. Findings: R61's significant change Minimum Data Set (MDS) dated 11/22/16 identifies R61's as severely impaired and requires extensive assistance with two persons for bed mobility, dressing and personal hygiene. Also has two stage 2 pressure ulcers currently. R61's care plan with Target date of 12/6/16, included at risk for skin breakdown as skin in generally thin and fragile, R61 has history of	F 314	The resident cited in this tag has been discharged. Licensed nurses will complete a body audit on all residents currently residing in the facility. The IDT will review the body audits and reassess all residents with pressure ulcers and/or other skin impairments. The care plans will be updated as indicated by the findings. All new admissions will have thorough body audits upon admission and ongoing as determined by their assessment and/or facility protocol. Residents with potential for pressure ulcers will have care planned interventions to prevent pressure ulcers as indicated by their individual assessment.	3/22/17

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F 314	Continued From page 21 pressure ulcers both heels. Interventions reposition in chair every two hours, offload (remove all pressure to area) heels, administer treatments as orders. Review of R61's return from hospital assessment completed dated 12/16/16 the day she return from a short stay in the hospital for a urinary tract infection. The assessment read that she has left heel pressure wound measuring 3 centimeters (cm) x 3 cm x 0.2 and a right heel pressure 2 cm x 2 cm. Both pressure ulcers were open and a stage 2 on each heel. Review of document titled clinical Document Copy, Primary Care Internal Med Nursing Home , Limited Evaluation dated 12/6/16 noted wounds on her left great (big) toe measuring 1.5 cm x 1.2 cm and heel measuring 2 cm diameter. Orders read: Iodosorb/Curasol dressings to both areas daily Nursing to monitor area daily and perform weekly skin updates Bed cradle to be used at all times when patient lying in bed Pillow to be placed under bilateral lower extremities to ensure heels are not in contact with the bed Review of document titled clinical Document Copy, Primary Care Internal Med Nursing Home, Subsequent Visit dated 12/8/16 noted a follow up on wounds after intervention orders. Document reads that the facility using cradle and elevating heels, but did have dressing in place. Orders read: Nursing to continue treatments to both areas on left foot	F 314	The DON or designee will audit every resident with pressure ulcers twice daily for 2 weeks to ensure the pressure ulcer interventions are in place. Based on the outcome of the audits, education/training will be completed as indicated by the outcome of the audits. Failure to adhere to these protocols will result in retraining and/or corrective counseling. The results of the audits and compliance rates (track, trend, analysis) will be reported to the facility QAPI committee monthly for the first 3 months then quarterly ongoing. Upon this review, system revisions and/or staff education will be implemented as indicated by the outcomes. Facility DON and/or designee will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by March 22, 2017.	

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DON to monitor closely
Continue bed cradle when resting in bed
Ensure heels are floating when in bed as well in recliner.

Review of Electronic Treatment Administration Record (ETAR) for the month of 2/2017 reads:
Bed cradle to be used at all times when resident is in bed. Nursing to monitor Left toe and heel wounds and notify PA/NP if actually worsening or no improvement in two weeks, 12/20/16. Avoid shoes and make sure heels are off loaded at all times. Documentation per shift.
Missing documentation on morning and night shift once in nine day, three missing documentation on the afternoon shift in nine days.
Wound documentation 3 times week Monday, Wednesday and Fridays.
Missing documentation one day and two days were documented by a Trained Medication Aide (TMA) out of nine days
Left heel and left great toe wound care every evening shift.
Missing wound care treatments for three days in a row and four was documented by a TMA out of nine days.

During observation on 2/8/17 from 12:50 p.m. to 3:07 p.m. observed R61 to have her heels resting on the end of her recliner no cushion or pillow placed properly to float her heels as ordered by physician. R61 had not been repositioned while in her recliner. Nursing assistant (NA)-E entered to complete a bladder scan while in her recliner. Surveyor asked how often R61 is to be repositioned NA-E stated does not work all the time not sure. NA-E was asked where do you find that information if needed, NA-E stated in the

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care plan but does not work as a NA very much, was hired as a TMA. NA-E completed bladder scan and went to get nurse stated will be placing in bed to complete procedure.

During constant observation on 2/9/17 between 7:11 a.m. and 8:48 a.m. feet not floated (all pressure removed from heels) observed to be resting on the bed. NA-B in room to get her ready to the day.

Observed 2/9/17 10:52 a.m. sitting in recliner, pillow under legs not floated. 11:08 a.m. LPN-B in room pillow adjusted foot floated.

Observation 2/10/17 at 8:16 a.m. R61 found lying in bed with heels in contact with mattress and not floated. LPN-B verified at 8:21 a.m. through observation with surveyor that R61's heels were not floated and no pillow under legs.

Interview with nursing assistant (NA)-F on 2/09/17 at 12:02 p.m. regarding R61 skin care plan intervention in place to help promote healing. NA-F stated that staff place a pillow underneath feet in chair and bed, a bar on bed to keep blankets of feet and do not place shoes on her, only socks. NA-F gave a demonstration using the pillow on how it should look when R61's heels are floated. NA-F conclude by saying that skin updates are reported to the nurse.

Interview on 2/9/17 at 12:06 p.m. LPN-B was asked about pressure ulcer intervention in place to promote healing to R61's pressure ulcers located on heels. LPN-B stated dressing changes are completed in the evening, bath day are Mondays, feet elevated on pillow when in chair and in bed, no shoes, but wears socks

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F 314	Continued From page 24 like heavy blankets on to keep warm and has lift in bed to keep blankets off feet. Interview with DON on 2/09/17 at 2:59 p.m. stated interventions to promote healing for R61's stage two pressure ulcers on heels was to add moisture to wound, dressing changes completed, use bed cradle and nothing heavy on feet. DON stated that R61 gets repositioned every three-four hours. Reviewed of current pressure ulcer care plan with DON which included to reposition every 2 hours and offload heals. DON was asked about the dressing changes and who can complete them. DON stated that the dressing are completed every day in the evening and is to be completed by an nurse. DON reviewed the ETAR and verified that the dressing changes were not completed and the ones that were initialed as being completed was by a TMA who can not complete dressing changes or documentation on wounds.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (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	F 315		3/22/17

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F 315	Continued From page 25 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a bowel and bladder assessment had been completed with a corresponding toileting schedule to maintain or improve urinary incontinence after a decline in bladder continence for 1 of 1 resident (R99) reviewed for urinary incontinence. Findings include: R99's diagnosis found on the Admission Record, identifies unspecified dementia without behavioral disturbance (9/14/16), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (9/8/16).	F 315	Resident 99 has a bowel and bladder assessment in process. An appropriate individualized toileting schedule will be determined based on assessment. Bowel and bladder assessments are being completed for all residents residing here who are incontinent. Toileting schedules will be put in place for those residents based on results of the assessments. All admissions will have bowel and bladder assessments completed. Individualized toileting schedules and/or other interventions will be placed on the kardex and care plan as indicated.	

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F 315	Continued From page 26 Care Area Assessment (CAA) dated 9/19/16, identifies R99 to be receiving treatment for toileting to achieve the highest practical self-sufficiency. R99 was identified as being able to remove and open clothing in preparation, able to transfer and position self, able to void into the toilet, able to tear/use toilet paper to cleanse self, able to flush the toilet and able to adjust clothing and wash hands. CAA summary identifies R99 having been incontinent of urine but less than 7 x a week. R99's admission Minimum Data Set (MDS) assessment completed on 9/15/16, identifies occasionally incontinent. Quarterly MDS review dated 12/12/16, identifies R99 to be frequently incontinent and severe impaired cognition. Care plan dated 12/22/16, identifies R99 to have been incontinent of urine. Interventions include: able to tell need or urge to void, offer to take to toilet when caring for resident/when repositioning every 2 hours. Assist of 1 for toileting needs. Reviewed progress notes from 9/8/16 to 10/24/16, no mention of urinary incontinence. Reviewed progress notes from 12/1/16 to 2/8/17, no mention or urinary incontinence. Reviewed assessments from admission on 9/8/16, no bowel and bladder assessment completed. Observation on 2/9/17, at 7:24 a.m. with nursing assistant (NA)-C. R99 was toileted but was unable to void. NA-C stated R99 is sometimes able to tell staff when needing to use the bathroom and other times isn't able to. Sometimes R99 is able to use the toilet and other	F 315	The DON will implement measures to ensure this deficient practice does not recur including: all nurses will be educated on continence management including the completion of bowel and bladder assessments and determining individualized toileting schedules and interventions needed based on the assessment results. Interventions will be placed on the kardex and care plan as indicated; all CNAs will be educated on completion of bowel and bladder assessments and the importance of following the toileting schedule in the kardex and/or care plan and notifying nurses of any changes in the residents' bowel and bladder routines. The DON or designee will monitor the corrective actions to ensure the effectiveness of these actions including: auditing every new admission's bowel and bladder assessment and individual toileting schedule for 2 weeks to see that the assessments are complete and toileting schedule is being followed, followed by random weekly audits. Based on the outcome of the audits, education will be completed timely. Failure to adhere to these protocols will result in re-training and/or corrective counseling. The results of the audits and compliance rates (track, trend, analysis) will be reported to the facility QAPI Committee monthly for the first 3 months, then quarterly ongoing. Based on the analysis of the data, system revisions and/or staff education will be implemented as	

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F 315	Continued From page 27 times has gone (urinated) in the pad before being assisted to the toilet. Interview on 2/9/17, at 8:17 a.m. with director of nursing (DON) stated bowel and bladder assessments are completed on admission and quarterly. DON stated the floor nurses are responsible for completing the assessment and the aides document how much assistance the resident needs and whether the resident was incontinent or continent prior to using the toilet. DON stated that information is what is used to complete the MDS assessments. DON stated the MDS coordinator is responsible for completing the care plans based off of assessments. DON verified there was no bowel and bladder assessment completed for R99. Interview on 2/10/17, at 8:13 a.m. with nursing assistant (NA)-D stated R99 is a one assist to use the bathroom and every once in a while can say when she needs to use the bathroom. NA-D stated she offers R99 assistance with the bathroom every 2-3 hours. Interview on 2/10/17, at 8:17 a.m. with licensed practical nurse (LPN)-C stated bowel and bladder tracking is completed on admission and also if an aide tells nursing that a resident has had a decline in incontinence tracking can be initiated. Interview on 2/10/17, at 8:39 a.m. with MDS coordinator when asked how the MDS is completed for urinary continence stated the nursing aides document in point click care (online charting system) whether the resident is continent or incontinent every time the resident is assisted to the bathroom. MDS coordinator stated that she looks at that information to complete the MDS.	F 315	indicated. Facility DON or designee will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by March 22, 2017.	

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F 315	Continued From page 28 MDS coordinator stated she will look at the bowel and bladder assessments if one has been completed for the resident. When asked how she knew the information the aides documented was accurate, MDS coordinator continued to state the MDS is completed off of the aides charting and also by reading the nurses notes. MDS coordinator stated she usually doesn't interview the residents when completing the bowel and bladder section of the MDS. MDS coordinator stated the care plans are a group effort. MDS was unable to answer when asked how an accurate care plan could be completed without a bowel and bladder assessment. MDS coordinator stated if there is missing information the floor nurses are delegated to do the assessments. MDS coordinator stated that she would like to think that the MDS and care plan are both correct but could not verify they were correct because there was not a bowel and bladder assessment completed for R99 that could verify that a 2 hour toileting schedule was sufficient in preventing further incontinence. Interview on 2/10/17, at 8:49 a.m. with DON stated the MDS should be based on assessments and clarifications with staff. DON stated she couldn't confirm the MDS is accurate for the decline in urinary incontinence because a bowel and bladder assessment had not been completed for R99. DON stated there should have been a bladder assessment completed that we would have based our care plan interventions off of. DON stated with R99's decline in urinary incontinence she would have expected a bowel and bladder assessment be completed and the care plan revised to reflect the change and to prevent further decline.	F 315		

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F 315	Continued From page 29 Facility policy titled, Bowel and Bladder 3-Day Screening dated 2010, identifies a bowel and bladder screening will be completed on all new admissions, readmissions, annual and quarterly reviews or new incontinence. This 72 hour data collection tool will be used to assist in determining the resident's best toileting schedule to maintain or improve continence levels. Policy identifies if the resident has been incontinent most of the time when toileted every two hours, change interval to every one and one-half hours. If more data is needed, continue Bowel and Bladder screening until a toileting plan can be established.	F 315		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently obtain and	F 325	The residents cited in this tag have been discharged.	3/22/17

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F 325	Continued From page 30 monitor weights to prevent sever weight loss for 2 of 3 residents (R22, R67) who had been reviewed for nutritional status. Findings Include: R22's admission Minimum Data Set (MDS) dated 12-13-16, identified diagnoses of Alzheimer's disease and dementia. R22 needed assistance of one staff member for eating and had severely impaired cognition. This was a closed record reveiw. Review of R22's weights in pounds was documented as follows: 12/2/16: 179 12/14/16: 180 12/21/16: 168 12/28/16: 168 R22 had an 11 lbs. weight loss in the first 16 days since admission; this was a 6 % weight loss and a severe weight loss. Registered Dietician progress note dated 12/15/16, included, "[family member (FM)-A] accompanied R22 during my visit. He appears to be a poor historian as he was unable to answer most questions. [FM-A] states he has his own teeth with no trouble chewing or swallowing. He can feed himself after set up. He is a good eater and has not had any recent weight loss. No special diet followed at home. No immediate concerns identified." The initial dietary/nutritional data collection dated 12/19/16, included, "Diet order of Regular, regular textures, thin liquids ... Meal tray to room is preferred dining location. Limited assistance for	F 325	Weights: Facility staff will obtain weights for all residents currently residing here. Nursing and the Registered Dietitian will review weights weekly ongoing to identify weight changes and report them to the attending physician/NP/PA. All new admissions will have weights obtained within the first 3 days. The DON will implement measures to ensure this deficient practice does not recur including: all nurses will be educated on ensuring weights are obtained according to individual resident's care plan and/or facility protocol. The licensed nurse will notify the dietitian and providers of any significant weight changes. All CNAs will be educated on accurate and timely weights as directed by the licensed nurse. The DON or designee will monitor the corrective actions to ensure the effectiveness of these actions including: auditing all weight records to ensure all weights are obtained according to resident care plan 3 times per week for two weeks, weekly for 3 weeks, followed by random weekly audits. The facility alleges that it will be in substantial compliance with the standard indicated by March 22, 2017.	

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F 325	Continued From page 31 eating self-performance Setup help only ... Summary: R22 admitted for rehab [rehabilitation] following a hospital stay for a hip fracture and urinary tract infection. He has a PMH [personal medical history] of Alzheimer's dementia and multiple strokes. His [FM-A] is his historian as he is unable reply to questions appropriately r/t [related to] cognitive status. He appears normal weight, alert with periods of somnolence and well nourished. He eats with assistance in the dining room or his room. His [FM-A] is his primary care giver. He has no trouble chewing or swallowing and eats well with intake of >75% each meal daily. Fluid intake ~1500 ml/day per nursing task records. Weight has remained stable...Continue with Regular diet ...Monitor intake/fluids daily and weights weekly ..." Registered Dietitian 30 Day review dated 1/18/17, included, "Diet: Regular, Regular textures, thin liquids, Intake: declined to ~ [around] 50% on average at each meal daily x 1 week. Fluids: Declined to ~1100 ml .Weights: Admit wt. 179# [pounds], last recorded wt [weight]12/21/16 167.8# -11# (6%) since admission. No weight recorded this month. R22 has had a decrease in intake over the past week. Most currently the last few days he has had issues with swallowing. Nursing has ordered a 3-day trial of mech [mechanical soft] soft/pureed textures. This writer notified DON/SLP/therapy [director of nursing/speech language therapist] for a screening of his swallowing ability and recommendations. Weight loss of 6% since admission noted. Recommend weights be done 3 times per week given decline in intake for closer monitoring. Following up for SLP recommendations."	F 325		

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F 325	Continued From page 32 R22's nutritional care plan printed 2/9/17, included, "Potential nutrition risk related to dementia AEB [as evidenced by] periods of somnolence, forgetfulness and confusion." Interventions included: "Weigh resident every Wednesday." On 2/8/17, at 2:36 p.m., registered dietician (RD)-A stated when a resident displayed weight loss, she expected staff to alert her to complete a consult for weight loss. RD-A stated weights are to be completed every Wednesday and stated she checked the weights and vital reports under clinical tab. RD-A stated since staff had not weighed R22, he did not trigger for a weight loss. RD-A stated she was unaware of R22's weight loss until she completed the nutritional 30-day review and noticed R22 was not being weighed. RD-A stated every resident in the building was to be weighed on Wednesdays, unless they had a different order for more frequent weights. RD-A stated staff obtaining weights weekly had been a problem and that was why she would sometimes order daily weights or weights three times a week for residents to help ensure weights would be taken. RD-A verified this was why she indicated R22 should have weights taken three times a week as a part of her 30-day nutritional review. RD-A stated her expectation was staff to follow the care plan and weigh residents on Wednesday. On 2/9/17 at 7:40 a.m. nursing assistant (NA)-A stated staff try to get all resident weights on Wednesdays. NA-A stated sometimes based upon acuity and workload weights do not always get done. On 2/9/17, at 11:32 a.m., stated she was not	F 325		

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F 325	Continued From page 33 aware of R22's weight loss. The DON stated she was aware of the trial for mechanical soft and recommendations for swallowing evaluation. The DON stated when weights are recorded under the weights and vitals section in the computer, there is an alert if there was a weight change. The DON stated the dietician monitored the weights alerts and residents weights in the computer. The DON stated she was aware weights were not being done weekly prior to the identification by corporate during an audit on 2/2/17. The DON stated she expected weekly weights to be completed on weight day and entered into the computer system. The DON stated expected staff to follow the care plan for weekly weights. The Weight Monitoring - Nursing Services policy dated 2006, included, "Each resident will be weighed and measured within 24 hours of admission. Each resident will be weighed weekly for the first four weeks of her/his stay, monthly thereafter unless an adverse trend has been identified. Residents will be weighed weekly or more often based upon ongoing assessment of nutritional intake, fluid retention, and other medical factors." R67 diagnosis found on the Diagnosis Report identified Alzheimer's Disease, unspecified Dementia without behavioral disturbance and weakness all dated 12/19/16 (day of admission). Order Listing Report dated 12/19/16, identifies R67 received a regular diet, regular texture, thin fluid consistency, for General diet. Order Summary Report dated 12/19/16, indicates R67 to be weighed every Wednesday. Care plan dated 1/8/17, identifies potential	F 325		

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F 325	Continued From page 34 nutrition risk related to Alzheimer's dementia, recent cognitive and functional decline and low BMI (body mass index). Interventions include: monitor intake, offer bedtime snack, offer substitutes for uneaten foods, and provide diet as ordered, regular. Observe changes in weight, notify physician, and weigh resident every Wednesday. Medication Administration Record (MAR) dated December 2016, identifies R67 was weighted on 12/21/16 and 12/28/16. January 2017, MAR identifies R67 was weighed on 1/4/17, 1/11/17 and 1/18/17. However, the Weights and Vitals Summary identifies R67 weight on 12/19/16, was 125.6 pounds. 1/11/17, 120.8 pounds. 1/18/17, 115.8 pounds a 9.2 pound loss in one month or 9 percent which is a severe weight loss. No other weights identified. Meal Intake and Fluids forms reviewed from 12/19/16 to 1/18/17, identifies R67 consistently consumed 76-100% of meals. Nutritional Summary found in progress notes dated 12/27/16, identifies R67 receiving a regular diet with think liquids and not receiving any nutritional supplements. R67 was identified as having an admission weight of 125.6 and a BMI of 19.7. Summary identifies R67 to appear thin and well nourished. R67 had reported no recent weight loss and identified usual body weight to be 130 pounds. Summary identifies to continue with regular diet, monitor intake daily and weights weekly. Progress note dated 1/17/17, indicates R67's weight to be 120.8. Registered Dietician had entered a note recommending a re-weigh for	F 325		

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F 325	Continued From page 35	F 325		

accuracy. However, no indication this was completed nor any information provided when asked for the re-weigh.

Progress note dated 1/20/17, indicates R67's weight to be 115.8. Registered Dietician's entered note indicates R67 had discharged from the facility.

Review of daily nursing charting from 12/19/16 to 1/19/17, assessments include a section to document weights. Charting on 12/19/16, indicated a weight of 125.6. All other assessments the section for weight were left blank.

Interview on 2/8/17, at 2:36 p.m., registered dietician (RD)-A stated when a resident displayed weight loss, she expected staff to alert her to complete a consult for weight loss. RD-A stated weights are to be completed every Wednesday and stated she checked the weights and vital reports under clinical tab. RD-A stated every resident in the building was to be weighed on Wednesdays, unless they had a different order for more frequent weights. RD-A stated staff obtaining weights weekly had been a problem and that was why she would sometimes order daily weights or weights three times a week for residents to help ensure weights would be taken. RD-A stated her expectation was staff to follow the care plan and weigh residents on Wednesday.

Interview on 2/9/17, at 7:10 a.m. with licensed practical nurse (LPN)-A stated everyone gets weighed on Wednesday's unless they have an order to complete more often. If we enter a weight and it is a 3 pound difference in a day or a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 36 5 pound difference in a week the computer will prompt a message that indicates a weight loss and then nursing is to notify the provider. Interview on 2/9/17, at 7:26 a.m. with nursing assistant (NA)-C stated when entering weights into the computer system they are able to see the previously entered weight and are to alert the nurse if there is a change. Interview on 2/9/17, at 10:43 a.m. with director of nursing (DON) stated weights are to be completed at least once weekly unless ordered otherwise. DON stated when a decline in weight is identified the inner disciplinary team (IDT) meets to try and determine the cause of the weight loss. DON stated the dietician talks with the resident to determine appropriate interventions. DON verified R67 had only 3 documented weights during her stay in the facility. DON stated she was aware weight loss was a problem within the facility, including weights being completed as ordered. Facility provided two policies, "Nutritional Assessment Policy and Procedure" undated, and "Food and Nutrition" dated 11/2016. Neither policy addressed obtaining and monitoring weights.	F 325		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or	F 329		3/22/17

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F 329	Continued From page 37 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to ensure AIMS assessments were completed for 4 of 5 residents (R189, R103, R87, R173): failed to ensure behavior and mood monitoring was completed for 2 of 5 residents (R103, R173): failed to ensure comprehensive sleep assesments were completed for 2 of 5 residents (R189, R173): and failed to document the reason for administration of as needed (PRN) pain medications and failed to document non-pharmacological interventions attempted prior to the administration of PRN pain medications for 2 of 5 residents (R189, R173) reviewed for medication use. Findings include: LACK OF AIMS ASSESSMENT: R189 was admitted to the facility on 1/24/17 per the facility admission record. R189's physician orders dated 1/24/17 included, "olanzapine tablet 5 mg [milligrams], give 1 tablet	F 329	Resident 87 had an AIMS assessment completed. All other residents noted are discharged. AIMS assessments will be completed for all residents on antipsychotic medications. All residents with psychotropic medications will be monitored for behavior and mood. All residents with medications for sleep will have sleep assessments. All residents who receive PRN pain medications will have a documented reason for administration as well as non-pharmacological interventions attempted prior to administration each time, as well as documentation to show effectiveness of the intervention. The DON will implement measures to ensure this deficient practice does not recur including: all nurses will be educated regarding AIMS assessments, behavior and mood monitoring, sleep assessments and documenting reason	

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F 329	Continued From page 38 by mouth one time a day for mood augmentation." Review of Medication Administration Record (MAR) from January 2017 to February 2017, indicated R189 received scheduled doses of olanzapine as ordered. R189's assessments were reviewed since admission on 1/24/17, and revealed an AIMS assessment had not been completed for R189. R189's progress notes were reviewed from 1/24/17 to 2/8/17 and there was no documentation of an AIMS assessment being completed. On 2/09/2017, at 11:32 p.m. the director of nursing (DON) stated an AIMS assessment was not completed for R189. The DON stated by day four of a resident's stay she expected an AIMS assessment to be completed. The DON stated the AIMS assessment was assigned to be completed by the nurse manger and currently there was not a nurse manager on R189's unit. The DON stated another nurse should have completed the AIMS assessment for R189. LACK OF SLEEP ASSESSMENT: R189 was admitted to the facility on 1/24/17 per the facility admission record. R189'S admission Minimum Data Assessment dated 1/30/17, indicated R189 was cognitively intact, and had trouble with falling asleep, staying asleep, or sleeping too much. R189's physician orders dated 1/24/17 included,	F 329	and non-pharmacological interventions prior to each PRN pain medication. Members of IDT have been educated on the procedure for completing behavior and mood reviews for residents receiving psychotropic medications and their role. The DON or designee will monitor the corrective actions to ensure the effectiveness of these actions including: auditing all resident charts that pertain to antipsychotic medications for AIMS assessments, psychotropic medications for behavior and mood documentation, sleep medications for sleep assessments and PRN pain medications for reason and non-pharmacologic interventions documentation according to facility protocol for 2 weeks followed by random weekly audits. Upon completion of these audits, education will be completed timely based on outcome of the audits. Failure to adhere to these protocols will result in re-training and/or corrective counseling. The results of the audits and compliance rates (track, trend, analysis) will be reported to the facility QAPI Committee monthly for the first 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility DON will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by March 22, 2017.	

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"Melatonin Tablet 3 MG [milligrams], give 4 tablet by mouth one time a day for sleep."

Review of Medication Administration Record (MAR) from January 2017 to February 2017, indicated R189 received scheduled doses of melatonin as ordered.

R189's assessments were reviewed since admission on 1/24/17, and revealed a comprehensive sleep assessment had not been completed for R189.

R189's progress notes were reviewed from 1/24/17 to 2/8/17 and there was no documentation of a comprehensive sleep assessment being completed.

On 2/09/2017, at 11:32 p.m. the director of nursing (DON) stated a sleep assessment was not completed for R189. The DON stated when a resident was on admitted with melatonin there should be documented hours of sleep completed to be used to complete a comprehensive sleep assessment to determine the effectiveness of the sleep aide.

On 2/10/2017, at 10:45 a.m. the DON stated comprehensive sleep assessments were not being completed for any residents in the building at this time.

LACK OF DOCUMENTED REASON FOR USE FOR AN AS NEEDED PAIN MEDICATION AND LACK OF NON-PHARMACOLOGICAL INTERVENTIONS BEING ATTEMPTED AND

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F 329	Continued From page 40 DOCUMENTED PRIOR TO THE ADMINISTRATION OF A AN AS NEEDED PAIN MEDICATION: R189 was admitted to the facility on 1/24/17 per the facility admission record. R189'S admission Minimum Data Assessment dated 1/30/17, indicated R189 was cognitively intact. R189's medication orders found on the medication administration records (MAR) for January 2017 and February 2017 included PRN orders for the following pain medications: "Acetaminophen Tablet 500 MG [milligrams], Give 2 tablet by mouth every 6 hours. Order date 1/24/17. " "Ultram Tablet 50 MG (TraMADol HCl) *Narcotic* date ordered 1/24/17, Give 1 tablet by mouth every 6 hours as needed for pain." "Ultram Tablet 50 MG (TraMADol HCl) *Narcotic* date ordered 2/1/17, Give 1 tablet by mouth every 4 hours as needed for pain." "OxyCODONE HCl Tablet 5 MG *Narcotic* order date 1/24/17, Give 1 tablet by mouth every 4 hours as needed for pain rated greater than 3 or comfort level AND Give 2 tablet by mouth every 4 hours as needed for pain rated greater than 6 Review of the January 2017 MAR revealed: R189 received PRN acetaminophen 13 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 13 of the 13 times	F 329		

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F 329	Continued From page 41 the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN acetaminophen being administered. R189 received PRN oxycodone, 5 MG, 1 tablet, 6 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 6 of the 6 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered. R189 received PRN oxycodone, 5 MG, 2 tablet, 5 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 5 of the 5 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered. R189 received PRN tramadol, 20 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 20 of the 20 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN tramadol being administered. Review of the February 2017 MAR revealed: R189 received PRN acetaminophen 1 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 1 of the 1 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN acetaminophen being	F 329		

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F 329	Continued From page 42 administered. R189 received PRN oxycodone, 5 MG, 1 tablet, 2 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 2 of the 2 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered. R189 received PRN oxycodone, 5 MG, 2 tablet, 2 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 2 of the 2 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered. R189 received PRN tramadol 50 MG, 1 tablet, every 6 hours, 2 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 2 of the 2 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN tramadol being administered. R189 received PRN tramadol 50 MG, 1 tablet, every 4 hours, 18 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 18 of the 18 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN tramadol being administered. R189's care plan included, PAIN: Has c/o [complaints of] pain to right knee, right arm and back. Is able to report pain verbally. Did have	F 329		

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F 329	Continued From page 43	F 329		

Continued From page 43

right total shoulder arthroplasty. Has arthritis. Has dx [diagnoses] of Major depression that could affect perception of pain. Interventions included, "give pain medications as indicated. ok to try non-medication interventions such as: repositioning, ice/warm packs. observe effectiveness of any intervention tried. consult with CNP/MD if concerns/present plan for pain relief not effective."

R189 was observed on 2/7/17, at 6:25 p.m., R189 during a medication pass observation, to receive a prn pain medication. The nurse did not offer any non-pharmacological interventions prior to the administration of the pain medication.

R189 was interviewed on 2/08/2017, at 1:29 p.m., R189 stated she communicated her pain levels to staff and requested the PRN pain medication she felt she needed to help her with her pain. R189 had stated she had just requested an icepack from staff to help with shoulder pain. R189 stated she would ask for an icepack when she wanted to use one and staff would get an icepack for her. R189 stated staff did not offer her non-pharmacological options for pain management when she requested a prn pain medication.

On 2/8/17 at 9:11 a.m., registered nurse (RN)-F stated staff should offer and try non-pharmacological interventions prior to administration of PRN pain medications. RN-F stated non-pharmacological interventions tried should be documented in the medical record. RN-F stated knew this was an area of concern and stated medication pass and completing treatments were a priority.

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F 329	Continued From page 44 On 2/09/2017, at 11:32 a.m. the director of nursing (DON) stated she expected staff start with the non-pharmacological interventions prior to the administration of a PRN pain medication. The DON stated upon admission nursing visited with residents about non-pharmacological interventions that have worked for them for pain, so we have their preferences. The DON verified this assessment was completed for R189 and stated a pain care plan was developed that included non-pharmacological interventions. The DON stated she expected staff to offer non-pharmacological interventions, document what was tried prior to the administration of the PRN medication and stated she expected staff to document the reason why PRN pain medication was administered. LACK OF AIMS ASSESSMENT AND MONITORING OF BEHAVIOR/MOOD: R103 was admitted to the facility on 12/8/16. R103's diagnosis found on the Admission Record dated 12/8/16, identifies anxiety. R103 medication orders found on the Order Summary Report identifies Lexapro 10 mg give one tablet by mouth one time a day for depression with a start date of 12/8/16, and Seroquel 25 mg give 0.25 tablet by mouth one time a day for mood/insomnia dated 12/8/17. Orders for monitoring of anti-depressant and anti-psychotic medications were entered on 2/8/17, after entering the facility. Behavior monitoring record for February 2017 identifies behavior monitoring from MDS. No other behavior/mood monitoring identified.	F 329		

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Care plan dated 12/28/16, identifies R103 to be on psychotropic medications. "Arrived here on antipsychotic medications (Seroquel). It appears to be for mood (recent history of agitation/confusion) and anxiety. It may help seizure as husband and record hint that insomnia is result of seizures. Per hospital admission records, dose had been usually 12.5 mg daily and up to 25 mg daily right before hospital admission. Was in ER in earlier November for anxiety. Also arrived her on an antidepressant (Lexapro 10 mg daily). Also unclear how long has been on this. Hint of diagnosis of depression but no recent documentation about it. Initial PHQ-9 score was 14".

Treatment Administration Record (TAR) dated February 2017, identifies to monitor for side effects of anti-depressant use with a start date of 2/8/17. January 2017, TAR doesn't identify to monitor for any side-effects of medications.

Medication Administration Record (MAR) dated February 2017, identifies R103 to have received Lexapro 10 mg daily and Seroquel 25 mg give 0.25 tablet daily. MAR identifies monitoring for side effects of anti-psychotic medications and monitoring of behaviors with a start date of 2/8/17. MAR for January 2017, does not identify any monitoring of anti-psychotic behaviors.

Progress note dated 12/8/16, identifies R103 to have a PHQ-9 score of 12 which indicates moderate depression. Progress note dated 12/15/16, identifies a PHQ-9 score of 5 which indicates mild depression. Progress note dated 1/11/17, identifies a staff interview was completed as R103 was unable to be interviewed. Progress

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F 329	Continued From page 46 note dated 1/31/17, identifies a staff interview was completed which indicated no depression. Review of progress notes from 12/8/16 through 2/9/17, identifies no mention of R103 having any behaviors or mood concerns. Review of assessments indicated an AIMS assessment had not been completed for R103. Interview on 2/9/17, at 7:29 a.m. with licensed practical nurse (LPN)-A stated R103's behaviors are directed towards her husband and that she gets angry and can be mean and also gets very agitated. LPN-A stated that he had documented these behaviors in the past but stated he doesn't document every time it happens. LPN-A stated R103's behaviors weren't a new issue and they are why R103 entered the facility. Interview on 2/9/17, at 8:40 a.m. with director of nursing (DON) stated by day 4 there is supposed to be an AIMS assessment that is completed for any resident receiving an antipsychotic. DON verified an AIMS assessment had not been completed for R103. DON stated the nurse managers are responsible for completing the assessments. Interview on 2/9/17, at 12:09 p.m. with nursing assistant (NA)-A stated R103 will occasionally have agitation and times where she isn't able to have conversations that are reality based. NA-A stated R103 has agitation towards her husband and others and can be confused at times. NA-A stated she is able to document only specific behaviors in point of care (online charting system) but isn't able to explain the situation. NA-A stated she reports behaviors or mood concerns to the	F 329		

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F 329	Continued From page 47 nurse. Interview on 2/9/17, at 12:15 p.m. with the nurse manager (RN)-A stated that she hadn't completed any AIMS assessments. RN-A stated she was unaware that she was responsible for completing the assessment and stated she doesn't have a list or isn't alerted to what assessments she is required to complete. Interview on 2/9/17, at 1:58 p.m. with DON verified there was no behavior or mood monitoring documentation that had been completed for R103. DON stated usually an order is entered along with the medication to alert the nurses to monitor for side effects and specific behaviors or mood, but this was not completed. DON stated nurses should be documenting behaviors whenever they are occurring and should be monitoring mood to ensure medications are effective. Policy titled, "Psychoactive Medication use and Gradual Dose Reduction" dated 8/2013, identifies Abnormal Involuntary Movement Scale (AIMS) will be performed on residents receiving antipsychotic medications to screen for tardive dyskinesia every 6 months. Policy titled, "Mood/Behavior/Sleep Observation" dated 8/2013, identifies target mood/behaviors will be monitored every shift. All members of the care team are to complete the daily mood/behavior observation tool/ PCC POC (point click care and point of care, online charting systems) when a resident exhibits mood or behaviors. Communication to the licensed nurse and or social worker as appropriate. The licensed nurses are to review documentation of the daily	F 329		

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F 329	Continued From page 48 mood/behavior observation/PCC POC for completion and the need for any additional documentation. A summary of the mood/behavior/sleep is to be completed during the monthly charting cycle to include a summary of the interventions used as well as a summary of the resident's response. LACK OF AIMS ASSESSMENT FOR R87: R87's diagnosis found on the Diagnosis Report identifies Delusional Disorders and Visual hallucinations dated 10/28/16. R87's medication orders found on the Order Summary Report dated 2/9/17, identifies Seroquel 25 mg give 1 tablet by mouth as needed for behaviors, agitated persistent delusional/paranoid outbursts may give additional dose PRN when unable to redirect behaviors. Seroquel 25 mg give one tablet by mouth two times a day for behaviors: persistent paranoid outbursts, delusions. Review of Medication Administration Record (MAR) from December 2016 to February 2017, indicates R87 received scheduled and PRN (as needed) doses of Seroquel as ordered. Care plan dated 1/14/17, identifies a behavior problem due to yelling and making threats of harm to wife. Has ambivalent family relationships. Disrupts roommate which is his wife. Will yell at staff at times also. Has diagnosis of psychosis with delusions. History of hallucinations/Charles Bonnet syndrome. Reviewed progress notes dated 12/5/16 through 2/9/17, no mention of any AIMS assessment	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 49 being completed. Review of assessments identified AIMS assessment had not been completed for R87. Interview on 2/9/17, at 8:40 a.m. with director of nursing (DON) stated by day 4 there is supposed to be an AIMS assessment that is completed for any resident receiving an antipsychotic. DON verified an AIMS assessment had not been completed for R87. DON stated the nurse managers are responsible for completing the assessments. Interview on 2/9/17, at 12:15 p.m. with the nurse manager (RN)-A stated that she hadn't completed any AIMS assessments. RN- stated she was unaware that she was responsible for completing the assessment and stated she doesn't have a list or isn't alerted to what assessments she is required to complete. Policy titled, "Psychoactive Medication use and Gradual Dose Reduction" dated 8/2013, identifies Abnormal Involuntary Movement Scale (AIMS) will be performed on residents receiving antipsychotic medications to screen for tardive dyskinesia every 6 months. LACK OF SLEEP ASSESSMENT: R173 admitted to the facility on initially on 12/26/17 and readmitted on 1/12/17 per the facility admission record. R173 admission Minimum Date Assessment 1/20/17 indicated R173 was cognitively intact and was trouble with falling asleep, staying asleep or sleeping too much. R173's physician orders dated 1/13/17 through	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING ________ B. WING ________	02/10/2017

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F 329	Continued From page 50	F 329		

2/04/17 and reordered on 2/4/17 included, "Trazodone Tablet 50 MG Give 1 tablet by mouth in the evening for sleep may repeat x1 if needed after 1 hour AND Give 1 tablet by mouth as needed for sleep May take repeat dose if still awake after 1 hour"

Review of Medication Administration Record (MAR) from January 2017 to February 2017, indicated R173 received scheduled doses of trazodone nightly along with prn dose given on 2/8/17.

R173's assessments were reviewed since admission on 1/12/17, and revealed a comprehensive sleep assessment had not been completed for R173.

R173's progress notes were reviewed from 1/13/17 to 2/8/17 and there was no documentation of a comprehensive sleep assessment being completed.

LACK OF AIMS ASSESSMENT AND MONITORING OF BEHAVIOR/MOOD:

R173's diagnosis found on the Admission Record dated 1/13/17, identifies severe major depressive disorder.

R173 medication orders found on the Order Summary Report identifies: mirtazapine 15 mg give one tablet by mouth one time a day for depression, and Seroquel 25 mg give 0.25 tablet by mouth twice daily , and Zoloft 100 mg two times daily for depression all with start dates of 1/13/17. Orders for monitoring of anti-depressant and anti-psychotic medications were entered on 2/8/17, after entering the facility.

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F 329	Continued From page 51	F 329		

Behavior monitoring record for February 2017 identifies behavior monitoring from MDS. No other behavior/mood monitoring identified.

Care plan dated 1/20/17, identifies R173 is on psychotropic medications. Indicates that R173 has diagnosis of depression and history of several psychiatric hospitalizations. R173 takes antidepressant and antipsychotic medications.

Treatment Administration Record (TAR) dated February 2017, identifies to monitor for side effects of anti-depressant, use with a start date of 2/8/17. January 2017, TAR does not identify to monitor for any side-effects of medications.

Medication Administration Record (MAR) dated February 2017, identifies R173 to have received mirtazapine 15 mg daily at bed time for depression and once daily as needed for anxiety and Seroquel 25 mg give 0.25 tablet two times daily and Zoloft 100 mg two times daily. MAR identifies monitoring for side effects of anti-psychotic medications and monitoring of behaviors with a start date of 2/8/17. MAR for January 2017, does not identify any monitoring of anti-psychotic behaviors.

Progress note dated 1/27/17, identifies R173 to have a PHQ-9 score of 4 which indicates no depression. Progress note dated 1/20/16, identifies a PHQ-9 score of 9 which indicates mild depression. Progress note dated 1/06/17, identifies a PHQ-9 score of 3 which indicates no depression, Progress noted dated 12/27/16 identifies a PHQ-9 score of 5 which indicates mild depression.

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F 329	Continued From page 52	F 329		

Review of progress notes from 12/8/16 through 2/9/17, identifies no mention of R173 having any behaviors or mood concerns.

Review of assessments indicated an AIMS assessment had not been completed for R173.

LACK OF DOCUMENTED REASON FOR USE FOR AN AS NEEDED PAIN MEDICATION AND LACK OF NON-PHARMACOLOGICAL INTERVENTIONS BEING ATTEMPTED AND DOCUMENTED PRIOR TO THE ADMINISTRATION OF A AN AS NEEDED PAIN MEDICATION:

R173's medication orders found on the medication administration records (MAR) for January 2017 and February 2017 included PRN orders for the following pain medications:

During interview on 02/09/2017, at 11:15 a.m. R173 stated they would asked periodically if she would to try ice first. R173 indicated that she usually say "No, because it does not work for her."

Dilaudid Tablet 2 MG (HYDROmorphone HCl) Give 0.5 tablet by mouth every 4 hours as needed for pain rated <5/10 AND Give 1 tablet by mouth every 4 hours as needed for pain rated >5/10

Review of the January 2016 Medications Administration Record (MAR) revealed:
R173 received PRN (as needed) Dilaudid *Narcotic pain medication 17 times from readmission date of 1/13/17 to 1/31/17. The facility did not document the reason for use 17 of 17 times the medication was administered. In addition, the facility failed to document

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F 329	Continued From page 53 non-pharmacological interventions attempted prior to the PRN Dilaudid being administered. Review of the February 2017 MAR revealed: R189 received PRN Dilaudid 4 times from 2/1/17 to 2/1/17. The facility did not document the reason for use 4 of the 4 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN Dilaudid being administered. 2/10/17 at 9:13 a.m. with DON when asked about sleep and AIMs assessments stated that she had already stated to other surveyors that no sleep or AIMs assessment had been completed for any residents. Also, stated that she did an audit for medication requiring monitoring and added them when the questions started.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		3/22/17

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F 371	Continued From page 54 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prevent the potential spread of food borne illness, which had the potential to affect all 36 residents on the Rehab units also including staff and visitors who use ice from a portable ice chest. Findings include: On 02/07/17,11:40 a.m. A metal cart with a plastic cooler containing ice was by rehab one dining room/hallway. The cooler was unlocked and allowed free access to ice. The cooler was half to three/fourths full of ice, with plastic scoop left inside the container in contact with the ice. The ice container was in a location anyone had access. At 2:37 p.m. the plastic cooler with ice scoop still in contact with ice, continues to be in hallway, unlocked. Again at 3:56 p.m. the ice cooler with scoop still in contact with ice. Interview at this time with registered nurse (RN)-C concerning the ice cooler accessible to all residents and visitors and the ice scoop in contact with the ice, stated, "Nursing staff use the ice for filling resident water cups." "I don't see any scoop though [looking for scoop next to cooler]." RN-C informed scoop was inside ice container and when shown, RN-C stated, "Well, that shouldn't be there, I will take this back to the	F 371	No specific residents were directly affected by this deficient practice. The dietary manager will implement measures to ensure this deficient practice does not recur including: the process for water pass and ice availability for residents throughout each day will be changed to avoid ice chests. The residents will be able to obtain fresh ice via ice machines. Dietary staff will be educated regarding the water pass procedure and ice availability change to avoid ice chests. Ice chests will be removed by 3/17/17. The dietary manager or designee will monitor the corrective actions to ensure the effectiveness of these actions including: auditing that there are no ice chests put into place by checking 2 times per day for 2 weeks followed by random weekly audits. Upon completion of these audits, education will be completed immediately. Failure to adhere to these protocols will result in corrective counseling. The results of the audits and compliance rates (track, trend, analysis) will be reported to the facility QAPI	

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F 371	Continued From page 55 kitchen" and proceeded to return cart with ice container to kitchen. 02/08/17, 2:57 p.m. the metal cart with ice cooler containing ice noted in hallway on rehab two by dining room. The container was full of ice with scoop inside again in contact with ice. Interview with RN-B concerning the plastic ice container and scoop in contact with ice, stated, "I think the kitchen staff brings out the ice." RN-B had been shown scoop which was located inside ice chest. RN-B stated, "That should not be there [reference to ice scoop in contact with ice], I will check into this." At 3:05 p.m. the Dietary Manager was interviewed and said that the aide gets the cart from outside the kitchen door and fills the cooler with ice. Dietary manager observed cart with ice container and the ice scoop touching the ice. The Dietary manager stated, "No, that is the wrong cart." "No, that is not supposed to be there [in reference to ice scoop touching ice], I will figure out what happened." Received Hydration General Policies for VOA-Rochester Rehabilitation & Living Center dated 2015. regarding Water pass Procedure, which indicates Culinary staff to fill ice coolers and place on hydration carts then locate them by Rehab unit kitchen door for Nursing Assistant staff to pick up. Nursing assistant staff to leave coolers with remaining ice on respective units between causal room and dining room until bringing to kitchen for refilling with fresh ice. Procedure does not indicate that scoop should not be stored in contact with the ice.	F 371	Committee monthly for the first 3 months, then quarterly ongoing. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility dietary manager will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by March 22, 2017.	

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

F5626002

Printed: 02/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 02/09/2017

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Rochesster Rehab & Living) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The Facility is a 1 story building with a partial basement. The facility was constructed in 2015 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 56 certified beds.	K 000		

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

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.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted

February 28, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5626002

Dear Ms. Otto:

The above facility was surveyed on February 7, 2017 through February 10, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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

after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: ______ B. WING ______	02/10/2017

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

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On February 7, 8, 9, & 10, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services to prevent further falls for 1 of 1 residents (R101) who were reviewed for falls with injury. Findings: R101's Significant Minimum Data Set (MDS) dated 1/27/17 reviewed for activities of daily living (ADL)'s R101 requires one-person physical assist for transfers, toilet use, personal hygiene. R101's care plan reviewed identifies at risk for	2 830	Corrected	3/22/17

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2 830	Continued From page 3	2 830		

falls with intervention that staff are to remind R101 to get help by using the call light. Care plan also reads that R101 needs assist from one staff and the use of a walker with ambulation to and from the bathroom, with transfers and personal hygiene.

R101 had a fall with injury to the left leg and groin area on 1/7/17.

Review of Therapy Functional Mobility and ADL update dated 1/11/17 read R101 is an assist of two person for transfers and pivot transfer to and from a wheelchair to the bathroom. Same document dated 1/30/17 and 2/9/17 reads requires one assist with transfers and toileting.

Observation of R101 on 2/9/17 at 7:13 a.m. and on 2/10/17 at 8:23 a.m. Coming out of her bathroom, said getting self-ready for the day. R101 walking with walker with no staff in room.

Interview with R101 on 2/9/2017 1:37 p.m. Said will use wheel chair to get somewhere fast, and staff know if she needs help, resident stated that she knows when to call for help.

Interview on 2/9/17 at 1:22 p.m. With nursing assistant (NA)-F was asked, what help does R101 need. NA-F said R101 does not need help in her room, and does not need assistance going to the bathroom, staff feel she knows when she needs help.

On 02/09/2017 at 2:27 p.m. interview with NA-F asked how thing get communicated about the residents regarding their cares. NA-F stated staff talk to each other.

Interview with Director of nursing (DON) on

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2/9/17 at 2:42 p.m. was questioned regarding staff communication about resident choices/preferences and ADL's. DON said that the information placed in their computer system in the care plan and then auto populates for the NA's to view.

DON reviewed R101 care plan on computer and verified that R101 ADL's read that she is an assist of one for transfers, toilet use and personal hygiene. DON expectation would be to have the staff follow the care plan.

Policy review dated 11/16 titled Care Plan Policy and Procedure reads; the care plan will describe services to attain or maintain the resident's highest practicable physical, mental and psychosocial wellbeing.

R67 was admitted to the facility on 12/19/16 according to the face sheet.

R67 diagnosis found on the Diagnosis Report identified Alzheimer's Disease, unspecified Dementia without behavioral disturbance and weakness all dated 12/19/16.

Order Listing Report dated 12/19/16, identifies R67 received a regular diet, regular texture, thin fluid consistency, for General diet.

Order Summary Report dated 12/19/16, indicates R67 to be weighed every Wednesday.

Care plan dated 1/8/17, identifies potential nutrition risk related to Alzheimer's dementia, recent cognitive and functional decline and low BMI (body mass index). Interventions include: monitor intake, offer bedtime snack, offer substitutes for uneaten foods, and provide diet as

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ordered, regular. Observe changes in weight, notify physician, and weigh resident every Wednesday.

Weights and Vitals Summary identified R67 weight on 12/19/16, was 125.6 pounds. 1/11/17, 120.8 pounds. 1/18/17, 115.8 pounds a 9.2 pound weight loss and a 9 percent decline in one month (significant weight loss). No other weights were done.

Interview on 2/9/17, at 7:10 a.m. with licensed practical nurse (LPN)-A stated everyone gets weighed on Wednesday's unless they have an order to complete more often. If we enter a weight and it is a 3 pound difference in a day or a 5 pound difference in a week the computer will prompt a message that indicates a weight loss and then nursing is to notify the provider.

Interview on 2/9/17, at 7:26 a.m. with nursing assistant (NA)-C stated residents are weighed weekly. When entering weights into the computer system they are able to see the previously entered weight and are to alert the nurse if there is a change.

Interview on 2/9/17, at 10:43 a.m. with director of nursing (DON) stated weights are to be completed at least once weekly unless ordered otherwise. DON stated when a decline in weight is identified the inner disciplinary team (IDT) meets to try and determine the cause of the weight loss. DON stated the dietician talks with the resident to determine appropriate interventions. DON verified R67 had only 3 documented weights during her stay in the facility. DON stated she was aware weight loss was a problem within the facility, including weights being completed as ordered.

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LACK OF FOLLOWING CARE PLAN IN REGARDS TO INTERVENTIONS TO PROMOTE HEALING OF PRESSURE ULCERS:

R61's 14 day schedule assessment Minimum Data Set (MDS) dated 11/29/16 identifies R61's moderately impaired and requires extensive assistance with two persons for bed mobility, dressing and personal hygiene.

R61's care plan with a target date of 12/6/16, reviewed at risk for skin breakdown as skin in generally thin and fragile, R61 has history of pressure ulcers both heels. Interventions reposition in chair every two hours, offload (to remove pressure) heels, administer treatments as orders.

During observations on 2/8/17 from 12:50 p.m. to 3:07 p.m. observed R61 to have her heels resting on the end of her recliner no cushion or pillow placed properly to float (offload) her heels as an intervention in R61 care plan and had been in place for two hours and 17 minutes.

During constant observation on 2/9/17 between 7:11 a.m. and 8:48 a.m. heels not floated (offload) while resting in bed. Feet resting directly on bed surface.

Observed 2/9/17 10:52 a.m. sitting in recliner, pillow under legs and again heels not floated. 11:08 a.m.

Observation 2/10/17 at 8:16 a.m. R61 found lying in bed and again her heels not floated. LPN-B was notified and observed R61 in bed with surveyor verified at 8:21 a.m. her heels were not floated.

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Interview with nursing assistant (NA)-F on 2/09/17 at 12:02 p.m. regarding R61 intervention in place to help promote healing of pressure ulcer. NA-F stated that staff place a pillow underneath feet in chair and bed, a bar on bed to keep blankets off feet and do not place shoes, but socks only. NA-F gave a demonstration using the pillow on how it should look when R61's heels are floated.

Interview on 2/9/17 12:06 p.m. LPN-B was asked about the intervention in place to promote healing to R61 left foot. LPN-B stated dressing changes are completed in the evening, bath day are Mondays, feet elevated on pillow when in chair and in bed, no shoes, but wears socks liked heavy blankets on to keep warm and has lift in bed to keep blankets off feet.

Interview with DON on 2/9/17 at 2:59 p.m. had reviewed of current care plan for R61 and verified it includes to be repositioned every 2 hours and to float heels at all times.

Policy titled, "Care Plan Policy and Procedure" dated 11/2016, doesn't address following the care plan to provide the highest level of care for each resident.

SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise policies and procedures and educate staff to follow care plan interventions and monitor for compliance.

TIME PERIOD FOR CORRECTION: Forty (21) days.

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide pressure ulcer services to promote healing and prevent further pressure ulcers from developing for 1 of 1 resident (R61) with a current heel pressure ulcer. Findings: R61's significant change Minimum Data Set (MDS) dated 11/22/16 identifies R61's as severely impaired and requires extensive assistance with two persons for bed mobility, dressing and personal hygiene. Also has two stage 2 pressure ulcers currently. R61's care plan with Target date of 12/6/16, included at risk for skin breakdown as skin in	2 900	Corrected	3/22/17

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generally thin and fragile, R61 has history of pressure ulcers both heels. Interventions reposition in chair every two hours, offload (remove all pressure to area) heels, administer treatments as orders.

Review of R61's return from hospital assessment completed dated 12/16/16 the day she return from a short stay in the hospital for a urinary tract infection. The assessment read that she has left heel pressure wound measuring 3 centimeters (cm) x 3 cm x 0.2 and a right heel pressure 2 cm x 2 cm. Both pressure ulcers were open and a stage 2 on each heel.

Review of document titled clinical Document Copy, Primary Care Internal Med Nursing Home , Limited Evaluation dated 12/6/16 noted wounds on her left great (big) toe measuring 1.5 cm x 1.2 cm and heel measuring 2 cm diameter.
Orders read:
Iodosorb/Curasol dressings to both areas daily
Nursing to monitor area daily and perform weekly skin updates
Bed cradle to be used at all times when patient lying in bed
Pillow to be placed under bilateral lower extremities to ensure heels are not in contact with the bed

Review of document titled clinical Document Copy, Primary Care Internal Med Nursing Home, Subsequent Visit dated 12/8/16 noted a follow up on wounds after intervention orders. Document reads that the facility using cradle and elevating heels, but did have dressing in place.
Orders read:
Nursing to continue treatments to both areas on left foot

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DON to monitor closely
Continue bed cradle when resting in bed
Ensure heels are floating when in bed as well in recliner.

Review of Electronic Treatment Administration Record (ETAR) for the month of 2/2017 reads:
Bed cradle to be used at all times when resident is in bed. Nursing to monitor Left toe and heel wounds and notify PA/NP if actually worsening or no improvement in two weeks, 12/20/16. Avoid shoes and make sure heels are off loaded at all times. Documentation per shift.
Missing documentation on morning and night shift once in nine day, three missing documentation on the afternoon shift in nine days.
Wound documentation 3 times week Monday, Wednesday and Fridays.
Missing documentation one day and two days were documented by a Trained Medication Aide (TMA) out of nine days
Left heel and left great toe wound care every evening shift.
Missing wound care treatments for three days in a row and four was documented by a TMA out of nine days.

During observation on 2/8/17 from 12:50 p.m. to 3:07 p.m. observed R61 to have her heels resting on the end of her recliner no cushion or pillow placed properly to float her heels as ordered by physician. R61 had not been repositioned while in her recliner. Nursing assistant (NA)-E entered to complete a bladder scan while in her recliner. Surveyor asked how often R61 is to be repositioned NA-E stated does not work all the time not sure. NA-E was asked where do you find that information if needed, NA-E stated in the care plan but does not work as a NA very much,

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was hired as a TMA. NA-E completed bladder scan and went to get nurse stated will be placing in bed to complete procedure.

During constant observation on 2/9/17 between 7:11 a.m. and 8:48 a.m. feet not floated (all pressure removed from heels) observed to be resting on the bed. NA-B in room to get her ready to the day.

Observed 2/9/17 10:52 a.m. sitting in recliner, pillow under legs not floated. 11:08 a.m. LPN-B in room pillow adjusted foot floated.

Observation 2/10/17 at 8:16 a.m. R61 found lying in bed with heels in contact with mattress and not floated. LPN-B verified at 8:21 a.m. through observation with surveyor that R61's heels were not floated and no pillow under legs.

Interview with nursing assistant (NA)-F on 2/09/17 at 12:02 p.m. regarding R61 skin care plan intervention in place to help promote healing. NA-F stated that staff place a pillow underneath feet in chair and bed, a bar on bed to keep blankets of feet and do not place shoes on her, only socks. NA-F gave a demonstration using the pillow on how it should look when R61's heels are floated. NA-F conclude by saying that skin updates are reported to the nurse.

Interview on 2/9/17 at 12:06 p.m. LPN-B was asked about pressure ulcer intervention in place to promote healing to R61's pressure ulcers located on heels. LPN-B stated dressing changes are completed in the evening, bath day are Mondays, feet elevated on pillow when in chair and in bed, no shoes, but wears socks like heavy blankets on to keep warm and has lift in bed to keep blankets off feet.

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2 900	Continued From page 12 Interview with DON on 2/09/17 at 2:59 p.m. stated interventions to promote healing for R61's stage two pressure ulcers on heels was to add moisture to wound, dressing changes completed, use bed cradle and nothing heavy on feet. DON stated that R61 gets repositioned every three-four hours. Reviewed of current pressure ulcer care plan with DON which included to reposition every 2 hours and offload heals. DON was asked about the dressing changes and who can complete them. DON stated that the dressing are completed every day in the evening and is to be completed by an nurse. DON reviewed the ETAR and verified that the dressing changes were not completed and the ones that were initialed as being completed was by a TMA who can not complete dressing changes or documentation on wounds. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could in-service staff and monitor for compliance with physician orders concerning pressure ulcer care and treatment(s) and in-service staff regarding prompt repositioning, reviewing care plan and audit for compliance to help promote healing of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the	2 910		3/22/17

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comprehensive resident assessment, a nursing home must ensure that:
A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and
B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure a bowel and bladder assessment had been completed with a corresponding toileting schedule to maintain or improve urinary incontinence after a decline in bladder continence for 1 of 1 resident (R99) reviewed for urinary incontinence.

Corrected

Findings include:

R99's diagnosis found on the Admission Record, identifies unspecified dementia without behavioral disturbance (9/14/16), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (9/8/16).

Care Area Assessment (CAA) dated 9/19/16, identifies R99 to be receiving treatment for toileting to achieve the highest practical self-sufficiency. R99 was identified as being able to remove and open clothing in preparation, able to transfer and position self, able to void into the toilet, able to tear/use toilet paper to cleanse self, able to flush the toilet and able to adjust clothing

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and wash hands. CAA summary identifies R99 having been incontinent of urine but less than 7 x a week.

R99's admission Minimum Data Set (MDS) assessment completed on 9/15/16, identifies occasionally incontinent. Quarterly MDS review dated 12/12/16, identifies R99 to be frequently incontinent and severe impaired cognition.

Care plan dated 12/22/16, identifies R99 to have been incontinent of urine. Interventions include: able to tell need or urge to void, offer to take to toilet when caring for resident/when repositioning every 2 hours. Assist of 1 for toileting needs.

Reviewed progress notes from 9/8/16 to 10/24/16, no mention of urinary incontinence. Reviewed progress notes from 12/1/16 to 2/8/17, no mention or urinary incontinence.

Reviewed assessments from admission on 9/8/16, no bowel and bladder assessment completed.

Observation on 2/9/17, at 7:24 a.m. with nursing assistant (NA)-C. R99 was toileted but was unable to void. NA-C stated R99 is sometimes able to tell staff when needing to use the bathroom and other times isn't able to. Sometimes R99 is able to use the toilet and other times has gone (urinated) in the pad before being assisted to the toilet.

Interview on 2/9/17, at 8:17 a.m. with director of nursing (DON) stated bowel and bladder assessments are completed on admission and quarterly. DON stated the floor nurses are responsible for completing the assessment and the aides document how much assistance the

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resident needs and whether the resident was incontinent or continent prior to using the toilet. DON stated that information is what is used to complete the MDS assessments. DON stated the MDS coordinator is responsible for completing the care plans based off of assessments. DON verified there was no bowel and bladder assessment completed for R99.

Interview on 2/10/17, at 8:13 a.m. with nursing assistant (NA)-D stated R99 is a one assist to use the bathroom and every once in a while can say when she needs to use the bathroom. NA-D stated she offers R99 assistance with the bathroom every 2-3 hours.

Interview on 2/10/17, at 8:17 a.m. with licensed practical nurse (LPN)-C stated bowel and bladder tracking is completed on admission and also if an aide tells nursing that a resident has had a decline in incontinence tracking can be initiated.

Interview on 2/10/17, at 8:39 a.m. with MDS coordinator when asked how the MDS is completed for urinary continence stated the nursing aides document in point click care (online charting system) whether the resident is continent or incontinent every time the resident is assisted to the bathroom. MDS coordinator stated that she looks at that information to complete the MDS. MDS coordinator stated she will look at the bowel and bladder assessments if one has been completed for the resident. When asked how she knew the information the aides documented was accurate, MDS coordinator continued to state the MDS is completed off of the aides charting and also by reading the nurses notes. MDS coordinator stated she usually doesn't interview the residents when completing the bowel and bladder section of the MDS. MDS coordinator

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2 910	Continued From page 16	2 910		

stated the care plans are a group effort. MDS was unable to answer when asked how an accurate care plan could be completed without a bowel and bladder assessment. MDS coordinator stated if there is missing information the floor nurses are delegated to do the assessments. MDS coordinator stated that she would like to think that the MDS and care plan are both correct but could not verify they were correct because there was not a bowel and bladder assessment completed for R99 that could verify that a 2 hour toileting schedule was sufficient in preventing further incontinence.

Interview on 2/10/17, at 8:49 a.m. with DON stated the MDS should be based on assessments and clarifications with staff. DON stated she couldn't confirm the MDS is accurate for the decline in urinary incontinence because a bowel and bladder assessment had not been completed for R99. DON stated there should have been a bladder assessment completed that we would have based our care plan interventions off of. DON stated with R99's decline in urinary incontinence she would have expected a bowel and bladder assessment be completed and the care plan revised to reflect the change and to prevent further decline.

Facility policy titled, Bowel and Bladder 3-Day Screening dated 2010, identifies a bowel and bladder screening will be completed on all new admissions, readmissions, annual and quarterly reviews or new incontinence. This 72 hour data collection tool will be used to assist in determining the resident's best toileting schedule to maintain or improve continence levels. Policy identifies if the resident has been incontinent most of the time when toileted every two hours, change interval to every one and one-half hours. If more

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2 910	Continued From page 17 data is needed, continue Bowel and Bladder screening until SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees the need to follow incontinence protocol according to the state licensing requirement. Also monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently obtain and monitor weights to prevent sever weight loss for 2 of 3 residents (R22, R67) who had been reviewed for nutritional status. Findings Include: R22's admission Minimum Data Set (MDS) dated 12-13-16, identified diagnoses of Alzheimer's disease and dementia. R22 needed assistance of	2 965	Corrected	3/22/17

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2 965	Continued From page 18	2 965		

one staff member for eating and had severely impaired cognition. This was a closed record review.

Review of R22's weights in pounds was documented as follows:
12/2/16: 179
12/14/16: 180
12/21/16: 168
12/28/16: 168

R22 had an 11 lbs. weight loss in the first 16 days since admission; this was a 6 % weight loss and a severe weight loss.

Registered Dietician progress note dated 12/15/16, included, "[family member (FM)-A] accompanied R22 during my visit. He appears to be a poor historian as he was unable to answer most questions. [FM-A] states he has his own teeth with no trouble chewing or swallowing. He can feed himself after set up. He is a good eater and has not had any recent weight loss. No special diet followed at home. No immediate concerns identified."

The initial dietary/nutritional data collection dated 12/19/16, included, "Diet order of Regular, regular textures, thin liquids ... Meal tray to room is preferred dining location. Limited assistance for eating self-performance Setup help only ... Summary: R22 admitted for rehab [rehabilitation] following a hospital stay for a hip fracture and urinary tract infection. He has a PMH [personal medical history] of Alzheimer's dementia and multiple strokes. His [FM-A] is his historian as he is unable reply to questions appropriately r/t [related to] cognitive status. He appears normal weight, alert with periods of somnolence and well nourished. He eats with assistance in the dining

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room or his room. His [FM-A] is his primary care giver. He has no trouble chewing or swallowing and eats well with intake of >75% each meal daily. Fluid intake ~1500 ml/day per nursing task records. Weight has remained stable...Continue with Regular diet ...Monitor intake/fluids daily and weights weekly ..."

Registered Dietitian 30 Day review dated 1/18/17, included, "Diet: Regular, Regular textures, thin liquids, Intake: declined to ~ [around] 50% on average at each meal daily x 1 week.
Fluids: Declined to ~1100 ml .Weights: Admit wt. 179# [pounds], last recorded wt [weight]12/21/16 167.8# -11# (6%) since admission. No weight recorded this month.
R22 has had a decrease in intake over the past week. Most currently the last few days he has had issues with swallowing. Nursing has ordered a 3-day trial of mech [mechanical soft] soft/pureed textures. This writer notified DON/SLP/therapy [director of nursing/speech language therapist] for a screening of his swallowing ability and recommendations. Weight loss of 6% since admission noted. Recommend weights be done 3 times per week given decline in intake for closer monitoring. Following up for SLP recommendations."

R22's nutritional care plan printed 2/9/17, included, "Potential nutrition risk related to dementia AEB [as evidenced by] periods of somnolence, forgetfulness and confusion." Interventions included: "Weigh resident every Wednesday."

On 2/8/17, at 2:36 p.m., registered dietician (RD)-A stated when a resident displayed weight loss, she expected staff to alert her to complete a consult for weight loss. RD-A stated weights are

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to be completed every Wednesday and stated she checked the weights and vital reports under clinical tab. RD-A stated since staff had not weighed R22, he did not trigger for a weight loss. RD-A stated she was unaware of R22's weight loss until she completed the nutritional 30-day review and noticed R22 was not being weighed. RD-A stated every resident in the building was to be weighed on Wednesdays, unless they had a different order for more frequent weights. RD-A stated staff obtaining weights weekly had been a problem and that was why she would sometimes order daily weights or weights three times a week for residents to help ensure weights would be taken. RD-A verified this was why she indicated R22 should have weights taken three times a week as a part of her 30-day nutritional review. RD-A stated her expectation was staff to follow the care plan and weigh residents on Wednesday.

On 2/9/17 at 7:40 a.m. nursing assistant (NA)-A stated staff try to get all resident weights on Wednesdays. NA-A stated sometimes based upon acuity and workload weights do not always get done.

On 2/9/17, at 11:32 a.m., stated she was not aware of R22's weight loss. The DON stated she was aware of the trial for mechanical soft and recommendations for swallowing evaluation. The DON stated when weights are recorded under the weights and vitals section in the computer, there is an alert if there was a weight change. The DON stated the dietician monitored the weights alerts and residents weights in the computer. The DON stated she was aware weights were not being done weekly prior to the identification by corporate during an audit on 2/2/17. The DON stated she expected weekly weights to be

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completed on weight day and entered into the computer system. The DON stated expected staff to follow the care plan for weekly weights.

The Weight Monitoring - Nursing Services policy dated 2006, included, "Each resident will be weighed and measured within 24 hours of admission. Each resident will be weighed weekly for the first four weeks of her/his stay, monthly thereafter unless an adverse trend has been identified. Residents will be weighed weekly or more often based upon ongoing assessment of nutritional intake, fluid retention, and other medical factors.

R67 diagnosis found on the Diagnosis Report identified Alzheimer's Disease, unspecified Dementia without behavioral disturbance and weakness all dated 12/19/16 (day of admission).

Order Listing Report dated 12/19/16, identifies R67 received a regular diet, regular texture, thin fluid consistency, for General diet.

Order Summary Report dated 12/19/16, indicates R67 to be weighed every Wednesday.

Care plan dated 1/8/17, identifies potential nutrition risk related to Alzheimer's dementia, recent cognitive and functional decline and low BMI (body mass index). Interventions include: monitor intake, offer bedtime snack, offer substitutes for uneaten foods, and provide diet as ordered, regular. Observe changes in weight, notify physician, and weigh resident every Wednesday.

Medication Administration Record (MAR) dated December 2016, identifies R67 was weighted on 12/21/16 and 12/28/16. January 2017, MAR

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identifies R67 was weighed on 1/4/17, 1/11/17 and 1/18/17. However, the
Weights and Vitals Summary identifies R67 weight on 12/19/16, was 125.6 pounds. 1/11/17, 120.8 pounds. 1/18/17, 115.8 pounds a 9.2 pound loss in one month or 9 percent which is a severe weight loss. No other weights identified.

Meal Intake and Fluids forms reviewed from 12/19/16 to 1/18/17, identifies R67 consistently consumed 76-100% of meals.

Nutritional Summary found in progress notes dated 12/27/16, identifies R67 receiving a regular diet with think liquids and not receiving any nutritional supplements. R67 was identified as having an admission weight of 125.6 and a BMI of 19.7. Summary identifies R67 to appear thin and well nourished. R67 had reported no recent weight loss and identified usual body weight to be 130 pounds. Summary identifies to continue with regular diet, monitor intake daily and weights weekly.

Progress note dated 1/17/17, indicates R67's weight to be 120.8. Registered Dietician had entered a note recommending a re-weigh for accuracy. However, no indication this was completed nor any information provided when asked for the re-weigh.

Progress note dated 1/20/17, indicates R67's weight to be 115.8. Registered Dietician's entered note indicates R67 had discharged from the facility.

Review of daily nursing charting from 12/19/16 to 1/19/17, assessments include a section to document weights. Charting on 12/19/16, indicated a weight of 125.6. All other

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assessments the section for weight were left blank.

Interview on 2/8/17, at 2:36 p.m., registered dietician (RD)-A stated when a resident displayed weight loss, she expected staff to alert her to complete a consult for weight loss. RD-A stated weights are to be completed every Wednesday and stated she checked the weights and vital reports under clinical tab. RD-A stated every resident in the building was to be weighed on Wednesdays, unless they had a different order for more frequent weights. RD-A stated staff obtaining weights weekly had been a problem and that was why she would sometimes order daily weights or weights three times a week for residents to help ensure weights would be taken. RD-A stated her expectation was staff to follow the care plan and weigh residents on Wednesday.

Interview on 2/9/17, at 7:10 a.m. with licensed practical nurse (LPN)-A stated everyone gets weighed on Wednesday's unless they have an order to complete more often. If we enter a weight and it is a 3 pound difference in a day or a 5 pound difference in a week the computer will prompt a message that indicates a weight loss and then nursing is to notify the provider.

Interview on 2/9/17, at 7:26 a.m. with nursing assistant (NA)-C stated when entering weights into the computer system they are able to see the previously entered weight and are to alert the nurse if there is a change.

Interview on 2/9/17, at 10:43 a.m. with director of nursing (DON) stated weights are to be completed at least once weekly unless ordered otherwise. DON stated when a decline in weight

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2 965	Continued From page 24 is identified the inner disciplinary team (IDT) meets to try and determine the cause of the weight loss. DON stated the dietician talks with the resident to determine appropriate interventions. DON verified R67 had only 3 documented weights during her stay in the facility. DON stated she was aware weight loss was a problem within the facility, including weights being completed as ordered. Facility provided two policies, "Nutritional Assessment Policy and Procedure" undated, and "Food and Nutrition" dated 11/2016. Neither policy addressed obtaining and monitoring weights. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the registered dietician (RD) could develop, review, and/or revise policies and procedures to ensure a system is in place to decrease the risk of weight loss and to identify weight loss in a timely manner so interventions can be implemented. The DON and RD could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		3/22/17

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This MN Requirement is not met as evidenced by:
Based on observation and interview, the facility failed to prevent the potential spread of food borne illness, which had the potential to affect all 36 residents on the Rehab units also including staff and visitors who use ice from a portable ice chest.

Corrected

Findings include:

On 02/07/17,11:40 a.m. A metal cart with a plastic cooler containing ice was by rehab one dining room/hallway. The cooler was unlocked and allowed free access to ice. The cooler was half to three/fourths full of ice, with plastic scoop left inside the container in contact with the ice. The ice container was in a location anyone had access. At 2:37 p.m. the plastic cooler with ice scoop still in contact with ice, continues to be in hallway, unlocked. Again at 3:56 p.m. the ice cooler with scoop still in contact with ice. Interview at this time with registered nurse (RN)-C concerning the ice cooler accessible to all residents and visitors and the ice scoop in contact with the ice, stated, "Nursing staff use the ice for filling resident water cups." "I don't see any scoop though [looking for scoop next to cooler]." RN-C informed scoop was inside ice container and when shown, RN-C stated, "Well, that shouldn't be there, I will take this back to the kitchen" and proceeded to return cart with ice container to kitchen.

02/08/17, 2:57 p.m. the metal cart with ice cooler containing ice noted in hallway on rehab two by dining room. The container was full of ice with scoop inside again in contact with ice. Interview with RN-B concerning the plastic ice container and scoop in contact with ice, stated, "I think the

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21015	Continued From page 26 kitchen staff brings out the ice." RN-B had been shown scoop which was located inside ice chest. RN-B stated, "That should not be there [reference to ice scoop in contact with ice], I will check into this." At 3:05 p.m. the Dietary Manager was interviewed and said that the aide gets the cart from outside the kitchen door and fills the cooler with ice. Dietary manager observed cart with ice container and the ice scoop touching the ice. The Dietary manager stated, "No, that is the wrong cart." "No, that is not supposed to be there [in reference to ice scoop touching ice], I will figure out what happened." Received Hydration General Policies for VOA-Rochester Rehabilitation & Living Center dated 2015. regarding Water pass Procedure, which indicates Culinary staff to fill ice coolers and place on hydration carts then locate them by Rehab unit kitchen door for Nursing Assistant staff to pick up. Nursing assistant staff to leave coolers with remaining ice on respective units between causal room and dining room until bringing to kitchen for refilling with fresh ice. Procedure does not indicate that scoop should not be stored in contact with the ice. SUGGESTED METHOD OF CORRECTION: The dietary manager/dietician could in-service dietary staff on the need to maintain a sanatary environment for food storage, preperation and service. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		3/22/17

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21426	Continued From page 27 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review, facility failed to ensure tuberculosis symptom screening was completed for 1 of 6 staff (S1) and Mantoux skin tests were completed for 3 of 6 staff (S1, S2, S3) employed with the facility who were reviewed for Tuberculosis. Findings include: S1 was hired on 8/18/16. Facility was unable to provide documentation of a tuberculosis symptom screening or a step 1 and step 2 Mantoux skin test being completed. S2 was hired on 1/3/17. S2 had a completed	21426	Corrected	

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symptom screening completed on 1/3/17 along with a step 1 Mantoux skin test. Documentation identifies S2 did not receive a step 2 Mantoux skin test.

S3 was hired on 1/16/17. S3 received a symptom screening on 1/10/17, along with a step 1 Mantoux skin test. Documentation identifies the step 1 Mantoux skin test was not read and a step 2 Mantoux skin test was not completed.

Interview on 2/9/17, at 1:09 p.m. with director of nursing (DON), stated once a staff member is hired they receive the Tuberculosis symptom screening and the step 1 Mantoux skin test before they provide direct patient care. After the step 1 Mantoux skin test is read, the step 2 Mantoux skin test is scheduled. DON stated the facilities human resources department had kept all employee Tuberculosis records in a binder. DON stated records are to be maintained in the individual employee records.

Facility provided two separate policies titled, "Infection Control TB Control Plan" dated 2015 and "Infection Control TB Exposure Control Plan" dated 2015. Neither policy addresses the steps necessary for staff Tuberculosis screening and testing.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance.

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21426	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and record review facility failed to ensure AIMS assessments were completed for 4 of 5 residents (R189, R103, R87, R173): failed to ensure behavior and mood monitoring was completed for 2 of 5 residents (R103, R173): failed to ensure comprehensive	21535	Corrected	3/22/17

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sleep assesments were completed for 2 of 5 residents (R189, R173): and failed to document the reason for administration of as needed (PRN) pain medications and failed to document non-pharmacological interventions attempted prior to the administration of PRN pain medications for 2 of 5 residents (R189, R173) reviewed for medication use.

Findings include:

LACK OF AIMS ASSESSMENT:

R189 was admitted to the facility on 1/24/17 per the facility admission record.

R189's physician orders dated 1/24/17 included, "olanzapine tablet 5 mg [milligrams], give 1 tablet by mouth one time a day for mood augmentation."

Review of Medication Administration Record (MAR) from January 2017 to February 2017, indicated R189 received scheduled doses of olanzapine as ordered.

R189's assessments were reviewed since admission on 1/24/17, and revealed an AIMS assessment had not been completed for R189.

R189's progress notes were reviewed from 1/24/17 to 2/8/17 and there was no documentation of an AIMS assessment being completed.

On 2/09/2017, at 11:32 p.m. the director of nursing (DON) stated an AIMS assessment was not completed for R189. The DON stated by day four of a resident's stay she expected an AIMS assessment to be completed. The DON stated

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the AIMS assessment was assigned to be completed by the nurse manger and currently there was not a nurse manager on R189's unit. The DON stated another nurse should have completed the AIMS assessment for R189.

LACK OF SLEEP ASSESSMENT:

R189 was admitted to the facility on 1/24/17 per the facility admission record. R189'S admission Minimum Data Assessment dated 1/30/17, indicated R189 was cognitively intact, and had trouble with falling asleep, staying asleep, or sleeping too much.

R189's physician orders dated 1/24/17 included, "Melatonin Tablet 3 MG [milligrams], give 4 tablet by mouth one time a day for sleep."

Review of Medication Administration Record (MAR) from January 2017 to February 2017, indicated R189 received scheduled doses of melatonin as ordered.

R189's assessments were reviewed since admission on 1/24/17, and revealed a comprehensive sleep assessment had not been completed for R189.

R189's progress notes were reviewed from 1/24/17 to 2/8/17 and there was no documentation of a comprehensive sleep assessment being completed.

On 2/09/2017, at 11:32 p.m. the director of nursing (DON) stated a sleep assessment was not completed for R189. The DON stated when a resident was on admitted with melatonin there

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should be documented hours of sleep completed to be used to complete a comprehensive sleep assessment to determine the effectiveness of the sleep aide.

On 2/10/2017, at 10:45 a.m. the DON stated comprehensive sleep assessments were not being completed for any residents in the building at this time.

LACK OF DOCUMENTED REASON FOR USE FOR AN AS NEEDED PAIN MEDICATION AND LACK OF NON-PHARMACOLOGICAL INTERVENTIONS BEING ATTEMPTED AND DOCUMENTED PRIOR TO THE ADMINISTRATION OF A AN AS NEEDED PAIN MEDICATION:

R189 was admitted to the facility on 1/24/17 per the facility admission record. R189'S admission Minimum Data Assessment dated 1/30/17, indicated R189 was cognitively intact.

R189's medication orders found on the medication administration records (MAR) for January 2017 and February 2017 included PRN orders for the following pain medications:

"Acetaminophen Tablet 500 MG [milligrams], Give 2 tablet by mouth every 6 hours. Order date 1/24/17. "

"Ultram Tablet 50 MG (TraMADol HCl) *Narcotic* date ordered 1/24/17,
Give 1 tablet by mouth every 6 hours as needed for pain."

"Ultram Tablet 50 MG (TraMADol HCl) *Narcotic*

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date ordered 2/1/17,
Give 1 tablet by mouth every 4 hours as needed for pain."

"OxyCODONE HCl Tablet 5 MG *Narcotic* order date 1/24/17, Give 1 tablet by mouth every 4 hours as needed for pain rated greater than 3 or comfort level AND Give 2 tablet by mouth every 4 hours as needed for pain rated greater than 6

Review of the January 2017 MAR revealed:

R189 received PRN acetaminophen 13 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 13 of the 13 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN acetaminophen being administered.

R189 received PRN oxycodone, 5 MG, 1 tablet, 6 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 6 of the 6 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered.

R189 received PRN oxycodone, 5 MG, 2 tablet, 5 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 5 of the 5 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered.

R189 received PRN tramadol, 20 times from 1/24/17 to 2/1/17. The facility did not document the reason for use 20 of the 20 times the

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medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN tramadol being administered.

Review of the February 2017 MAR revealed:

R189 received PRN acetaminophen 1 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 1 of the 1 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN acetaminophen being administered.

R189 received PRN oxycodone, 5 MG, 1 tablet, 2 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 2 of the 2 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered.

R189 received PRN oxycodone, 5 MG, 2 tablet, 2 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 2 of the 2 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN oxycodone being administered.

R189 received PRN tramadol 50 MG, 1 tablet, every 6 hours, 2 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 2 of the 2 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN tramadol being administered.

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21535	Continued From page 35 R189 received PRN tramadol 50 MG, 1 tablet, every 4 hours, 18 times from 2/1/17 to 2/8/17. The facility did not document the reason for use 18 of the 18 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN tramadol being administered. R189's care plan included, PAIN: Has c/o [complaints of] pain to right knee, right arm and back. Is able to report pain verbally. Did have right total shoulder arthroplasty. Has arthritis. Has dx [diagnoses] of Major depression that could affect perception of pain. Interventions included, "give pain medications as indicated. ok to try non-medication interventions such as: repositioning, ice/warm packs. observe effectiveness of any intervention tried. consult with CNP/MD if concerns/present plan for pain relief not effective." R189 was observed on 2/7/17, at 6:25 p.m., R189 during a medication pass observation, to receive a prn pain medication. The nurse did not offer any non-pharmacological interventions prior to the administration of the pain medication. R189 was interviewed on 2/08/2017, at 1:29 p.m., R189 stated she communicated her pain levels to staff and requested the PRN pain medication she felt she needed to help her with her pain. R189 had stated she had just requested an icepack from staff to help with shoulder pain. R189 stated she would ask for an icepack when she wanted to use one and staff would get an icepack for her. R189 stated staff did not offer her non-pharmacological options for pain management when she requested a prn pain	21535		

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medication.

On 2/8/17 at 9:11 a.m., registered nurse (RN)-F stated staff should offer and try non-pharmacological interventions prior to administration of PRN pain medications. RN-F stated non-pharmacological interventions tried should be documented in the medical record. RN-F stated knew this was an area of concern and stated medication pass and completing treatments were a priority.

On 2/09/2017, at 11:32 a.m. the director of nursing (DON) stated she expected staff start with the non-pharmacological interventions prior to the administration of a PRN pain medication. The DON stated upon admission nursing visited with residents about non-pharmacological interventions that have worked for them for pain, so we have their preferences. The DON verified this assessment was completed for R189 and stated a pain care plan was developed that included non-pharmacological interventions. The DON stated she expected staff to offer non-pharmacological interventions, document what was tried prior to the administration of the PRN medication and stated she expected staff to document the reason why PRN pain medication was administered.

LACK OF AIMS ASSESSMENT AND MONITORING OF BEHAVIOR/MOOD:

R103 was admitted to the facility on 12/8/16.

R103's diagnosis found on the Admission Record dated 12/8/16, identifies anxiety.

R103 medication orders found on the Order Summary Report identifies Lexapro 10 mg give

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one tablet by mouth one time a day for depression with a start date of 12/8/16, and Seroquel 25 mg give 0.25 tablet by mouth one time a day for mood/insomnia dated 12/8/17. Orders for monitoring of anti-depressant and anti-psychotic medications were entered on 2/8/17, after entering the facility.

Behavior monitoring record for February 2017 identifies behavior monitoring from MDS. No other behavior/mood monitoring identified.

Care plan dated 12/28/16, identifies R103 to be on psychotropic medications. "Arrived here on antipsychotic medications (Seroquel). It appears to be for mood (recent history of agitation/confusion) and anxiety. It may help seizure as husband and record hint that insomnia is result of seizures. Per hospital admission records, dose had been usually 12.5 mg daily and up to 25 mg daily right before hospital admission. Was in ER in earlier November for anxiety. Also arrived her on an antidepressant (Lexapro 10 mg daily). Also unclear how long has been on this. Hint of diagnosis of depression but no recent documentation about it. Initial PHQ-9 score was 14".

Treatment Administration Record (TAR) dated February 2017, identifies to monitor for side effects of anti-depressant use with a start date of 2/8/17. January 2017, TAR doesn't identify to monitor for any side-effects of medications.

Medication Administration Record (MAR) dated February 2017, identifies R103 to have received Lexapro 10 mg daily and Seroquel 25 mg give 0.25 tablet daily. MAR identifies monitoring for side effects of anti-psychotic medications and monitoring of behaviors with a start date of

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2/8/17. MAR for January 2017, does not identify any monitoring of anti-psychotic behaviors.

Progress note dated 12/8/16, identifies R103 to have a PHQ-9 score of 12 which indicates moderate depression. Progress note dated 12/15/16, identifies a PHQ-9 score of 5 which indicates mild depression. Progress note dated 1/11/17, identifies a staff interview was completed as R103 was unable to be interviewed. Progress note dated 1/31/17, identifies a staff interview was completed which indicated no depression.

Review of progress notes from 12/8/16 through 2/9/17, identifies no mention of R103 having any behaviors or mood concerns.

Review of assessments indicated an AIMS assessment had not been completed for R103.

Interview on 2/9/17, at 7:29 a.m. with licensed practical nurse (LPN)-A stated R103's behaviors are directed towards her husband and that she gets angry and can be mean and also gets very agitated. LPN-A stated that he had documented these behaviors in the past but stated he doesn't document every time it happens. LPN-A stated R103's behaviors weren't a new issue and they are why R103 entered the facility.

Interview on 2/9/17, at 8:40 a.m. with director of nursing (DON) stated by day 4 there is supposed to be an AIMS assessment that is completed for any resident receiving an antipsychotic. DON verified an AIMS assessment had not been completed for R103. DON stated the nurse managers are responsible for completing the assessments.

Interview on 2/9/17, at 12:09 p.m. with nursing

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assistant (NA)-A stated R103 will occasionally have agitation and times where she isn't able to have conversations that are reality based. NA-A stated R103 has agitation towards her husband and others and can be confused at times. NA-A stated she is able to document only specific behaviors in point of care (online charting system) but isn't able to explain the situation. NA-A stated she reports behaviors or mood concerns to the nurse.

Interview on 2/9/17, at 12:15 p.m. with the nurse manager (RN)-A stated that she hadn't completed any AIMS assessments. RN-A stated she was unaware that she was responsible for completing the assessment and stated she doesn't have a list or isn't alerted to what assessments she is required to complete.

Interview on 2/9/17, at 1:58 p.m. with DON verified there was no behavior or mood monitoring documentation that had been completed for R103. DON stated usually an order is entered along with the medication to alert the nurses to monitor for side effects and specific behaviors or mood, but this was not completed. DON stated nurses should be documenting behaviors whenever they are occurring and should be monitoring mood to ensure medications are effective.

Policy titled, "Psychoactive Medication use and Gradual Dose Reduction" dated 8/2013, identifies Abnormal Involuntary Movement Scale (AIMS) will be performed on residents receiving antipsychotic medications to screen for tardive dyskinesia every 6 months.

Policy titled, "Mood/Behavior/Sleep Observation" dated 8/2013, identifies target mood/behaviors

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will be monitored every shift. All members of the care team are to complete the daily mood/behavior observation tool/ PCC POC (point click care and point of care, online charting systems) when a resident exhibits mood or behaviors. Communication to the licensed nurse and or social worker as appropriate. The licensed nurses are to review documentation of the daily mood/behavior observation/PCC POC for completion and the need for any additional documentation. A summary of the mood/behavior/sleep is to be completed during the monthly charting cycle to include a summary of the interventions used as well as a summary of the resident's response.

LACK OF AIMS ASSESSMENT FOR R87:

R87's diagnosis found on the Diagnosis Report identifies Delusional Disorders and Visual hallucinations dated 10/28/16.

R87's medication orders found on the Order Summary Report dated 2/9/17, identifies Seroquel 25 mg give 1 tablet by mouth as needed for behaviors, agitated persistent delusional/paranoid outbursts may give additional dose PRN when unable to redirect behaviors. Seroquel 25 mg give one tablet by mouth two times a day for behaviors: persistent paranoid outbursts, delusions.

Review of Medication Administration Record (MAR) from December 2016 to February 2017, indicates R87 received scheduled and PRN (as needed) doses of Seroquel as ordered.

Care plan dated 1/14/17, identifies a behavior problem due to yelling and making threats of harm to wife. Has ambivalent family relationships.

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Disrupts roommate which is his wife. Will yell at staff at times also. Has diagnosis of psychosis with delusions. History of hallucinations/Charles Bonnet syndrome.

Reviewed progress notes dated 12/5/16 through 2/9/17, no mention of any AIMS assessment being completed.

Review of assessments identified AIMS assessment had not been completed for R87.

Interview on 2/9/17, at 8:40 a.m. with director of nursing (DON) stated by day 4 there is supposed to be an AIMS assessment that is completed for any resident receiving an antipsychotic. DON verified an AIMS assessment had not been completed for R87. DON stated the nurse managers are responsible for completing the assessments.

Interview on 2/9/17, at 12:15 p.m. with the nurse manager (RN)-A stated that she hadn't completed any AIMS assessments. RN- stated she was unaware that she was responsible for completing the assessment and stated she doesn't have a list or isn't alerted to what assessments she is required to complete.

Policy titled, "Psychoactive Medication use and Gradual Dose Reduction" dated 8/2013, identifies Abnormal Involuntary Movement Scale (AIMS) will be performed on residents receiving antipsychotic medications to screen for tardive dyskinesia every 6 months.

LACK OF SLEEP ASSESSMENT:

R173 admitted to the facility on initially on 12/26/17 and readmitted on 1/12/17 per the

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facility admission record. R173 admission Minimum Date Assessment 1/20/17 indicated R173 was cognitively intact and was trouble with falling asleep, staying asleep or sleeping too much.

R173's physician orders dated 1/13/17 through 2/04/17 and reordered on 2/4/17 included, "Trazodone Tablet 50 MG Give 1 tablet by mouth in the evening for sleep may repeat x1 if needed after 1 hour AND Give 1 tablet by mouth as needed for sleep May take repeat dose if still awake after 1 hour"

Review of Medication Administration Record (MAR) from January 2017 to February 2017, indicated R173 received scheduled doses of trazodone nightly along with prn dose given on 2/8/17.

R173's assessments were reviewed since admission on 1/12/17, and revealed a comprehensive sleep assessment had not been completed for R173.

R173's progress notes were reviewed from 1/13/17 to 2/8/17 and there was no documentation of a comprehensive sleep assessment being completed.

LACK OF AIMS ASSESSMENT AND MONITORING OF BEHAVIOR/MOOD:

R173's diagnosis found on the Admission Record dated 1/13/17, identifies severe major depressive disorder.

R173 medication orders found on the Order Summary Report identifies: mirtazapine 15 mg give one tablet by mouth one time a day for

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depression, and Seroquel 25 mg give 0.25 tablet by mouth twice daily , and Zoloft 100 mg two times daily for depression all with start dates of 1/13/17. Orders for monitoring of anti-depressant and anti-psychotic medications were entered on 2/8/17, after entering the facility.

Behavior monitoring record for February 2017 identifies behavior monitoring from MDS. No other behavior/mood monitoring identified.

Care plan dated 1/20/17, identifies R173 is on psychotropic medications. Indicates that R173 has diagnosis of depression and history of several psychiatric hospitalizations. R173 takes antidepressant and antipsychotic medications.

Treatment Administration Record (TAR) dated February 2017, identifies to monitor for side effects of anti-depressant, use with a start date of 2/8/17. January 2017, TAR does not identify to monitor for any side-effects of medications.

Medication Administration Record (MAR) dated February 2017, identifies R173 to have received mirtazapine 15 mg daily at bed time for depression and once daily as needed for anxiety and Seroquel 25 mg give 0.25 tablet two times daily and Zoloft 100 mg two times daily. MAR identifies monitoring for side effects of anti-psychotic medications and monitoring of behaviors with a start date of 2/8/17. MAR for January 2017, does not identify any monitoring of anti-psychotic behaviors.

Progress note dated 1/27/17, identifies R173 to have a PHQ-9 score of 4 which indicates no depression. Progress note dated 1/20/16, identifies a PHQ-9 score of 9 which indicates mild depression. Progress note dated 1/06/17,

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identifies a PHQ-9 score of 3 which indicates no depression, Progress noted dated 12/27/16 identifies a PHQ-9 score of 5 which indicates mild depression.

Review of progress notes from 12/8/16 through 2/9/17, identifies no mention of R173 having any behaviors or mood concerns.

Review of assessments indicated an AIMS assessment had not been completed for R173.

LACK OF DOCUMENTED REASON FOR USE FOR AN AS NEEDED PAIN MEDICATION AND LACK OF NON-PHARMACOLOGICAL INTERVENTIONS BEING ATTEMPTED AND DOCUMENTED PRIOR TO THE ADMINISTRATION OF A AN AS NEEDED PAIN MEDICATION:

R173's medication orders found on the medication administration records (MAR) for January 2017 and February 2017 included PRN orders for the following pain medications:

During interview on 02/09/2017, at 11:15 a.m. R173 stated they would asked periodically if she would to try ice first. R173 indicated that she usually say "No, because it does not work for her."

Dilaudid Tablet 2 MG (HYDROmorphone HCl) Give 0.5 tablet by mouth every 4 hours as needed for pain rated <5/10 AND Give 1 tablet by mouth every 4 hours as needed for pain rated >5/10

Review of the January 2016 Medications Administration Record (MAR) revealed:
R173 received PRN (as needed) Dilaudid *Narcotic pain medication 17 times from

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readmission date of 1/13/17 to 1/31/17. The facility did not document the reason for use 17 of 17 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN Dilaudid being administered.

Review of the February 2017 MAR revealed: R189 received PRN Dilaudid 4 times from 2/1/17 to 2/1/17. The facility did not document the reason for use 4 of the 4 times the medication was administered. In addition, the facility failed to document non-pharmacological interventions attempted prior to the PRN Dilaudid being administered.

2/10/17 at 9:13 a.m. with DON when asked about sleep and AIMs assessments stated that she had already stated to other surveyors that no sleep or AIMs assessment had been completed for any residents. Also, stated that she did an audit for medication requiring monitoring and added them when the questions started.

SUGGESTED METHOD OF CORRECTION:The director of nursing (DON) or designee could develop systems to ensure resident medication regimens are thoroughly reviewed for unnecessary medications. The DON or designee could educate all appropriate staff on unnecessary medications. The DON or designee could develop a monitoring system to ensure ongoing compliance and report the findings to the Quality Assurance Committee.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.

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21800	Continued From page 46	21800		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice	21800	Corrected	3/22/17

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21800	Continued From page 47 (SNFABN) upon termination of Medicare Part A skilled services for of 4 of 4 residents (R113, R35, R40, R120), reviewed for liability and beneficiary rights. Findings Include: R113 was discharged from Medicare Part A on 10/22/16, used 8 days and remained in the facility. The facility did not provide R113 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R35 was discharged from Medicare Part A on 10/27/16, used 6 days and remained in the facility. The facility did not provide R35 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R40 was discharged from Medicare Part A on 12/8/16, used 35 days and remained in the facility. The facility did not provide R40 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R120 was discharged from Medicare Part A on 8/27/16 used 43 days and remained in the facility. The facility did not provide R120 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered	21800		

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21800	Continued From page 48 services and of her right to appeal the denial to Medicare. On Wednesday 2/8/17, at 4:10 p.m. Administrator stated in response to a question regarding when they provide the SNFABN form to the residents, "We have not been giving these out. We will change our practice and will be starting to give them in the future." SUGGESTED METHOD OF CORRECTION: The director of nursing could designate and educate staff on the requirement to give demand notice timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify	21830		3/22/17

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21830	Continued From page 49 either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the	21830		

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21830	Continued From page 50 patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine preferences for bathing for 3 of 3 residents (R188, R81, R173) reviewed for choices. Findings include: R188 was admitted to the facility on 2/3/17 per the facility admission record.	21830	Corrected	

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On 2/07/17, 2:06 p.m. R188 stated she had a shower today. R188 stated she had been asking for a shower since admission on 2/3/17. R188 stated she had been unware of when her next shower would be and stated she was not asked if she would like a shower or a bath today when she was given a shower.

R188's Nursing Day 1 of Admission/Readmission assessment dated 2/3/16 included, "REQUIRED QUESTION: Ask the resident their preferences for bathing and past routine mark answers here for their plan of care." The questions that addressed bathing frequency or preferences were not answered and were left blank.

R188's progress note dated 2/10/17, indicated, "Resident would prefer a bath x2 [two times] a week and on day shift."

On 2/09/17, at 7:35 a.m., nursing assistant (NA)-A stated baths were scheduled once a week and as requested. NA-A stated residents are assigned their bath day based on their room assignment. NA-A stated if a resident requested a different bath day staff can make a schedule change to reflect a resident's preference in the computer and update the bath sheet.

On 2/09/17, 11:32 a.m. the director of nursing (DON) stated she expected the nurse to complete the bathing preference questions on the nursing admission assessment and verified this portion of the assessment had not been completed for R188. The DON stated at the time the assessment was completed nursing should be explaining the normal routine was a weekly bath/shower and if a resident had a specific bathing request we would work with them on the

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day of week and time of day to try to accommodate bathing their bathing preferences. The DON stated nursing should have reviewed with R188 her bathing schedule, frequency of bathing and preference for type of bathing upon admission.

On 2/10/17, at 10:19 a.m. the DON stated she had assigned a staff member to speak to R188 about her bathing preferences today and stated she would provide this writer a copy of the assessment once the nurse had completed it.

On 2/10/2017, at 10:48 a.m., the DON stated today was the first time R188 was interviewed by staff regarding her bathing preferences. R188 had requested a bath two times a week on the day shift.

A bathing choices and preferences policy was requested and not provided.

R81's quarterly Minimum Data Set (MDS) dated 10/25/16; identified R81 had severe cognitive impairment and needed extensive assistance for dressing and bed mobility.

During the initial interview on 2/7/17 at 3:37 p.m., R81 was asked about her choice to get up in the morning. R81 had said, when girls come in they tell us when to get up, we cannot sleep in, staff tell us we need to get up to go get breakfast.

During an interview with R81 on 2/08/17 at 12:40 p.m. R81 had been asked when she got up this morning she stated that she got up in time for breakfast. Surveyor asked if ready to get up she stated with a laugh, turned her head up, and stated, "O, no I was not ready."

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At 2/9/17 at 7:46 a.m. R81 observed to be rising to the edge of bed. Surveyor asked if getting up for the day, R81 stated, "I guess so."

Interview on 2/9/17 at 7:52 a.m. with nursing assistant (NA)-B when asked if R81 gets woke up or if she usually gets up on own. NA-B stated R81 is woke up, does not know R81 time to get up NA-B stated that R81 has not told staff what time she wants to get up in the morning. Surveyor asked how staff know the residents preferences. NA-B stated that they look in the kardex (a reference tool for staff for resident's information). NA-B went to computer to review kardex and was not able to find any wake times for R81.

Interview on 2/9/17 at 12:12 p.m. with licensed practical nurse (LPN)-B asked if she knew R81 wake time LPN-B stated R81 is not an early riser and varies between 7:45 a..m-8:20 a.m. R81 is sometimes woke up by staff and other times she gets up on her own. LPN-B was asked about where to find the preferences residents would like. LPN-B stated, "We do not have a lot of float staff here on this unit and the staff just know their preferences."

Interview on 2/9/17 at 1:27 p.m. with LPN-B had been asked who completes the admission paper when residents was admitted to the facility. LPN-B stated that the floor nurses complete the admission papers with each resident that comes on the unit. LPN-B asked when the preferences or choices were asked of the residents LPN-B stated they do not ask their preferences or choices on admission.

Interview on 2/9/17 at 2:50 p.m. with director of nursing (DON) updated the nurse on the floor

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21830	Continued From page 54 completes the admission on the residents then information is placed in the computer that auto populates to other areas. Questions on wake and bedtime are asked on admission. Facility also has a program in place to wake at will. DON expectation would be not wake up R81 if she prefers to sleep. R173 admitted to the facility on 12/26/16. A nursing day one admission/readmission assessment form was completed indicating that resident prefer showers and one time per week. R173 (per nursing notes) admitted back to hospital on 1/9/17 and readmitted to facility on 1/13/17. Progress note dated 1/13/17, title: nursing day 1 admission/readmission note, there is no indication of bathing preferences. During interviews with R173 on 2/7/17, at 3:45 p.m. R173 had indicated that she takes a shower at home every day but would be ok with every other day because they are so busy. On 2/8/17 at 12:36 p.m. R173 stated she had asked everyday if she could get a shower and then is told by staff they would look into it but it never happens. On 2/9/17 at 1:14 a.m. R173 she stated that she will ask the nursing assistant and they will tell her they will get back to her. 2/9/17, at 12:09 p.m. NA-A stated I do not recall if R173 asked for any extra showers. However, R173 added, frankly, if I was scheduled a shower one time a week I would want more. On 2/9/17, at 2:05 p.m. Interview with RN-B and RN-D, regarding resident preferences regarding addition showers, neither RN-B nor RN-D	21830		

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21830	Continued From page 55 indicated that they were aware of R173 preference or that she had been requesting to have an additional shower during the week. Both nurses stated, "Everyone is guaranteed one shower weekly, but with only having one aide and one nurse here most times it is sometimes difficult to give them an extra shower. On 2/10/17, at 9:15 a.m. during interview with DON, she stated that if resident requests to have an extra shower that staff should make every attempt to accommodate the request. On 2/10/17, at 10:16 a.m. R173 said that someone (staff) had come in to talk with her regarding her bathing preferences. Document titled Sleep Program Cornerstones not dated reads; Open breakfast is served to facilitate wake-at-will and residents and family are informed about the importance of sleep and reviewed at care conferences. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all employees on the need for self choice in residents choices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or	21915		3/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: ______ B. WING ______	02/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21915	Continued From page 56 visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to make a good faith attempt to establish a family council in the past calendar year. Findings include: During interview with the facility's Licensed Social Worker at 2:00 p.m. on 2/10/17, LSW-A verified that they only had posted a notice on the walls in the facility in regards to developing a family council. There was no other attempts such as mail notices or phone calls made to encourage families to attend/form a committee at the facility. Suggested Method of Correction: The Administrator could review and revise policies and procedures to ensure annual attempts to establish a family council. The Administrator could document and keep record of forming a family council, and identify when the attempt had occurred in the calendar year. Time Period for Correction: Twenty-one (21) days.	21915	Corrected	