DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICAT PART I - TO BE COMPLETED BY THE					ID: H3H8 Facility ID: 29822		
1. MEDICARE/MEDICAID PROVIDER N (L1) 245626 2.STATE VENDOR OR MEDICAID NO. 859497200		3. NAME AND ADI	DRESS OF FACILIT R REHABILITAT NGTON BOULEV	Y TION AND	LIVING CENTER (L6) 55901	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	JERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 05/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other)8/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30		
11LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY X A. In Complian Program Rea Compliance	nce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	 Following Requirements: 6. Scope of Services Limit 7. Medical Director 		
12.Total Facility Beds 13.Total Certified Beds	56 (L18)56 (L17)	B. Not in Com	acceptable POC pliance with Program and/or Applied Waive		4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code:	8. Patient Room Size 9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 56 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARK								
17. SURVEYOR SIGNATURE	17. SURVEYOR SIGNATURE Date :					PROVAL Date:		
Kyla Einertson, H	IFE NE II		10/26/2017	(L19)	Kamala Fiske-Downing	Enforcement Specialist 10/26/2017 (L20)		
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT	'E AGENCY		
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. E. Vituting and Market State			IPLIANCE WITH CI ITS ACT:	VIL	 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 07/07/2015 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMEN ENDING DATE (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>01</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of		(L23)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active		
(L27)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(1.28)	00160		(L31)				
31. RO RECEIPT OF CMS-1539	(L28) 32	. DETERMINATION (OF APPROVAL DAT		Posted 03/31/2017 Co.			
	(L32)			(L33)	DETERMINATION APPRO	VAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Kumala 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: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe 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.

Rochester Rehabilitation And Living Center October 26, 2017 Page 2

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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 A	ND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: H3H8		
MEDICARE/MEDICAID PROVIDER NO (L1) 245626 2.STATE VENDOR OR MEDICAID NO. (L2) 859497200		3. NAME AND AD	DRESS OF FACII CR REHABILIT NGTON BOUL	LITY ATION AN	TE SURVEY AGENCY ND LIVING CENTER W (L6) 55901	Facility ID: 29822 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
 5. EFFECTIVE DATE CHANGE OF OWNE (L9) 	RSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
 6. DATE OF SURVEY 03/29/201 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	.7 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30		
11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds	56 (L18)	Complian		5:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI	6. Scope of Services Limit 7. Medical Director		
13.Total Certified Beds	56 (L17)	X B. Not in Con Requirements	mpliance with Prog and/or Applied Wa		5. Life Safety Code * Code: B *	9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 56 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARKS See Attached Remarks	(IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE):				
17. SURVEYOR SIGNATURE Marietta Lee, HFE NE II		Date :	03/29/2017		18. STATE SURVEY AGENCY APPROVAL Date: Shellae Dietrich, Certification Specialist 09/19/2017			
ΡΔΒ	T II - TO BE	COMPLETED	BV HCFA RI	(L19) EGIONAI	C OFFICE OR SINGLE ST	(L20)		
19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Partici 2. Facility is not Eligible		20. COM	MPLIANCE WITH GHTS 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 2.	3. LTC AGREEM	ENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 07/07/2015	BEGINNING	DATE	ENDING DAT	Έ	<u>VOLUNTARY</u> <u>0</u> (01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24) 25. LTC EXTENSION DATE: 27	(L41) 7. ALTERNATIV A. Suspension	/E SANCTIONS	(L25)		02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	5		
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)			00-Adve		
28. TERMINATION DATE:	29	. INTERMEDIARY/0	CARRIER NO.		30. REMARKS			
	(L28)	06201		(L31)				
 RO RECEIPT OF CMS-1539 03/30/2017 	32	. DETERMINATION (03/30/2017	OF APPROVAL D	ATE				

(L33)

DETERMINATION APPROVAL

(L32)

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 <u>https://dab.efile.hhs.gov</u> 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 <u>Tamika.Brown@cms.hhs.gov</u>.

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 <u>Email: gary.nederhoff@state.mn.us</u> 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;

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- 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY
		245626	B. WING			-C 29/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00//	25/2011
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
	completed on Marc are tag/s that were	ification revisit (PCR) was h 27, 28 & 29, 2017. There not found corrected at the which are located on the				
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.				
{F 282} SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility will be conducted to initial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	{F 28	32}		5/3/17
		ive Care Plans led or arranged by the facility, comprehensive care plan,				
	care. This REQUIREMEN by: Based on observat review, the facility fa	T is not met as evidenced ion, interview and document ailed to follow the care plan to nts for 1 of 3 residents (R99)		It is the policy of Rochester Rehab and Living Center to obtain weight admission and weekly for four wee monthly thereafter or as prescribed physician. This policy was reviewed 3/29/17.	upon ks, I by d on	
				R99 was changed to monthly weigh	its on	
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					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.

STATEMEN	OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245626	B. WING _		R-C 03/29/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
ROCHES	STER REHABILITATIC	ON AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
{F 282}	R99's current care unintentional weigh to cognitive decline interest in food AEE loss and interventic every Wednesday. R99's nursing assis resident every Wed On 3/28/17, at 9:18 be in the dining roo R99's record identi under weights in th 3/10/17, at 2:51 p.r R99's medication a identified aides will Wednesday, day sl was documented o On 3/28/17, at 9:09 (LPN)-A reviewed F weights in the com the above. LPN-A c weighed every Wed On 3/28/17, at 10:2 nursing (IDON) cor not been obtained o planned. The facility policy V indicated Policy 1. monitor residents' v admission and to p	plan identified focus: nutrition, it loss since admission related /forgetfulness and lack of 3 (as evidenced by) weight ons included weigh resident stant Kardex identified weigh dnesday. 8 a.m., R99 was observed to im eating breakfast. fied the last weight recorded e computer system was dated	{F 28	 4/3/17. Her weight remains s For all other residents who m been affected by this; all long residents are weighed on the bath/shower day, the first we month. All new admissions a upon admission, weekly for f and then monthly, unless oth specified by the physician. A corporate template was crea PointClickCare and impleme 3/29/17 for new admission w Daily weights are reviewed ir meeting on Monday through including holidays. If there ar missing weights during the m meeting, the nurse managers are obtained after the meetin dietician continues to trend th weights and any weight chan Manager on Duty over the we to ensure the daily weights a on the weekend. Care plans and kardexs have reviewed and revised as nee regarding weights and freque weights. Education for obtaining weight and physician order was com nursing staff April 5-7, and Af Audits will be completed daily weeks, weekly for 3 months thereafter. Director of Nursing or Design responsible for compliance. Date Certain: May 3, 2017. 	hay have g-term ek of the re weighed our weeks erwise a new ted for nted on eights. a morning Friday, not e any horning s ensure they ig. The he daily iges. The bekend audits re obtained e been ded ency of hts per policy ipleted with oril 11-13. y for two and randomly		

If continuation sheet Page 2 of 15

TATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
			A. BUILDI	NG		R-C	
		245626	B. WING _			/29/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	TER REHABILITATIC	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
{F 282}	Continued From pa	ge 2	{F 28	2}			
	or more often base	d upon ongoing assessment of uid retention, and other	•				
{F 315} SS=D	483.25(e)(1)-(3) NC RESTORE BLADD) CATHETER, PREVENT UTI, ER	{F 31	5}		5/3/17	
	continent of bladde receives services a continence unless	t ensure that resident who is r and bowel on admission nd assistance to maintain his or her clinical condition is hat continence is not possible					
	(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-						
	indwelling catheter	nters the facility without an is not catheterized unless the ondition demonstrates that necessary;					
	indwelling catheter is assessed for rem as possible unless	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary					
	receives appropriat	is incontinent of bladder e treatment and services to t infections and to restore xtent possible.					
	on the resident's co	vith fecal incontinence, based omprehensive assessment, the that a resident who is					

If continuation sheet Page 3 of 15

		AND HUMAN SERVICES			PRINTED: FORM A MB NO.	APPROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		PLETED
		245626	B. WING		R-C 03/29/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
{F 315}	treatment and servi bowel function as p This REQUIREMEN by: Based on observat review, the facility fr and analyze data of assessments for 3 R50) reviewed for u Findings include: R99's Admission Re diagnoses of unspe- behavioral disturba hemiparesis followi right dominant side R99's quarterly Min 3/10/17, identified r program, occasiona frequently incontine assist to toilet and h impairment. R99's current care (activities of daily liv to weakness and ba interventions includ not leave alone in b Transfers: assist of wheeled walker). Fo elimination: revised incontinence. Interv need or urge to void	el receives appropriate ices to restore as much normal iossible. NT is not met as evidenced tion, interview and document ailed to accurately complete f the bowel and bladder of 3 residents (R99, R49 and urinary incontinence. ecord, dated 3/28/17, included ecified dementia without nce and hemiplegia and ng cerebral infarction affecting	{F 315	 5) It is the policy of Rochester Reha and Living Center to ensure that re who are continent of bladder and lupon admission receives services assistance to maintain continence his or her clinical condition is or be such that continence is not possib maintain. For R99, R49 and R50, the bowel bladder assessments were compl 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 ensure all Bowel and Bladder assessments were completed and plans and kardexs were updated v assessment results. All new admissions have had 3-da gathering and Bowel and Bladder assessments completed and anal policy. Education on the Bowel and Bladder assessments will be done weekly weeks, monthly for 3 months and submitted to QAPI team. The QA will determine, based on the audit what further auditing is indicated The Director of Nursing or Design 	esidents powel and unless ecomes le to and eted eto d care with the ay data yzed per der nent April 5-7, for 4 PI team data,	

Facility ID: 29822

If continuation sheet Page 4 of 15

		AND HUMAN SERVICES				FORM	04/26/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED - C
		245626	B. WING				-0 29/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIC	ON AND LIVING CENTER			900 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 315}	mental awareness/ or personal unwillin Provide frequent to R99's nursing assis and bladder inform to void/defecate but to take to toilet whe repositioning reside Functional Incontin awareness/decreas personal unwillingn Provide frequent to Toileting assist of o bathroom/on toilet, two hours. R99's Facility Bowe Screening Tool, dat indicated when plac times, urine stream at times and dry at toilet yes at times a movement yes (no incontinence). R99's facility Bowe dated 3/27/17 (five 3/22/17 per plan of long tern memory le sometimes identify Resident able to as the 3-Day Screenin had asked to use th had incontinent epi incontinent of urine program in use at t	Incontinence (decreased decreased or loss of mobility igness) type incontinence. ileting and cares as needed. stant Kardex identified bowel ation able to tell need or urge t does not always do so; offer en caring for resident/ when ent every two hours. ence (decreased mental sed or loss of mobility or ess) type incontinence. ileting and cares as needed. one, do not leave alone in toilet when repositioned every el and Bladder 3-Day ted 3/17/17 through 3/19/17, ced on toilet resident voided at a strong, condition of pad wet times, resident asked to use and no at times and bowel	{F 3	15}	Date Certain: May 3, 2017.		

If continuation sheet Page 5 of 15

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245626	B. WING _			R-C 8/ 29/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
ROCHES	STER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD ROCHESTER, MN 55901	NW	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
{F 315}	incontinent of bower of bowel - no respo pattern - no regular restorative bowel pre elimination patterns other. Requires assist transfers. One pers Elimination pattern incontinence every Summary of Assess documented inform On 3/28/17, at 8:23 RN-E had stated to R99 replied I do no encouraged R99 to up and to change in agreed and was plat soiled incontinent p On 3/28/17, at 10:0 the person who had Bladder Assessment the assessment had date certain of 3/22 correction. RN-B st the facility and had complete the bowel RN-B confirmed the documentation for r toilet - no, should had analysis and summ stated I missed thad revised the care plat	ntinence. Is resident I or have incontinent episodes nse marked. Normal bowel times. Resident is not on a rogram. Symptoms affecting - functionally disabled and bist with ambulation and on physical assist to toilet. shows patterns of urinary two hours. The Analysis and sment Data had no ation. a.m. observation revealed R99 let's go on the toilet and	{F 31	15}		

If continuation sheet Page 6 of 15

		AND HUMAN SERVICES				FORM	APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI	TIPI	LE CONSTRUCTION	1	0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		l		PLETED
		045000	B. WING				-C
	PROVIDER OR SUPPLIER	245626	D. WING	_	STREET ADDRESS, CITY, STATE, ZIP CODE	03/2	29/2017
					1900 BALLINGTON BOULEVARD NW		
ROCHES	TER REHABILITATIO	IN AND LIVING CENTER		F	ROCHESTER, MN 55901		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO	(-)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
			<u> </u>		DEFICIENCY)		
{F 315}	Continued From pa	age 6	{F 3	151			
[N-D may have revised the	11.5	133			
	care plan.						
	∩n 3/28/17_at 10·1	6 a.m., the IDON confirmed					
	R99's Bowel and Bl	ladder Assessment had not					
		the date certain of 3/22/17 per					
	the facility plan of c	orrection.					
		86 a.m., RN-D stated she had					
		an for toileting for R99 on ed the revision for the care					
		based off of the facility 3-Day					
	Screening Tool (dat	ted 3/17/17 through 3/19/17),					
		n discussion at a meeting that I report needed to use the					
	toilet R99 does not	always do so. R99 could not					
	get up safely by sel	lf, but at times does.					
		cluded Alzheimer's dementia					
	Admission Record.						
	Document review o	of facility Bowel and Bladder					
		assessment signed by the					
	interim director of n	nursing (IDON) on 3/27/17,					
		date certain of 3/22/17 per revealed evaluation reviewed					
		ast assessment and indicated					
	R49 required limited	d assistance of one staff for					
	toileting related to c	occasional bladder bendent with ambulation and					
		eed for assist with toileting.					
		entified R49 had no toileting					
	always continent of	al urinary incontinence and					
		of the significant change					
		(MDS) dated 3/20/17, no toileting program and was					
		inent of bowel and bladder.					

Facility ID: 29822

If continuation sheet Page 7 of 15

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING	i		-C
		245626	B. WING				29/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SHOULD BE COMPLI	
{F 315}	Continued From pa	ge 7	{F 31	15}			
	Day screening tool 3/18/17, revealed n voiding data collect included instruction toileting plan from the for comprehensive patterns. The scree to use the toilet 28 to incontinent brief wa voided on the toilet incontinence.	s wet 10 times in three days, 27 times, and no bowel f R49's care plan target date					
	of 2/27/17, revealed living needs hands related to unsteady Alzheimer's disease increase in overall v include may need a	d focus of activities of daily on assist along with cueing gait, use of walker, e, history of falls, recent weakness. Interventions assist of one to cue to use the ionally incontinent, and					
	altered elimination, bladder, may need toileting. Intervention potential for urinary toilet frequently throu incontinent briefs as	get date of 2/27/17, revealed incontinent of bowel and guidance of limbs with ons included diuretics taken, r frequency or urgency, offer ough out the day, provide s needed, encourage fluid and symptoms of urinary tract an.					
	Kardex printed 3/29 assist of one, may r	of facility nursing assistant 9/17, revealed transfers with need assist of one to cue to sionally incontinent of urine.					

If continuation sheet Page 8 of 15

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 04/26/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
		245626	B. WING				I-C 29/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	25/2011
ROCHES	STER REHABILITATIO	ON AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 315}	During interview or assistant (NA)-A st bowel and bladder, call light for assista brief. During interview or licensed practical n toileted self and wa During interview or verified R49's bowe was completed on correction date due team, cooperation stated she and reg completed the bow themselves. IDON care plan discrepar aware R49 had bow indicated analysis a bladder assessmen evaluation reviewed assessment and in toileting, occasiona independent ambul analysis and summ data gathered for b including three day facility did not deve toileting data collect R50 had diagnosis vascular and vascu facility Admission F	a 3/29/17, at 8:30 a.m., nursing ated R49 was continent of toileted self, and would put on ince to change incontinent a 3/29/17, at 8:32 a.m., hurse (LPN)-B stated R49 as occasionally incontinent. a 3/29/17, at 8:50 a.m., IDON el and bladder assessment 3/27/17, after the plan of to getting staff to work as a and education of staff. IDON istered nurse (RN)-A el and bladder assessments verified the assessment and ncies. IDON stated was not wel incontinence. IDON and summary of bowel and ht was the statement of d for changes since last cluded limited assist of one for and summary for bowel and ht was the statement of d for changes since last cluded limited assist of one for and summary for bowel and ht was the statement of d for changes since last cluded limited assist of one for and pladder assessment screening. IDON verified the heary failed to include all the bowel and bladder assessment screening. IDON verified the heary failed to include all the bowel and bladder assessment screening. IDON verified the heary failed to include all the bowel and bladder assessment screening. IDON verified the and pladder assessment screening. IDON verified the heary failed to include all the bowel and bladder assessment screening. IDON verified the heary failed to include all the bowel and bladder assessment screening. IDON verified the heary failed to include all the bowel and bladder assessment screening. IDON verified the heary failed to include all the bowel and bladder assessment screening. IDON verified the bladder assessment screening screening scree	{F 3	15}			

Facility ID: 29822

If continuation sheet Page 9 of 15

		AND HUMAN SERVICES				FORM	04/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245626	B. WING				-C 29/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 315}	3/6/17, to be freque bladder, no bowel the retraining program, ulcers and moderate Document review of Full assessment signursing (IDON) on a summary of data in incontinent of bowe mechanical lift and non-ambulatory, un to offer toileting upor meals and bedtime 2-3 hrs. Document review of Day screening tool 3/18/17, included in resident's toileting putilize data for compose note voiding pattern revealed R50 asked three days, incontine three days, voided of bowel incontinence Document review of of 6/17/17, revealed living and mobility, of balance, has dement anticipate needs. In two assist with med off commode, two a bedpan and one as are two assist with med of 6/17/17, revealed	A state of the second s	{F 3	15}			

Facility ID: 29822

If continuation sheet Page 10 of 15

		AND HUMAN SERVICES				FORM	04/26/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245626	B. WING				-C 29/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 315}	to report need to us in enough time to p Interventions incluce void, ok to offer to t or repositioning, ale and symptoms of u encourage fluids. Document review of Kardex printed 3/28 two assist and med urge to void or defe R50 when caring fo may not be able to enough to prevent if mechanical lift trans every morning, two bedpan and one as During interview on nursing assistant (N mechanical lift trans wants to toilet, and bowel movements. assistant Kardex di schedule. NA-B staturine most of the tim During interview on stated had toileted check for incontine time. During interview on verified the analysis include all the data bladder assessment	me bowel incontinence, is able se toilet but may not recognize prevent incontinence. The dable to tell need or urge to take him when caring for him ert appropriate staff to signs irinary tract infection, offer and of facility nursing assistant B/17, revealed transfers with thanical lift, able to tell need or ecate but ok to offer to take or R50 or repositioning R50, as report need and or tell soon incontinence, two assist and sfer on and off commode assist to transfer on and off esist to use urinal. A 3/28/17, at 11:17 a.m., NA)-B stated R50 was a sfer with two staff, staff ask if R50 does tell staff mostly for NA-B verified the nursing id not identify a toileting ted R50 was incontinent of	{F 31	15}			

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
			A. BUILD	NG			R-C
		245626	B. WING			03	8/29/2017
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIC	ON AND LIVING CENTER) BALLINGTON BOULEVARD NW CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
{F 315}	Continued From pa	age 11	{F 31	15}			
	implement a toilet s data collected.	schedule based on toileting					
	Screening dated 20 bladder screening v admissions, readm reviews or new inco collection tool will b the resident's best or improve continer indicated if the resi most of the time wh change interval to e If more data is need	owel and Bladder 3-Day 010, indicated a bowel and will be completed on all new issions, annual and quarterly ontinence. This 72 hour data be used to assist in determining toileting schedule to maintain nce levels. Procedure dent has been incontinent nen toileted every two hours, every one and one-half hours. ded continue Bowel and until a toileting plan can be					
(F 320)	Collection dated 20 the facility that base comprehensive ass ensure that each re- incontinence will re- and services to res and bladder function Each resident will b bowel and bladder annually, quarterly, catheterization and elimination patterns in retraining or toile and /or bladder cor collected, the inform written to analyze the	a summary will be he information collected.	JE 30				5/3/17
{F 329} SS=D	483.45(d)(e)(1)-(2) FROM UNNECESS	DRUG REGIMEN IS FREE SARY DRUGS	{F 32	29}			5/3/17

Facility ID: 29822

If continuation sheet Page 12 of 15

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	ΓΙΡΙ		T	0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPLETED	
		045000	B. WING				-C
	PROVIDER OR SUPPLIER	245626	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	03/2	29/2017
NAME OF 1	ROVIDER OR SUPPLIER				900 BALLINGTON BOULEVARD NW		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			ROCHESTER, MN 55901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
(5.000)			·				
{F 329}	Continued From pa	-	{F 32	29}			
		sary Drugs-General. g regimen must be free from					
		An unnecessary drug is any					
	drug when used						
	(1) In excessive dos	se (including duplicate drug					
	therapy); or						
	(2) For excessive d	uration; or					
	(3) Without adequa	te monitoring; or					
	(4) Without adequa	te indications for its use; or					
		of adverse consequences lose should be reduced or					
		ns of the reasons stated in nrough (5) of this section.					
	483.45(e) Psychotro Based on a compre resident, the facility	hensive assessment of a					
	drugs are not given medication is neces	have not used psychotropic these drugs unless the ssary to treat a specific sed and documented in the					
	gradual dose reduc interventions, unles an effort to discontin	use psychotropic drugs receive tions, and behavioral s clinically contraindicated, in nue these drugs; NT is not met as evidenced					

If continuation sheet Page 13 of 15

STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
		245626	A. BUILDIN	G	R	R-C 03/29/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		29/2017	
		N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
{F 329}	Based on interview facility failed to ens assessment was co (R49), who receive Findings include: R49's Admission R diagnosis of Alzhein Minimum Data Set indicated had no tro staying asleep, or s severe cognitive im R49's physician or order for Melatonin mg (milligrams), tw bedtime for insomn R49's medication a 3/17, identified R49 ordered. Review of R49's re comprehensive sle completed for R49. On 3/28/17, at 4:06 confirmed a compr had not been comp the melatonin medi On 3/29/17, at 8:22 nursing, when quer completed for R49, RN-A verified a slee completed for R49.	 and document review, the ure a comprehensive sleep ompleted for 1 of 1 resident d a medication for sleep. ecord dated 3/29/17, included mer's. R49's quarterly (MDS) dated 2/14/17, ouble with falling asleep, sleeping too much and had pairment. ders dated 3/5/17, included an (hormone to induce sleep) 3 o tablets by mouth every i.a. dministration record dated 9 received the medication as cord identified a ep assessment had not been a.m., registered nurse (RN)-B ehensive sleep assessment of the received for R49 before starting cation. a.m. the interim director of 	{F 329	 It is the policy of Rochester F and Living Center to ensure a have a drug regimen free fror unnecessary drugs. R49 had a comprehensive ske assessment completed on 3/2 care plan and Kardex were up For all other residents that ma affected by this the policy reg hypnotic medications was rev residents receiving a hypnotic for sleep were identified and a was completed by 4/1/17. Al and Kardex's were updated. Education for proper Hypnotic was completed with nursing s and April 11-13. New orders are being audited new hypnotic medications hav appropriate monitoring, non-pharmacological interver assessment completed. The be completed weekly for 4 we monthly for 3 months and sub QAPI team. The QAPI team determine, based on the audi further auditing is indicated. The Director of Nursing or De be responsible for compliance Date Certain: May 3, 2017 	Il residents n 28/17. Her odated. ay be arding iewed. All medication a sleep study l care plans c monitoring taff April 5-7, d to ensure ve the stions, and audits will beks, pomitted to will t data, what		

		AND HUMAN SERVICES				FORM	04/26/2017 APPROVED
							0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
						R	-C
		245626	B. WING			03/2	29/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID			ID				(X5) COMPLETION
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
{F 329}	Continued From pa	ao 14	{F 32	201			
(1 020)	Continued From pa	96 14	{F 32	29}			
		t policy was requested, but					
	not provided.						

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		D	ATE OF REVIS	IT
	5			00/0017	
245626 _{Y1}	B. Wing	Y2	2 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		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix F01	156	Correction	ID Prefix	F0242		Correction	ID Prefix	F0314		Correction
Reg. # 483 (13)	.10(d)(3)(g)(1)(4)(5))(16)-(18)	Completed	Reg. #	483.10	(f)(1)-(3)	Completed	Reg. #	483.25(b)(1)		Completed
LSC		03/22/2017	LSC			03/22/2017	LSC			03/22/2017
ID Prefix F03	325	Correction	ID Prefix	F0371		Correction	ID Prefix			Correction
Reg. #	.25(g)(1)(3)	Completed	Reg. #	483.60	(i)(1)-(3)	Completed	Reg. #			Completed
LSC		03/22/2017	LSC			03/22/2017	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC		-	LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC		-	LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC		-	LSC				LSC			
REVIEWED B STATE AGEN		VED BY LS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEWED B CMS RO	BY REVIEW	VED BY LS)	DATE		TITLE				DATE	
FOLLOWUP 2/10/2017	TO SURVEY COMPL	ETED ON		CK FOF ORREC	ANY UNCORRECTED DEFICIENCI	CTED DEFICIEN ES (CMS-2567)	ICIES. WAS SENT TO TI	A SUMMARY OF HE FACILITY?		s 🗌 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

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

Minnesc	ta Department of He	ealth			I OTAMINA THOTED
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG:	(X3) DATE SURVEY COMPLETED
		29822	B. WING _		R-C 03/29/2017
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY	Y, STATE, ZIP CODE	
ROCHES	STER REHABILITATIO	N AND LIVING CE	BALLINGTON	BOULEVARD NW 55901	
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{2 000}	Initial Comments		{2 000}		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has beer	d is ion e of v f v. v. v. vill tem		
	that may result fron orders provided tha the Department wit	hearing on any assessment n non-compliance with the at a written request is made hin 15 days of receipt of a cent for non-compliance.	se		
	27, 28 & 29, 2017. determined that the 0900, 0910 & 1535 uncorrected order/s be reviewed at the uncorrected order/s	TS: visit was completed on Ma During this onsite visit it wa following corrections orde were NOT corrected. The swill remain in effect and w next onsite visit. Also swill be reviewed for possi	as ers/s se vill		
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE	'S SIGNATURE	TITLE	(X6) DATE

Electronically Signed

6899

If continuation sheet 1 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED	
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29822			B. WING	R-C 03/29/2017		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
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	CLIMMA DV CTA		STER, MN 55	PROVIDER'S PLAN OF CORRECTION		
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{2 000}	Continued From pa	ige 1	{2 000}			
	penalty assessmen	ıt/s.				
{2 830}	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	{2 830}		5/3/17	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be our possible unless there is a he attending physician that the in in bed or the resident bed.	d t			
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to follow the care plan to hts for 1 of 3 residents (R99) onal status.		Corrected		
	R99's current care unintentional weigh to cognitive decline interest in food AEE	plan identified focus: nutrition, t loss since admission related /forgetfulness and lack of 3 (as evidenced by) weight ons included weigh resident				
	R99's nursing assis resident every Wed	stant Kardex identified weigh Inesday.				

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		IDENTIFICATION NOMBER.	A. BUILDING: _				
		29822	B. WING			R-C 3/29/2017	
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{2 830}	Continued From pa	ge 2	{2 830}				
	On 3/28/17, at 9:18 be in the dining roo	a.m., R99 was observed to meating breakfast.					
		ied the last weight recorded e computer system was dated n., 118.8 pounds.					
	identified aides will Wednesday, day sh	dministration record (MAR) weigh resident on every hift. The last recorded weight n 3/8/17 as 113.2 pounds.					
	(LPN)-A reviewed F weights in the comp the above. LPN-A c	a.m., licensed practical nurse R99's care plan, MAR and outer system and confirmed onfirmed R99 had not been Inesday as care planned.					
	nursing (IDON) con	4 a.m., the interim director of firmed weights for R99 had every Wednesday as care					
	indicated Policy 1. I monitor residents' v admission and to p and/or intervention Procedure 1. c. Res or more often base	Veight Monitoring, dated 2006, t is the policy of this facility to veights from the time of rovide interdisciplinary support to avert adverse trends. sidents will be weighed weekly d upon ongoing assessment of uid retention, and other					
{2 910}	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	{2 910}			5/3/17	
	have a continuous	nce. A nursing home must program of bowel and bladder luce incontinence and the					

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Marce of PhowDeer on SupPluer STREET ADDRESS, CITV, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, NN 55901 TAG PHOWDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, NN 55901 Phomoders PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSS DEMTIFYING INFORMATION) [2 910] Continued From page 3 [2 910] Innecessary 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. Corrected 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 program, occasionally incontinent bladder, frequently Mioninum Data Set (MDS) dated 31/017, identified no			20822			
DOCHESTER REHABILITATION AND LIVING IN 2000 BALLINGTON BOULEVARD NW ROCHESTER, NN 55901 PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG DENTFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSG DENTFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSG DENTFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY) CONS THE PREFIX (2910) Continued From page 3 (2910) (2910) (2910) (2910) 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. Corrected 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 (H99, R49 and R50) reviewed for urinary incontinence. Corrected 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 do					03/29/2017	
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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.		by: Based on observat review, the facility f and analyze data o assessments for 3 R50) reviewed for t	ion, interview and document ailed to accurately complete f the bowel and bladder of 3 residents (R99, R49 and		Corrected	
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 Admission R diagnoses of unspe behavioral disturba hemiparesis follow	ecified dementia without ince and hemiplegia and ing cerebral infarction affecting			
B99's current care plan identified focus: ADLS		3/10/17, identified r program, occasion frequently incontine assist to toilet and	no urinary or bowel toileting ally incontinent bladder, ent of bowel, required one			
(activities of daily living)/Mobility: Needs help due	poseta D	(activities of daily li				

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R-C 03/29/2017		
		29822					
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		1900 BA		ULEVARD NW			
NUCHES	TER REHABILITATIC	ROCHES	STER, MN 559	01			
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{2 910}	Continued From page 4		{2 910}				
	interventions includ not leave alone in the Transfers: assist of wheeled walker). F elimination: revised incontinent of urine incontinence. Intervine need or urge to voi do so; offer to take resident/ when repor hours. Functional the mental awareness/ or personal unwillin Provide frequent to R99's nursing assist and bladder inform	alance problems and led Toileting: assist of one, do pathroom/on toilet and f one with FWW (forward ocus: Incontinence/altered d 3/20/17. Has been but use of diuretic and bowel ventions included able to tell d/defecate but does not always to toilet when caring for positioning resident every two Incontinence (decreased decreased or loss of mobility agness) type incontinence. illeting and cares as needed.	5				
	to take to toilet whe repositioning reside Functional Incontin awareness/decreas personal unwillingn Provide frequent to Toileting assist of o	It does not always do so; offer en caring for resident/ when ent every two hours. ence (decreased mental sed or loss of mobility or less) type incontinence. vileting and cares as needed. one, do not leave alone in toilet when repositioned every					
	Screening Tool, dai indicated when plac times, urine stream at times and dry at	el and Bladder 3-Day ted 3/17/17 through 3/19/17, ced on toilet resident voided at a strong, condition of pad wet times, resident asked to use and no at times and bowel episodes of bowel					
		l and Bladder assessment, days after the date certain of					

H3H812

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29822		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		29822	B. WING			R-C 03/29/2017
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{2 910}	Continued From page 5		{2 910}			
	3/22/17 per plan of correction) indicated short and		4			
	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					
		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 inform	nation.				
		a.m. observation revealed				
		R99 let's go on the toilet and				
	R99 replied I do no					
		go into the bathroom to wash				
		ncontinent product. R99				
		aced on the toilet. R99 had a				
	solied incontinent p	ad (with visible urine).				
	On 3/28/17 at 10.0	9 a.m., RN-B sated she was				
		d completed R99's Bowel and				
		nt on 3/27/17. RN-B confirmed				
		d not been completed by the				
		2/17 per the facility plan of				
		ated she was a consultant for				
		come to help the facility				
	complete the bowe	I and bladder assessments.				
		e assessment had inaccurate	1			1

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		29822	B. WING		R-C 03/29/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	STER REHABILITATIO		LLINGTON BC	ULEVARD NW		
NUCHES		ROCHES	STER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 910}	Continued From pa	ige 6	{2 910}			
	toilet - no, should h according to the 3-l confirmed she had information on the a analysis and summ stated I missed tha revised the care pla Screening Tool and Assessment, but R care plan. On 3/28/17, at 10:1 R99's Bowel and B been completed by the facility plan of c On 3/28/17, at 10:3	6 a.m., RN-D stated she had	3 t			
	3/20/17. RN-D state plan had not been I Screening Tool (da but was based from although R99 could toilet R99 does not get up safely by sel R49's diagnosis inc	an for toileting for R99 on ed the revision for the care based off of the facility 3-Day ted 3/17/17 through 3/19/17), n discussion at a meeting that I report needed to use the always do so. R99 could not If, but at times does. cluded Alzheimer's dementia hence, according to facility				
	Quarterly Short, an interim director of r (five days after the plan of correction) r for changes since I R49 required limite toileting related to c incontinence, indep	of facility Bowel and Bladder assessment signed by the nursing (IDON) on 3/27/17, date certain of 3/22/17 per revealed evaluation reviewed ast assessment and indicated d assistance of one staff for occasional bladder bendent with ambulation and eed for assist with toileting.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		29822	B. WING			R-C 03/29/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
ROCHES	STER REHABILITATIC		LLINGTON BO TER, MN 559	OULEVARD NW 01			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 910}	Continued From pa	age 7	{2 910}				
		lentified R49 had no toileting al urinary incontinence and i bowel.					
	Minimum Data Set revealed R49 had r	of the significant change (MDS) dated 3/20/17, no toileting program and was inent of bowel and bladder.					
	Day screening tool 3/18/17, revealed n voiding data collect included instruction toileting plan from t for comprehensive patterns. The scree to use the toilet 28 incontinent brief wa	of facility Bowel and Bladder 3 dated 3/16/17, 3/17/17, no summary or analysis of tion. The screening tool as to individualize the resident's the data collected, utilize data assessment and note voiding ening tool revealed R49 asked times in three days, as wet 10 times in three days, 27 times, and no bowel	5				
	of 2/27/17, revealed living needs hands related to unsteady Alzheimer's disease increase in overall include may need a	of R49's care plan target date d focus of activities of daily on assist along with cueing gait, use of walker, e, history of falls, recent weakness. Interventions assist of one to cue to use the sionally incontinent, and of one.					
	altered elimination, bladder, may need toileting. Interventi potential for urinary toilet frequently thro incontinent briefs a	get date of 2/27/17, revealed incontinent of bowel and guidance of limbs with ons included diuretics taken, r frequency or urgency, offer ough out the day, provide s needed, encourage fluid and symptoms of urinary tract					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR COMPLETE		
		29822	B. WING			R-C 03/29/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
OCHES	TER REHABILITATIC						
(X4) ID	SUMMABY STA		ID ID	PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLE	
{2 910}	Continued From pa	age 8	{2 910}				
	infection to physicia	an.					
	Kardex printed 3/29 assist of one, may	of facility nursing assistant 9/17, revealed transfers with need assist of one to cue to sionally incontinent of urine.					
	assistant (NA)-A stabowel and bladder,	a 3/29/17, at 8:30 a.m., nursing ated R49 was continent of toileted self, and would put or nce to change incontinent					
	licensed practical n	a 3/29/17, at 8:32 a.m., aurse (LPN)-B stated R49 as occasionally incontinent.					
	verified R49's bowe was completed on a correction date due team, cooperation a stated she and regi completed the bow themselves. IDON care plan discrepan aware R49 had bow indicated analysis a bladder assessmen evaluation reviewed assessment and in toileting, occasiona independent ambul analysis and summ data gathered for b including three day	lation. IDON verified the hary failed to include all the owel and bladder assessment screening. IDON verified the lop a toilet schedule based on					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _		R-C		
		29822	B. WING			03/29/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
ROCHES	TER REHABILITATIC		LLINGTON BO TER, MN 559	OULEVARD NW 01			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
{2 910}	Continued From pa	ige 9	{2 910}				
		that included peripheral lar dementia according to Record.					
	Minimum Data Set 3/6/17, to be freque bladder, no bowel t retraining program.	d R50 on the quarterly (MDS), as assessment dated ently incontinent of bowel and raining program, no bladder at risk of developing pressure tely impaired cognition.					
	Full assessment sig nursing (IDON) on summary of data in incontinent of bowe mechanical lift and non-ambulatory, un to offer toileting upo	of facility Bowel and Bladder gned by the interim director of 3/21/17, revealed analysis and icluded R50 was frequently el and bladder, required two staff for transfers, nable to detect need void, staff on arising, before and after and check and change every					
	Day screening tool 3/18/17, included ir resident's toileting p utilize data for com note voiding pattern revealed R50 aske three days, incontir	of facility Bowel and Bladder 3 dated 3/16/17, 3/17/17, instructions to individualize the blan from the data collected, prehensive assessment and hs. The screening tool d to use the toilet 4 times in hent brief was wet 24 times in on the toilet 20 times, and 2					
	of 6/17/17, revealed living and mobility, balance, has deme anticipate needs. In two assist with med	of R50's care plan target date d a focus of activities of daily generally weak with poor ntia and is forgetful, and nterventions included toileting chanical lift to transfer on and assist to transfer on and off					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _		ПС		
		29822	B. WING			R-C 03/29/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
OCHES	TER REHABILITATIO		LLINGTON BC STER, MN 559	OULEVARD NW			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
{2 910}	Continued From pa	age 10	{2 910}				
	are two assist with Document review of of 6/17/17, revealed altered elimination, 7 times a week, so to report need to us in enough time to p Interventions include void, ok to offer to a or repositioning, ale and symptoms of u encourage fluids. Document review of Kardex printed 3/28 two assist and med urge to void or defe R50 when caring for may not be able to enough to prevent mechanical lift tran every morning, two bedpan and one as During interview or nursing assistant (I mechanical lift tran wants to toilet, and bowel movements. assistant Kardex di schedule. NA-B sta urine most of the ti During interview or stated had toileted	of R50's care plan target date d a focus of incontinence and incontinent of urine more them me bowel incontinence, is able se toilet but may not recognize prevent incontinence. ded able to tell need or urge to take him when caring for him ert appropriate staff to signs urinary tract infection, offer and of facility nursing assistant 8/17, revealed transfers with chanical lift, able to tell need or ecate but ok to offer to take or R50 or repositioning R50, as report need and or tell soon incontinence, two assist and usfer on and off commode o assist to transfer on and off essist to use urinal. n 3/28/17, at 11:17 a.m., NA)-B stated R50 was a usfer with two staff, staff ask if R50 does tell staff mostly for NA-B verified the nursing id not identify a toileting ated R50 was incontinent of					
	Duning interview						
	During interview or epartment of Health	n 3/28/17, at 1:30 p.m.,IDON					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY PLETED
		29822	B. WING		29/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BOULEVARD NW STER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
{2 910}	include all the data bladder assessmen screening. IDON ver implement a toilet s data collected. The facility policy Be Screening dated 20 bladder screening v admissions, readmi reviews or new inco collection tool will be the resident's best t or improve continer indicated if the reside most of the time wh change interval to e If more data is need Bladder screening the established. The facility policy Be Collection dated 20 the facility that base comprehensive ass ensure that each re incontinence will red and services to rest and bladder function Each resident will b bowel and bladder v annually, quarterly, catheterization and elimination patterns in retraining or toilet	and summary failed to gathered for bowel and it including three day erified the facility did not chedule based on toileting owel and Bladder 3-Day 10, indicated a bowel and vill be completed on all new ssions, annual and quarterly ontinence. This 72 hour data e used to assist in determining oileting schedule to maintain nee levels. Procedure dent has been incontinent ien toileted every two hours, every one and one-half hours. ded continue Bowel and until a toileting plan can be owel and Bladder Data 10, indicated it is the policy of	{2 910}		

If continuation sheet 12 of 14

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY IPLETED
	or connection	DENTITIOATION NOMBER.	A. BUILDING:			
		29822	B. WING		R-C 03/29/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO			DULEVARD NW		
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
{21535}	Continued From pa	age 12	{21535}			
	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	{21535}			5/3/17
	must be free from a unnecessary drug A. in excessive therapy; B. for excessive C. without ade D. in the prese which indicate the discontinued. In addition to the c part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manua Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th system and the Sta subject to frequent This MN Requirem by: Based on interview facility failed to ens assessment was c	quate indications for its use; or ence of adverse consequences dose should be reduced or drug regimen review required in the nursing home must comply he Interpretive Guidelines for egulations, title 42, section a Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change.		Corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	·····			
		29822	B. WING			R-C 03/29/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ROCHES	TER REHABILITATIC		LLINGTON BO STER, MN 559	OULEVARD NW 01			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
{21535}	Continued From pa	age 13	{21535}				
	indicated had no tro	(MDS) dated 2/14/17, puble with falling asleep, sleeping too much and had apairment.					
	order for Melatonin	ders dated 3/5/17, included an (hormone to induce sleep) 3 to tablets by mouth every nia.					
		dministration record dated received the medication as					
	Review of R49's re comprehensive sle completed for R49.	ep assessment had not been					
	confirmed a compr	p.m., registered nurse (RN)-E ehensive sleep assessment pleted for R49 before starting ication.	3				
	nursing, when quer comprehensive sle completed for R49, RN-A verified a sle completed for R49	2 a.m. the interim director of ried regarding a ep assessment had not been had no response. At the time ep assessment had not been and stated we have an action assessments to be done.					
	A sleep assessmer not provided.	nt policy was requested, but					

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. Building				DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building			1	
29822 _{Y1}	B. Wing	、 、	Y2	3/29/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHESTER REHABILITATIC	N 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).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20900	Correction	ID Prefix 2	20965	Correction	ID Prefix	21015	Correction
Reg. #	MN Rule 4658.05 Subp. 3	Completed		/IN Rule 4658.0600 Subp. 2	Completed	Reg. #	MN Rule 4658.0610 Subp. 7	Completed
LSC		03/22/2017	LSC _		03/22/2017	LSC		03/22/2017
ID Prefix Reg. # LSC	21426 MN St. Statute 14 Subd. 3	Correction 44A.04 Completed 03/28/2017		21800 //N St. Statute144.651 Subd. 4	Correction Completed 03/22/2017	ID Prefix Reg. # LSC	21830 MN St. Statute 144. Subd. 10	Correction 651 Completed 03/22/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 1 Subd. 27	44.651 Completed	Reg. #		Completed	Reg. #		Completed
LSC		03/22/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix _		Correction	ID Prefix		Correction
Reg. #	_	Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEW		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR		D	ATE
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			D	ATE
FOLLOW 2/10/201		COMPLETED ON		K FOR ANY UNCORREC PRECTED DEFICIENCI				YES 🗌 NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

				NAND TRANSMITTAL ID: H3H8 'ATE SURVEY AGENCY Facility ID: 29822			
1. MEDICARE/MEDICAID PROVIDER No. (L1) 245626 2.STATE VENDOR OR MEDICAID NO. 859497200		3. NAME AND ADDRESS OF FACILITY (L3) ROCHESTER REHABILITATION AND (L4) 1900 BALLINGTON BOULEVARD NW (L5) ROCHESTER, MN				4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	<u>2 (L8)</u> 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUF	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Co	
6. DATE OF SURVEY 02/10/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 06/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):		10.THE FACILITY X A. In Complian Program Red Compliance	nce With quirements Based On:		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	6. Scope of Servi	tor
12.Total Facility Beds 13.Total Certified Beds	56 (L18)56 (L17)	B. Not in Com	cceptable POC pliance with Program and/or Applied Waiv		4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: B) 8. Patient Room 8 9. Beds/Room (L12)	lize
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 56	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39) S (IF APPLICABLE S	(L42) HOW LTC CANCELL	(L43) ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AF	PPROVAL	Date:
Jennifer Kolsrud,	HFE NE II		03/10/2017	(L19)	Kate JohnsTon, Pr	ogram Specialist	t 03/30/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RF	GIONAL	OFFICE OR SINGLE STAT	FE AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible			PLIANCE WITH C ITS ACT:	IVIL		cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	L-1513)
	(L21)						
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEME BEGINNING I		4. LTC AGREEME ENDING DATE		26. TERMINATION ACTION:		L30) <u>ARY</u>
07/07/2015 (L24)	(L41)		(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimburseme		eet Health/Safety eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE A. Suspension of		(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider 00-Active	Status Change
(L27)	B. Rescind Susp	pension Date:	(L45)				
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		00160					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION (OF APPROVAL DAT	Έ	Posted 03/31/2017 Co.		
	(L32)			(L33)	DETERMINATION APPRC	VAL	



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:

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

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

<u>Remedies</u> - 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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 <u>Email: gary.nederhoff@state.mn.us</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala 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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		245626	B. WING		02/ ⁻	10/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		900 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 000			
F 156 SS=E	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electronic be used as verificat Upon receipt of an a on-site revisit of you validate that substat regulations has beet your verification. 483.10(d)(3)(g)(1)(4 RIGHTS, RULES, S (d)(3) The facility m remains informed o of contacting the ph professionals respon §483.10(g) Informat (1) The resident has	of correction (POC) will serve of compliance upon the obtance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with 4)(5)(13)(16)-(18) NOTICE OF SERVICES, CHARGES sust ensure that each resident of the name, specialty, and way hysician and other primary care onsible for his or her care. tion and Communication. s the right to be informed of d of all rules and regulations	F 156			3/22/17
	during his or her sta (g)(4) The resident notices orally (mean (including Braille) in or she understands (i) Required notices	has the right to receive ning spoken) and in writing a format and a language he				
		rights which includes - the manner of protecting				
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
	ically Signed					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.

PRINTED: 03/10/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245626 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER REHABILITATION AND LIVING CENTER ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 156 Continued From page 1 F 156 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

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 2 of 56

PRINTED: 03/10/2017

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245626	B. WING			02	/10/2017
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	02	10/2017
ROCHES	STER REHABILITATIO	ON AND LIVING CENTER			0 BALLINGTON BOULEVARD NW CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 156	U.S.C. 3001 et sec advocacy system (as established und Disabilities Assista 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) w November 28, 201 (iii) Information reg eligibility and cover [§483.10(g)(4)(iii) w November 28, 201 (iv) Contact informa Disability Resource Section 202(a)(20) Act); or other No W [§483.10(g)(4)(iv) w November 28, 201 (v) Contact informa Control Unit; and [§483.10(g)(4)(v) w November 28, 201 (v) Contact informa Control Unit; and [§483.10(g)(4)(v) w November 28, 201 (vi) Information and grievances or com suspected violation facility regulations, resident abuse, ne misappropriation o facility, non-complia directives requirem information regardi (g)(5) The facility m	 and the protection and as designated by the state, and ler the Developmental nce and Bill of Rights Act of 5001 et seq.) be implemented beginning 7 (Phase 2)] arding Medicare and Medicaid rage; will be implemented beginning 7 (Phase 2)] ation for the Aging and e Center (established under (B)(iii) of the Older Americans Arong Door Program; will be implemented beginning 7 (Phase 2)] ation for the Medicaid Fraud <i>v</i>ill be implemented beginning 7 (Phase 2)] ation for the Medicaid Fraud <i>v</i>ill be implemented beginning 7 (Phase 2)] ation for the Medicaid Fraud <i>v</i>ill be implemented beginning 7 (Phase 2)] d contact information for filing plaints concerning any n of state or federal nursing including but not limited to glect, exploitation, f resident property in the ance with the advance nents and requests for ing returning to the community. 	F 1	56			

Facility ID: 29822

If continuation sheet Page 3 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/10/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245626	B. WING			02/	10/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156	Continued From pa	ge 3	F 1	56			
	 (i) A list of names, a and telephone num agencies and advor Survey Agency, the protective services jurisdiction in long-t of the State Long-T program, the protect home and communand the Medicaid F (ii) A statement that complaint with the Sconcerning any sus federal nursing facilimited to resident a misappropriation of facility, and non-cordirectives requirem I) and requests for it to the community. (g)(13) The facility r written information, applicants for admisinformation about h Medicare and Medireceive refunds for such benefits. (g)(16) The facility r and services to the admission and duri (i) The facility must and in writing in a lagence of the service of the services to the admission and duri 	addresses (mailing and email), bers of all pertinent State cacy groups, such as the State State licensure office, adult where state law provides for erm care facilities, the Office erm Care Ombudsman ction and advocacy network, ity based service programs, raud Control Unit; and the resident may file a State Survey Agency pected violation of state or lity regulation, including but not buse, neglect, exploitation, resident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning must display in the facility and provide to residents and ssion, oral and written ow to apply for and use caid benefits, and how to previous payments covered by must provide a notice of rights resident prior to or upon ng the resident's stay. inform the resident both orally anguage that the resident or her rights and all rules and					

If continuation sheet Page 4 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING	i		02/*	10/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	regulations governi responsibilities duri (ii) The facility must the State-developed obligations, if any. (iii) Receipt of such amendments to it, r writing; (g)(17) The facility r (i) Inform each Med writing, at the time of facility and when the Medicaid of- (A) The items and s nursing facility serv for which the reside (B) Those other iter facility offers and fo charged, and the ar services; and (ii) Inform each Med changes are made specified in paragra this section. (g)(18) The facility r before, or at the tim periodically during t available in the faci services, including t	ng resident conduct and ng the stay in the facility. also provide the resident with d notice of Medicaid rights and information, and any nust be acknowledged in	F .	156			

If continuation sheet Page 5 of 56

		& MEDICAID SERVICES			MB NO. 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245626	B. WING _		02/10/2017
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
ROCHES	TER REHABILITATIC	ON AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI
F 156	Continued From pa facility's per diem ra	-	F 15	56	
	and services cover Medicaid State plan	in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e.			
it f	items and services facility must inform	are made to charges for other that the facility offers, the the resident in writing at least plementation of the change.			
	transferred and doe facility must refund representative, or e deposit or charges per diem rate, for the resided or reserved	s or is hospitalized or is es not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's ne days the resident actually d or retained a bed in the of any minimum stay or equirements.			
	resident representa	st refund to the resident or ative any and all refunds due 30 days from the resident's rom the facility.			
	behalf of an individ facility must not con these regulations.	admission contract by or on ual seeking admission to the nflict with the requirements of NT is not met as evidenced			
	Based on interview facility failed to prov Nursing Facility Adv (SNFABN) upon ter	v and document review, the vide the required Skilled vanced Beneficiary Notice rmination of Medicare Part A of 4 of 4 residents (R113, R35,		Residents 113, 120 and 40 have to discharged from the facility. ABN has been provided to resident 35. All residents who have a Medicare stay or equivalent who reside long	10055 Part A

Facility ID: 29822

		& MEDICAID SERVICES	1				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		245626	B. WING _			02 /1	0/2017	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 156	R40, R120), review rights. Findings Include: R113 was discharg 10/22/16, used 8 da facility. The facility of her legal representation for Medicare and M (CMS)-10055 to inf non-covered servic the denial to Medica R35 was discharge 10/27/16, used 6 da facility. The facility of legal representative Medicare and Medi inform her of poten services and of her Medicare. R40 was discharge 12/8/16, used 35 da facility. The facility of legal representative Medicare and Medi inform her of poten services and of her Medicare and Medi inform her of poten services and of her Medicare and Medi inform her of poten	ed for liability and beneficiary ed for liability and beneficiary ed for liability and beneficiary ative with a SNFABN/Centers ledicaid Services orm her of potential liability for es and of her right to appeal are. d from Medicare Part A on ays and remained in the did not provide R35 and/or her e with a SNFABN/Centers for caid Services (CMS)-10055 to tial liability for non-covered right to appeal the denial to d from Medicare Part A on ays and remained in the did not provide R40 and/or her e with a SNFABN/Centers for caid Services (CMS)-10055 to tial liability for non-covered right to appeal the denial to	F 15	56	what Medicare part A or equivalent will have an ABN form CMS 10055 provided to them. The facility has provided training/education to the MDS coordinators regarding proper notic each type of service discontinuation MDS coordinators will provide ABN notices appropriately to all resident staying longer than their rehabilitati service letting them know they may responsible for payment. MDS coordinators or trained design be responsible for giving proper not according to facility protocol. The administrator will monitor compliand ABN notices using weekly audit too based on who will be discharging fr rehabilitation services. The admini will monitor weekly for 3 months as process is integrated into the IDT p The results of the monitoring/audits reviewed by the QAPI committee of ongoing basis. System revisions a staff education will be implemented indicated based on the audits and/o committee recommendations. The alleges that it will be in substantial compliance with the standard indica March 22, 2017.	ees for h. The s on be hee will tices ce of ls om strator the rocess. s will be n an nd/or l as or QAPI facility		
	8/27/16 used 43 da The facility did not prepresentative with Medicare and Medi inform her of poten	ed from Medicare Part A on ys and remained in the facility. provide R120 and/or her legal a SNFABN/Centers for caid Services (CMS)-10055 to tial liability for non-covered right to appeal the denial to						

If continuation sheet Page 7 of 56

OF DEFICIENCIES		(X') (////////////////////////////////////		
OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
	245626	B. WING		02/10/2017
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
Continued From pa Medicare.	ge 7	F 15	6	
stated in response they provide the SN "We have not been	to a question regarding when IFABN form to the residents, giving these out. We will			
and procedure for M 483.10(f)(1)-(3) SE	Nedicare Denials. _F-DETERMINATION -	F 24	2	3/22/17
schedules (includin health care and pro consistent with his o	g sleeping and waking times), viders of health care services or her interests, assessments,			
about aspects of his	s or her life in the facility that			
members of the cor community activities facility. This REQUIREMEN	mmunity and participate in s both inside and outside the			
Based on observat review, the facility fa for bathing for 3 of 3 reviewed for choice	ailed to determine preferences 3 residents (R188, R81, R173)		Resident 81 has been given choices in regard to "awake at will" and bathing. Care plan and kardex have been updat All residents will be interviewed upon	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa Medicare. On Wednesday 2/8 stated in response to they provide the SN "We have not been change our practice them in the future." Asked for but did no and procedure for N 483.10(f)(1)-(3) SEI RIGHT TO MAKE C (f)(1) The resident h schedules (including health care and pro consistent with his of and plan of care an of this part. (f)(2) The resident h about aspects of his are significant to the (f)(3) The resident h members of the cor community activities facility. This REQUIREMEN by: Based on observat review, the facility fa for bathing for 3 of 3	PROVIDER OR SUPPLIER STER REHABILITATION AND LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 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.	PROVIDER OR SUPPLIER STER REHABILITATION AND LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 7 Medicare. F 15 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. 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES F 24 (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.	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STER REHABILITATION AND LIVING CENTER ID00 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCE) TO SHOULD BE CROSS REFERENCED TO SHOULD SE CROSS REFERENCED TO SHOULD SE TO SHOULD SE CROSS REFERENCED TO SHOULD SE CR

Event ID:H3H811

Facility ID: 29822

If continuation sheet Page 8 of 56

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MET				0938-039
	OF DEFICIENCIES	IDENTIFICATION NUMBER:					PLETED
		245626	B. WING			02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIC	ON AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 242	Continued From pa	age 8	F 24	2			
		I to the facility on 2/3/17 per			in their care plans. All current resid	dents	
	the facility admission				are being interviewed for their prefe		
	,				in regard to bathing and waking sc	hedules	
		m. R188 stated she had a			and care plans/kardex are being up		
		8 stated she had been asking			The DON will implement measures		
		admission on 2/3/17. R188 In unware of when her next			ensure this deficient practice does	not	
		nd stated she was not asked if			recur including: all nurses will be educated on the admission proces	e in	
		ower or a bath today when she			terms of obtaining resident prefere		
	was given a showe				and entering them into the care		
	0				plans/kardex. The CNAs will be ed	ducated	
		y 1 of Admission/Readmission			on accessing the care plan information		
		2/3/16 included, "REQUIRED			through the kardex in PCC, as well		
		ne resident their preferences			making sure to ask before doing ea	ach	
		t routine mark answers here e." The questions that			task (i.e. waking time and bathing preferences) and reporting any req	upete	
		frequency or preferences were			for changes to the nurses to update		
	not answered and				care plans.	••	
					The DON or designee will monitor	the	
		ote dated 2/10/17, indicated,			corrective actions to ensure the		
		efer a bath x2 [two times] a			effectiveness of these actions inclu		
	week and on day s	hift."			auditing all new admission paperwe		
	On 2/00/17 at 7.35	a.m., nursing assistant			resident choices and integration int care plans for 2 weeks followed by		
		s were scheduled once a week			random weekly audits. Upon comp		
		NA-A stated residents are			of these audits, education will be	5101.011	
	•	day based on their room			completed timely. Failure to adher	e to	
	assignment. NA-A	stated if a resident requested a			these protocols will result in re-edu		
		taff can make a schedule			and/or corrective counseling. The		
	change to reflect a computer and upda	resident's preference in the			of the audits and compliance rates		
		מום נווש טמווז אוושטו.			trend, analysis) will be reported to t facility QAPI Committee monthly for		
	On 2/09/17. 11:32 a	a.m. the director of nursing			months. Upon this review, system		
		expected the nurse to complete			revisions and/or staff education wil		
	the bathing prefere	nce questions on the nursing			implemented if indicated via a pres		
		nent and verified this portion of			corrective action plan. Facility DOI	N will	
		d not been completed for			be responsible for maintaining		
	R188. The DON sta				compliance. The facility alleges the		
	assessment was co	ompleted nursing should be			be in substantial compliance with the	ne	

Facility ID: 29822

If continuation sheet Page 9 of 56

STATEMEN	T OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	. 0938-039 TE SURVEY MPLETED
				G		
		245626	B. WING		02	/10/2017
	PROVIDER OR SUPPLIER	ON AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 242	explaining the norm bath/shower and if bathing request we day of week and tir accommodate bath The DON stated nu with R188 her bath bathing and prefere admission. On 2/10/17, at 10:1 had assigned a sta about her bathing p she would provide assessment once to On 2/10/2017, at 10:1 had assigned a sta about her bathing p she would provide assessment once to On 2/10/2017, at 11 today was the first staff regarding her had requested a bat day shift. A bathing choices a requested and not R81's quarterly Mir 10/25/16; identified impairment and ne dressing and bed m During the initial int R81 was asked ab morning. R81 had tell us when to get tell us we need to g During an interview p.m. R81 had been morning she stated	 a routine was a weekly a resident had a specific would work with them on the ne of day to try to ning their bathing preferences. ursing should have reviewed ing schedule, frequency of ence for type of bathing upon 9 a.m. the DON stated she ff member to speak to R188 oreferences today and stated this writer a copy of the he nurse had completed it. 0:48 a.m., the DON stated time R188 was interviewed by bathing preferences. R188 ath two times a week on the and preferences policy was provided. imum Data Set (MDS) dated I R81 had severe cognitive eded extensive assistance for 	F 24	2 standard indicated by March 22,	2017.	

If continuation sheet Page 10 of 56

		AND HUMAN SERVICES				FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING			02 / ⁻	10/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 242	stated with a laugh, stated, "O, no I was At 2/9/17 at 7:46 a.1 to the edge of bed. for the day, R81 sta Interview on 2/9/17 assistant (NA)-B wh or if she usually get R81 is woke up, do up NA-B stated that time she wants to g Surveyor asked how preferences. NA-B kardex (a reference information). NA-B kardex and was not for R81. Interview on 2/9/17 practical nurse (LPI wake time LPN-B s and varies between sometimes woke up gets up on her own where to find the pr like. LPN-B stated, staff here on this ur preferences." Interview on 2/9/17 been asked who co when residents was LPN-B stated that t admission papers v on the unit. LPN-B or choices were asl	, turned her head up, and s not ready." m. R81 observed to be rising Surveyor asked if getting up	F 2	42			

If continuation sheet Page 11 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/10/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY IPLETED
		245626	B. WING			02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 242	Continued From page 11 choices on admission.		F 2	242			
	Interview on 2/9/17 nursing (DON) upda completes the adm information is place populates to other a bedtime are asked a program in place expectation would b prefers to sleep. R173 admitted to th nursing day one ad assessment form w resident prefer show R173 (per nursing hospital on 1/9/17 a 1/13/17. Progress r nursing day 1 admis is no indication of b During interviews w p.m. R173 had india at home every day other day because On 2/8/17 at 12:36 asked everyday if s then is told by staff never happens. On 2/9/17 at 1:14 a will ask the nursing they will get back to 2/9/17, at 12:09 p.n R173 asked for any	at 2:50 p.m. with director of ated the nurse on the floor ission on the residents then ed in the computer that auto areas. Questions on wake and on admission. Facility also has to wake at will. DON be not wake up R81 if she ne facility on 12/26/16. A mission/readmission vas completed indicating that wers and one time per week. notes) admitted back to and readmitted to facility on note dated 1/13/17, title: ssion/readmission note, there athing preferences. with R173 on 2/7/17, at 3:45 cated that she takes a shower but would be ok with every they are so busy. p.m. R173 stated she had he could get a shower and they would look into it but it .m. R173 she stated that she assistant and they will tell her o her.					

If continuation sheet Page 12 of 56

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	MB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IG		E SURVEY IPLETED
		245626	B. WING _		02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 242	Continued From pa	ge 12	F 24	12		
	RN-D, regarding re addition showers, n indicated that they w preference or that s have an additional s nurses stated, "Eve shower weekly, but one nurse here mod difficult to give them On 2/10/17, at 9:15 DON, she stated th an extra shower that attempt to accomm On 2/10/17, at 10:1	a.m. during interview with at if resident requests to have at staff should make every odate the request. 6 a.m. R173 said that d come in to talk with her				
F 282 SS=E	dated reads; Open wake-at-will and rea informed about the reviewed at care co 483.21 (b)(3)(ii) SEF PERSONS/PER CA (b)(3) Comprehens The services provid	RVICES BY QUALIFIED ARE PLAN ive Care Plans led or arranged by the facility,	F 28	32		3/22/17
	must- (ii) Be provided by a accordance with ea care.	comprehensive care plan, qualified persons in th resident's written plan of NT is not met as evidenced				

If continuation sheet Page 13 of 56

		& MEDICAID SERVICES	0.00		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245626	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVAR ROCHESTER, MN 55901	D NW	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 282		ge 13	F 2	82		
	review, the facility fa obtain weekly weigh significant weight lo R67) who had been and failed to follow plan interventions fo had a pressure ulco Findings Include: LACK OF TAKING	tion, interview and document ailed to follow the care plan to hts, which resulted in bass for 2 of 3 residents (R22, in reviewed for nutritional status current pressure ulcer care for 1 of 1 resident (R61) who er. WEIGHTS AS ORDERED FICATION OF WEIGHT		All residents cited in this discharged from the faci Weights: Facility staff w for all residents currently Nursing and the Registe review weights weekly o weight changes and rep attending physician/NP/I admissions will have we within the first 3 days.	ility. ill obtain weights residing here. red Dietitian will ngoing to identify ort them to the PA. All new ights obtained	
	LOSS: R22's admission M 12-13-16, identified disease and demer one staff member for impaired cognition. review as he died of R22's nutritional ca nutrition risk related evidenced by] perior forgetfulness and c included: "Weigh re	inimum Data Set (MDS) dated diagnoses of Alzheimer's ntia. R22 needed assistance of or eating and had severely R22 was a closed record in 1/24/17. re plan included, "Potential d to dementia AEB [as ods of somnolence, onfusion." Interventions esident every Wednesday."		complete a body audit for conditions/impairments currently residing in the will review the body audit all resident with pressure other skin impairments). will be updated as indicat findings. All new admiss body audits upon admiss as determined by their at facility protocol. Resider for pressure ulcers will h interventions to prevent as indicated by their indi- assessment.	or all skin for all residents facility. The IDT its and reassess e ulcers (and/or The care plans ated by the sions will thorough sion and ongoing ssessment and/or nts with potential have care planned pressure ulcers	
	not have any weigh 1/24/17 when he ex	cal record revealed R22 did ts taken from 12/28/16 to pired. eights was documented as		The DON will implement ensure this deficient pra recur including: all nurse educated on ensuring w obtained according to in care plan and/or facility licensed nurse will notify providers of any significa changes; all nurses will	ctice does not es will be eights are dividual resident's protocol. The the dietitian and ant weight	

Facility ID: 29822

If continuation sheet Page 14 of 56

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	IPLE CONSTRUCTION	<u>OMB NO.</u> (X3) DATI	E SURVEY	
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:			IG		COMPLETED	
		245626	B. WING _		02/	10/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVA ROCHESTER, MN 55901	RD NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 282	Continued From pa	ge 14	F 28	32			
	 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 stableContinue with Regular dietMonitor 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 			 monitoring pressure uke impairments, ensuring updated for intervention interventions provided the care plans. All CNA on accurate and timely directed by the licensed will be educated on foll interventions for pressu- skin impairments and r there is a discrepancy in refusal of an intervention. The DON or designee to corrective actions to en effectiveness of these and auditing all weight reconveights are obtained and care plan 3 times per with weekly for 3 weeks, foll weekly audits. The DCD audit every resident with twice daily for 2 weeks pressure ulcer intervent Based on the outcome education/training will be timely. Failure to adhe protocols will result in r corrective counseling. audits and compliance analysis) will be reported QAPI Committee mont 	care plans are ns and ensuring the are prescribed by As will be educated weights as d nurse; all CNAs owing care planned ure ulcers and other notifying nurses if in the care plan or on by the resident. will monitor the actions including: rds to ensure all ccording to resident veek for 2 weeks, lowed by random DN or designee will h pressure ulcers to see that the tions are in place. of the audits, be completed re to these etraining and/or The results of the rates (track, trend, ed to the facility		
	recorded this month R22 has had a dec week. Most current issues with swallow 3-day trial of mech	ince admission. No weight n. rease in intake over the past ly the last few days he has had ving. Nursing has ordered a [mechanical soft] soft/pureed r notified DON/SLP/therapy		months, then quarterly this review, system rev education will be imple outcomes. Facility DO will be responsible for r compliance. The facilit be in substantial compl	isions and/or staff mented as by the N and/or designee maintaining		

Facility ID: 29822

If continuation sheet Page 15 of 56

			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245626	B. WING _		02	02/10/2017	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO			
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
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		F 28	32 standard indicated by March	22, 2017.		
	she checked the we clinical tab. RD-A s weighed R22, he di RD-A stated she wa loss until she comp review and noticed RD-A stated every be weighed on We different order for n stated staff obtainin problem and that w order daily weights for residents to help taken. RD-A verifie R22 should have w week as a part of h	eights and vital reports under tated since staff had not id not trigger for a weight loss. as unaware of R22's weight leted the nutritional 30-day R22 was not being weighed. resident in the building was to dnesdays, unless they had a nore frequent weights. RD-A ng weights weekly had been a ras why she would sometimes or weights three times a week o ensure weights would be d this was why she indicated eights taken three times a er 30-day nutritional review. pectation was staff to follow					
	Wednesday. On 2/9/17, 7:40 a.n stated staff try to ge Wednesdays. NA-A	n. nursing assistant (NA)-A et all resident weights on A stated sometimes based orkload weights do not always					

If continuation sheet Page 16 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	On 2/9/17, at 11:32 the DON, stated sh weight loss. The DO the trial mechanical for swallowing evalue weights are recorded section in the comp was a weight chang dietician monitored residents weights in stated she was awa done weekly prior to corporate during an stated she expected completed on weigh computer system. The Weight Monitol dated 2006, include weighed and measu admission. Each re for the first four wee thereafter unless an identified. Resident more often based u nutritional intake, flu medical factors." R67 was admitted to according to the face R67 diagnosis foun identified Alzheimer Dementia without b weakness all dated Order Listing Report	a.m., during an interview with e was not aware of R22's DN stated she was aware of soft and recommendations uation. The DON stated when ed under the weights and vitals buter, there is an alert if there ge. The DON stated the the weights alerts and a the computer. The DON are weights were not being the identification by a udit on 2/2/17. The DON d weekly weights to be at day and entered into the ring - Nursing Services policy ed, "Each resident will be ured within 24 hours of sident will be weighed weekly eks of her/his stay, monthly n adverse trend has been s will be weighed weekly or ipon ongoing assessment of uid retention, and other o the facility on 12/19/16 ce sheet. d on the Diagnosis Report 's Disease, unspecified ehavioral disturbance and 12/19/16. rt dated 12/19/16, identifies ular diet, regular texture, thin	F 282			

If continuation sheet Page 17 of 56

	ND PLAN OF CORRECTION		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
			B. WING			02/10/2017	
NAME OF	NAME OF PROVIDER OR SUPPLIER			ST			
ROCHES	TER REHABILITATIC	N AND LIVING CENTER			00 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 282	R67 to be weighed Care plan dated 1/8 nutrition risk related recent cognitive an BMI (body mass ind monitor intake, offe substitutes for unea ordered, regular. O notify physician, an Wednesday. Weights and Vitals weight on 12/19/16 120.8 pounds. 1/18 weight loss and a s (significant weight I done. Interview on 2/9/17 practical nurse (LP weighed on Wedne order to complete r weight and it is a 3 5 pound difference prompt a message and then nursing is Interview on 2/9/17 assistant (NA)-C st weekly. When ente system they are ab entered weight and is a change.	eport dated 12/19/16, indicates every Wednesday. B/17, identifies potential d to Alzheimer's dementia, d functional decline and low dex). Interventions include: er bedtime snack, offer aten foods, and provide diet as bserve changes in weight, d weigh resident every Summary identified R67 , was 125.6 pounds. 1/11/17, i/17, 115.8 pounds a 9.2 pound 9 percent decline in one month oss). No other weights were , at 7:10 a.m. with licensed N)-A stated everyone gets esday's unless they have an nore often. If we enter a pound difference in a day or a in a week the computer will that indicates a weight loss to notify the provider. , at 7:26 a.m. with nursing ated residents are weighed ring weights into the computer le to see the previously are to alert the nurse if there , at 10:43 a.m. with director of	F 2	282			

If continuation sheet Page 18 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245626 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER REHABILITATION AND LIVING CENTER ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 18 F 282 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 19 of 56

PRINTED: 03/10/2017

		AND HUMAN SERVICES				FORM	: 03/10/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245626	B. WING			02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CENTER			1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 19	F 2	282			
		0:52 a.m. sitting in recliner, nd again heels not floated.					
	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.						
	about the interventi to R61 left foot. LP are completed in th Mondays, feet elev and in bed, no sho	12:06 p.m. LPN-B was asked on in place to promote healing N-B stated dressing changes e evening, bath day are vated on pillow when in chair es, but wears socks liked to keep warm and has lift in ts off feet.					
	reviewed of current	on 2/9/17 at 2:59 p.m. had care plan for R61 and verified positioned every 2 hours and to es.					
	dated 11/2016, doe	Plan Policy and Procedure" sn't address following the care highest level of care for each					

If continuation sheet Page 20 of 56

		AND HUMAN SERVICES			FORM A	03/10/2017 APPROVED 0938-0391		
				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		245626	B. WING		02/1	0/2017		
NAME OF F	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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 314 SS=D	483.25(b)(1) TREA PREVENT/HEAL P	TMENT/SVCS TO RESSURE SORES	F 31	4		3/22/17		
	(b) Skin Integrity -							
	(1) Pressure ulcers comprehensive ass facility must ensure	essment of a resident, the						
	professional standa pressure ulcers and ulcers unless the in	es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and						
	necessary treatmer professional standa healing, prevent inf from developing.	oressure ulcers receives nt and services, consistent with ards of practice, to promote ection and prevent new ulcers NT is not met as evidenced						
	Based on observat review, the facility f services to promote pressure ulcers from	tion, interview, and document ailed to provide pressure ulcer healing and prevent further m developing for 1 of 1 a current heel pressure ulcer.		The resident cited in this tag has b discharged. Licensed nurses will complete a bo audit on all residents currently resid the facility. The IDT will review the	dy ling in			
		ange Minimum Data Set /16 identifies R61's as		audits and reassess all residents w pressure ulcers and/or other skin impairments. The care plans will b	rith e			
	severely impaired a assistance with two	nd requires extensive persons for bed mobility, nal hygiene. Also has two		updated as indicated by the finding new admissions will have thorough audits upon admission and ongoing determined by their assessment an facility protocol. Residents with pot for pressure ulcers will have care p	body g as id/or tential			
	included at risk for	h Target date of 12/6/16, skin breakdown as skin in ragile, R61 has history of		interventions to prevent pressure u as indicated by their individual assessment.				

Facility ID: 29822

If continuation sheet Page 21 of 56

STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
		245626	B. WING				
	PROVIDER OR SUPPLIER	243020	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2017	
		ON AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	DULEVARD NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 314	pressure ulcers bot reposition in chair e (remove all pressur treatments as order Review of R61's rei completed dated 12 from a short stay in infection. The asse heel pressure wour (cm) x 3 cm x 0.2 a x 2 cm. Both pressi stage 2 on each he Review of documer Copy, Primary Care Limited Evaluation on her left great (bi cm and heel measu Orders read: lodosorb/Curas daily Nursing to mor weekly skin update Bed cradle to b patient lying in bed Pillow to be pla extremities to ensu the bed Review of documer Copy, Primary Care Subsequent Visit da on wounds after int reads that the facili heels, but did have Orders read:	the heels. Interventions every two hours, offload re to area) heels, administer rs. turn from hospital assessment 2/16/16 the day she return the hospital for a urinary tract ssment read that she has left and measuring 3 centimeters and a right heel pressure 2 cm ure ulcers were open and a rel. th titled clinical Document e Internal Med Nursing Home , dated 12/6/16 noted wounds g) toe measuring 1.5 cm x 1.2 uring 2 cm diameter. sol dressings to both areas hitor area daily and perform s be used at all times when ced under bilateral lower re heels are not in contact with th titled clinical Document e Internal Med Nursing Home, ated 12/8/16 noted a follow up ervention orders. Document ty using cradle and elevating	F 31	4 The DON or designee will audit resident with pressure ulcers tw for 2 weeks to ensure the press interventions are in place. Base outcome of the audits, education will be completed as indicated b outcome of the audits. Failure t to these protocols will result in re and/or corrective counseling. The results of the audits and cor- rates (track, trend, analysis) will reported to the facility QAPI com- monthly for the first 3 months th quarterly ongoing. Upon this re- system revisions and/or staff ed will be implemented as indicated outcomes. Facility DON and/or will be responsible for maintainin compliance. The facility alleges be in substantial compliance wit standard indicated by March 22,	ce daily ure ulcer d on the n/training y the o adhere etraining mpliance be mittee en view, ucation I by the designee g that it will n the		

If continuation sheet Page 22 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245626 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER REHABILITATION AND LIVING CENTER ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 22 F 314 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 davs 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

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 23 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245626 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER REHABILITATION AND LIVING CENTER ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 23 F 314 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

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 24 of 56

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	. 0938-039 E SURVEY	
		245626	B. WING		02/10/2017		
NAME OF F	PROVIDER OR SUPPLIER	240020		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	02/10/2017	
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 314	Continued From pa	•	F 314	L			
	like heavy blankets in bed to keep blan	on to keep warm and has lift kets off feet.					
F 315 SS=D	stated interventions stage two pressure moisture to wound, use bed cradle and stated that R61 get hours. Reviewed of plan with DON whic 2 hours and offload the dressing chang them. DON stated to completed every da completed by an nu and verified that the completed and the being completed was completed dressing wounds.	on 2/09/17 at 2:59 p.m. s to promote healing for R61's ulcers on heels was to add dressing changes completed, d nothing heavy on feet. DON s repositioned every three-four current pressure ulcer care ch included to reposition every heals. DON was asked about es and who can complete that the dressing are ay in the evening and is to be urse. DON reviewed the ETAR e dressing changes were not ones that were initialed as as by a TMA who can not changes or documentation on D CATHETER, PREVENT UTI, ER	F 315	5		3/22/17	
	continent of bladde receives services a continence unless l	t ensure that resident who is r and bowel on admission nd assistance to maintain his or her clinical condition is hat continence is not possible					
		ith urinary incontinence, based omprehensive assessment, the that-					
		nters the facility without an is not catheterized unless the					

If continuation sheet Page 25 of 56

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED	
		245626	B. WING _		02/	02/10/2017	
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 315	Continued From pa	ge 25	F 31	5			
		ondition demonstrates that					
	indwelling catheter is assessed for rem as possible unless	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary					
	receives appropriat	is incontinent of bladder e treatment and services to t infections and to restore xtent possible.					
	on the resident's cc facility must ensure incontinent of bowe treatment and servi bowel function as p	with fecal incontinence, based omprehensive assessment, the that a resident who is receives appropriate ices to restore as much normal ossible. NT is not met as evidenced					
	Based on observat review, the facility f bladder assessmer corresponding toile improve urinary inc	tion, interview and record ailed to ensure a bowel and at had been completed with a ting schedule to maintain or ontinence after a decline in for 1 of 1 resident (R99) y incontinence.		Resident 99 has a bowel and b assessment in process. An app individualized toileting schedule determined based on assessment Bowel and bladder assessment being completed for all resident	oropriate will be ent. s are s residing		
	identifies unspecifie disturbance (9/14/1	ng cerebral infarction affecting		here who are incontinent. Toile schedules will be put in place for residents based on results of the assessments. All admissions we bowel and bladder assessment completed. Individualized toilet schedules and/or other intervent be placed on the kardex and car indicated.	r those e vill have s ing tions will		

Facility ID: 29822

If continuation sheet Page 26 of 56

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	IPL		NO. 0938-0	
	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		245626	B. WING _			02/10/2017	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIC	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE	
F 315	Continued From pa	ge 26	F 31	5			
		nent (CAA) dated 9/19/16,		•			
		e receiving treatment for			The DON will implement measures to		
		the highest practical			ensure this deficient practice does not		
		9 was identified as being able			recur including: all nurses will be		
		n clothing in preparation, able			educated on continence management		
		ition self, able to void into the se toilet paper to cleanse self,			including the completion of bowel and bladder assessments and determining		
		let and able to adjust clothing			individualized toileting schedules and		
		AA summary identifies R99			interventions needed based on the		
		inent of urine but less than 7×10^{-1}			assessment results. Interventions will I	be	
	a week.				placed on the kardex and care plan as		
					indicated; all CNAs will be educated on	1	
	R99's admission M			completion of bowel and bladder			
		eted on 9/15/16, identifies inent. Quarterly MDS review			assessments and the importance of following the toileting schedule in the		
		entifies R99 to be frequently			kardex and/or care plan and notifying		
		vere impaired cognition.			nurses of any changes in the residents bowel and bladder routines.	;	
		/22/16, identifies R99 to have					
		urine. Interventions include:			The DON or designee will monitor the		
		urge to void, offer to take to			corrective actions to ensure the		
		or resident/when repositioning			effectiveness of these actions including		
	every 2 nours. Assi	st of 1 for toileting needs.			auditing every new admission's bowel a bladder assessment and individual	ano	
	Reviewed progress	notes from 9/8/16 to			toileting schedule for 2 weeks to see th	nat	
		on of urinary incontinence.			the assessments are complete and		
		notes from 12/1/16 to 2/8/17,			toileting schedule is being followed,		
	no mention or urina	ary incontinence.			followed by random weekly audits. Bas		
	Deviewed				on the outcome of the audits, education	n	
		ents from admission on			will be completed timely. Failure to		
	completed.	nd bladder assessment			adhere to these protocols will result in re-training and/or corrective counseling	r	
					The results of the audits and compliand		
	Observation on 2/9	/17, at 7:24 a.m. with nursing			rates (track, trend, analysis) will be	-	
	assistant (NA)-C. F	199 was toileted but was			reported to the facility QAPI Committee	e	
		C stated R99 is sometimes			monthly for the first 3 months, then		
		en needing to use the			quarterly ongoing. Based on the analys		
		r times isn't able to.			of the data, system revisions and/or sta	att	
	Sometimes R99 is	able to use the toilet and other	1		education will be implemented as		

Facility ID: 29822

If continuation sheet Page 27 of 56

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		IG	· · /	IPLETED	
		245626	B. WING _		02/	02/10/2017	
NAME OF F	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZI			
ROCHES	TER REHABILITATIO	ON AND LIVING CENTER		1900 BALLINGTON BOULEVARE ROCHESTER, MN 55901) NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
F 315	Continued From pa	age 27	F 31	5			
	assisted to the toile Interview on 2/9/17	, at 8:17 a.m. with director of		indicated. Facility DON of be responsible for mainta compliance. The facility be in substantial complia	aining alleges that it will nce with the		
nu ase qu res the res inc DC co ME the ver	assessments are c quarterly. DON star responsible for con the aides document resident needs and incontinent or conti DON stated that in complete the MDS MDS coordinator is the care plans base	ed bowel and bladder completed on admission and ted the floor nurses are inpleting the assessment and at how much assistance the d whether the resident was inent prior to using the toilet. formation is what is used to assessments. DON stated the s responsible for completing ed off of assessments. DON no bowel and bladder eted for R99.		standard indicated by Ma	ırch 22, 2017.		
	assistant (NA)-D st use the bathroom a say when she need	7, at 8:13 a.m. with nursing cated R99 is a one assist to and every once in a while can ds to use the bathroom. NA-D 199 assistance with the 3 hours.					
	practical nurse (LP tracking is complet aide tells nursing th	7, at 8:17 a.m. with licensed N)-C stated bowel and bladder ed on admission and also if an nat a resident has had a ence tracking can be initiated.					
	coordinator when a completed for urina nursing aides docu charting system) w or incontinent even to the bathroom. M	7, at 8:39 a.m. with MDS asked how the MDS is ary continence stated the ment in point click care (online hether the resident is continent y time the resident is assisted IDS coordinator stated that she nation to complete the MDS.					

If continuation sheet Page 28 of 56

		AND HUMAN SERVICES				FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING			02 / ⁻	10/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	MDS coordinator st and bladder assess completed for the re- knew the informatic accurate, MDS coo- MDS is completed of also by reading the coordinator stated st the residents when bladder section of the stated the care plan unable to answer we care plan could be of and bladder assess if there is missing in delegated to do the coordinator stated the MDS and care point not verify they were not a bowel and bla for R99 that could we schedule was suffic incontinence. Interview on 2/10/11 stated the MDS sho and clarifications we couldn't confirm the decline in urinary in and bladder assess for R99. DON state bladder assessment have based our car DON stated with RS incontinence she we and bladder assess	ated she will look at the bowel sments if one has been esident. When asked how she on the aides documented was rdinator continued to state the off of the aides charting and nurses notes. MDS she usually doesn't interview completing the bowel and he MDS. MDS coordinator hs are a group effort. MDS was then asked how an accurate completed without a bowel sment. MDS coordinator stated nformation the floor nurses are assessments. MDS that she would like to think that plan are both correct but could e correct because there was adder assessment completed verify that a 2 hour toileting cient in preventing further 7, at 8:49 a.m. with DON buld be based on assessments ith staff. DON stated she e MDS is accurate for the continence because a bowel ament had not been completed d there should have been a nt completed that we would re plan interventions off of. 99's decline in urinary ould have expected a bowel ament be completed and the preflect the change and to	F3	315			

If continuation sheet Page 29 of 56

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
		245626	B. WING		02/10/2017
NAME OF F	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	
ROCHES	TER REHABILITATIC	ON AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
F 315	Continued From pa	-	F 31	5	
		, Bowel and Bladder 3-Day 010, identifies a bowel and			
		will be completed on all new			
		issions, annual and quarterly			
		ontinence. This 72 hour data be used to assist in determining			
		toileting schedule to maintain			
		nce levels. Policy identifies if			
		en incontinent most of the every two hours, change			
		e and one-half hours. If more			
	-	ntinue Bowel and Bladder			
F 325		ileting plan can be established. INTAIN NUTRITION STATUS	F 32	5	3/22/17
SS=D	UNLESS UNAVOID		1 02		0,22,17
		tric and gastrostomy tubes,			
		endoscopic gastrostomy and scopic jejunostomy, and			
	enteral fluids). Base				
	comprehensive ass ensure that a resid	sessment, the facility must ent-			
	status, such as usu body weight range the resident's clinic	otable parameters of nutritional ual body weight or desirable and electrolyte balance, unless al condition demonstrates that or resident preferences	i		
	nutritional problem orders a therapeuti	rapeutic diet when there is a and the health care provider c diet. NT is not met as evidenced			
			1		
	by:				

If continuation sheet Page 30 of 56

TATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245626			0.2/2	0/2017
NAME OF	PROVIDER OR SUPPLIER	240020		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2017
-		N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 325	monitor weights to p of 3 residents (R22 for nutritional status Findings Include: R22's admission M 12-13-16, identified disease and demer one staff member for impaired cognition. reveiw. Review of R22's we documented as follo 12/2/16: 179 12/14/16: 180 12/21/16: 168 12/28/16: 168 R22 had an 11 lbs. since admission; th a severe weight los Registered Dietician 12/15/16, included, accompanied R22 of be a poor historian most questions. [FN teeth with no trouble can feed himself af and has not had an special diet followed concerns identified. The initial dietary/m 12/19/16, included, textures, thin liquids	 brevent sever weight loss for 2 , R67) who had been reviewed is. nimum Data Set (MDS) dated diagnoses of Alzheimer's taia. R22 needed assistance of or eating and had severely This was a closed record bights in pounds was bows: weight loss in the first 16 days is was a 6 % weight loss and s. n progress note dated "[family member (FM)-A] during my visit. He appears to as he was unable to answer <i>A</i>-A] states he has his own a chewing or swallowing. He ter set up. He is a good eater y recent weight loss. No d at home. No immediate 	F 32	 Weights: Facility staff will obtain for all residents currently residin Nursing and the Registered Die review weights weekly ongoing weight changes and report then attending physician/NP/PA. All admissions will have weights ob within the first 3 days. The DON will implement measure ensure this deficient practice do recur including: all nurses will be educated on ensuring weights a obtained according to individual care plan and/or facility protoco licensed nurse will notify the die providers of any significant weig changes. All CNAs will be educ accurate and timely weights as by the licensed nurse. The DON or designee will mon corrective actions to ensure the effectiveness of these actions in auditing all weight records to en- weights are obtained according care plan 3 times per week for t weekly for 3 weeks, followed by weekly audits. The facility alleg will be in substantial compliance standard indicated by March 22 	g here. titian will to identify to the new stained res to es not e resident's . The titian and ht ated on directed tor the sure all to resident wo weeks, random es that it e with the	

If continuation sheet Page 31 of 56

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245626	B. WING		02/10/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 325	Summary: R22 adm following a hospital urinary tract infection medical history] of a multiple strokes. Hi is unable reply to q [related to] cognitive weight, alert with per nourished. He eats room or his room. He giver. He has no tro and eats well with in daily. Fluid intake ~ records. Weight ha with Regular diet weights weekly" Registered Dietitiar included, "Diet: Reg liquids, Intake: decl average at each me Fluids: Declined to 179# [pounds], last 167.8# -11# (6%) s recorded this month R22 has had a dec week. Most current issues with swallow 3-day trial of mech textures. This write [director of nursing/ a screening of his s recommendations. admission noted. R	ance Setup help only nitted for rehab [rehabilitation] stay for a hip fracture and on. He has a PMH [personal Alzheimer's dementia and s [FM-A] is his historian as he uestions appropriately r/t e status. He appears normal eriods of somnolence and well with assistance in the dining His [FM-A] is his primary care buble chewing or swallowing ntake of >75% each meal 1500 ml/day per nursing task s remained stableContinue Monitor intake/fluids daily and n 30 Day review dated 1/18/17, gular, Regular textures, thin lined to ~ [around] 50% on eal daily x 1 week. ~1100 ml .Weights: Admit wt. recorded wt [weight]12/21/16 ince admission. No weight h. rease in intake over the past dy the last few days he has had <i>r</i> ing. Nursing has ordered a [mechanical soft] soft/pureed r notified DON/SLP/therapy /speech language therapist] for swallowing ability and Weight loss of 6% since accommend weights be done 3 en decline in intake for closer ng up for SLP				

If continuation sheet Page 32 of 56

		AND HUMAN SERVICES			FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING		02/ [.]	10/2017
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	TER REHABILITATIO	ON AND LIVING CENTER		900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	included, "Potential dementia AEB [as e somnolence, forget Interventions includ Wednesday." On 2/8/17, at 2:36 p (RD)-A stated when loss, she expected consult for weight lo to be completed ev- she checked the we clinical tab. RD-A st weighed R22, he di RD-A stated she wa loss until she comp review and noticed RD-A stated every p be weighed on Wea different order for m stated staff obtainin problem and that w order daily weights for residents to help taken. RD-A verified R22 should have w week as a part of h RD-A stated her ex the care plan and w Wednesday. On 2/9/17 at 7:40 a stated staff try to ge Wednesdays. NA-A upon acuity and wo get done.	re plan printed 2/9/17, I nutrition risk related to evidenced by] periods of fulness and confusion." ded: "Weigh resident every p.m., registered dietician n a resident displayed weight staff to alert her to complete a oss. RD-A stated weights are ery Wednesday and stated eights and vital reports under tated since staff had not id not trigger for a weight loss. as unaware of R22's weight bleted the nutritional 30-day R22 was not being weighed. resident in the building was to dnesdays, unless they had a nore frequent weights. RD-A ng weights weekly had been a vas why she would sometimes or weights three times a week o ensure weights would be d this was why she indicated reights taken three times a er 30-day nutritional review. pectation was staff to follow veigh residents on a.m. nursing assistant (NA)-A et all resident weights on A stated sometimes based orkload weights do not always	F 325	DEFICIENCY)		
	On 2/9/17, at 11:32	a.m., stated she was not				

Facility ID: 29822

If continuation sheet Page 33 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/10/2017 APPROVED . 0938-0391
STATEMENT OF DEFICIENC AND PLAN OF CORRECTIC	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245626	B. WING			02/10/2017	
NAME OF PROVIDER OR	SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER REHAI	BILITATIO	N AND LIVING CENTER			1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
PREFIX (EACH I	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
was aware recommen DON state weights an is an alert stated the and reside stated she done week corporate stated she completed computer to follow th The Weigh dated 2000 weighed a admission for the first thereafter identified. more ofter nutritional medical fa R67 diagn identified A Dementia weakness Order Listi R67 receiv fluid consis	22's wei of the tr dations f d when w divitals s if there w dietician nts weigl was awa dy prior tr during ar expecte on weigl system. he care p nt Monito 5, include nd meas . Each re t four wei unless ar Resident based u intake, fli ctors." osis foun Alzheimel without b all dated ng Repo red a reg stency, for mary Re	ge 33 ght loss. The DON stated she ial for mechanical soft and or swallowing evaluation. The veights are recorded under the section in the computer, there vas a weight change. The DON monitored the weights alerts its in the computer. The DON are weights were not being the identification by audit on 2/2/17. The DON d weekly weights to be it day and entered into the The DON stated expected staff an for weekly weights. ring - Nursing Services policy ed, "Each resident will be ured within 24 hours of sident will be weighed weekly ets of her/his stay, monthly in adverse trend has been is will be weighed weekly or ipon ongoing assessment of uid retention, and other d on the Diagnosis Report 's Disease, unspecified ehavioral disturbance and 12/19/16 (day of admission). rt dated 12/19/16, identifies ular diet, regular texture, thin or General diet. Boprt dated 12/19/16, indicates every Wednesday. B/17, identifies potential	F 3	325			

If continuation sheet Page 34 of 56

TATEMENT	OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		245626	B. WING		02	02/10/2017	
	PROVIDER OR SUPPLIER	ON AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIF 1900 BALLINGTON BOULEVARD ROCHESTER, MN 55901	CODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
F 325	nutrition risk related recent cognitive an BMI (body mass in monitor intake, offe substitutes for unea- ordered, regular. C notify physician, an Wednesday. Medication Adminis December 2016, ic 12/21/16 and 12/28 identifies R67 was and 1/18/17. Howe Weights and Vitals weight on 12/19/16 120.8 pounds. 1/18 loss in one month weight loss. No oth Meal Intake and FI 12/19/16 to 1/18/17 consumed 76-1009 Nutritional Summa dated 12/27/16, ide diet with think liquid nutritional supplem having an admissio of 19.7. Summary i and well nourished weight loss and ide 130 pounds. Sumn regular diet, monito weekly. Progress note date	d to Alzheimer's dementia, id functional decline and low dex). Interventions include: er bedtime snack, offer aten foods, and provide diet as observe changes in weight, id weigh resident every stration Record (MAR) dated dentifies R67 was weighted on 8/16. January 2017, MAR weighed on 1/4/17, 1/11/17 ever, the Summary identifies R67 6, was 125.6 pounds. 1/11/17, 8/17, 115.8 pounds a 9.2 pound or 9 percent which is a severe her weights identified. uids forms reviewed from 7, identifies R67 consistently	F3	325			

If continuation sheet Page 35 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245626 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER REHABILITATION AND LIVING CENTER ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 36 of 56

	-	AND HUMAN SERVICES				FORM	: 03/10/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	· · ·	E SURVEY IPLETED
		245626	B. WING			02/	10/2017
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		1900 I	ET ADDRESS, CITY, STATE, ZIP CODE BALLINGTON BOULEVARD NW HESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	K	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325 F 329 SS=E	5 pound difference prompt a message and then nursing is Interview on 2/9/17 assistant (NA)-C st into the computer s previously entered nurse if there is a c Interview on 2/9/17 nursing (DON) state completed at least otherwise. DON state is identified the inner meets to try and de weight loss. DON state interventions. DON state interventions. DON state completed as order DON stated she was problem within the completed as order Facility provided tw Assessment Policy "Food and Nutrition addressed obtainin 483.45(d) DRUG R UNNECESSARY D (d) Unnecessary Dr drug regimen must drugs. An unneces used	in a week the computer will that indicates a weight loss to notify the provider. , at 7:26 a.m. with nursing ated when entering weights system they are able to see the weight and are to alert the hange. , at 10:43 a.m. with director of ed weights are to be once weekly unless ordered ated when a decline in weight er disciplinary team (IDT) termine the cause of the tated the dietician talks with ermine appropriate verified R67 had only 3 ts during her stay in the facility. as aware weight loss was a facility, including weights being red. o policies, "Nutritional and Procedure" undated, and " dated 11/2016. Neither policy g and monitoring weights. EGIMEN IS FREE FROM	F 3				3/22/17

Facility ID: 29822

If continuation sheet Page 37 of 56

		AND HUMAN SERVICES			FC	ORM A	03/10/2017 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		245626	B. WING _			02/10/2017		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	TER REHABILITATIO	N AND LIVING CENTER		-	000 BALLINGTON BOULEVARD NW OCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 pa	ge 37	F 32	29				
	(2) For excessive d	uration; or						
	(3) Without adequa	te monitoring; or						
	(4) Without adequa	te indications for its use; or						
		of adverse consequences dose should be reduced or						
	paragraphs (d)(1) the This REQUIREMENT	ns of the reasons stated in hrough (5) of this section. NT is not met as evidenced						
	review facility failed were completed for	tion, interview and record to ensure AIMS assessments 4 of 5 residents (R189, R103, to ensure behavior and mood			Resident 87 had an AIMS assessment completed. All other residents noted a discharged.			
	monitoring was con (R103, R173): faile sleep assesments residents (R189, R	npleted for 2 of 5 residents d to ensure comprehensive were completed for 2 of 5 173): and failed to document inistration of as needed (PRN)			AIMS assessments will be completed f all residents on antipsychotic medication All residents with psychotropic medications will be monitored for behat and mood. All residents with medication	ons. vior		
	pain medications an non-pharmacologic prior to the adminis	nd failed to document al interventions attempted tration of PRN pain f 5 residents (R189, R173)			for sleep will have sleep assessments. residents who receive PRN pain medications will have a documented reason for administration as well as non-pharmacological interventions			
	Findings include:				attempted prior to administration each time, as well as documentation to show effectiveness of the intervention.	v		
	LACK OF AIMS AS	SESSMENT:						
	the facility admission				The DON will implement measures to ensure this deficient practice does not recur including: all nurses will be educated regarding AIMS assessments	s,		
		rders dated 1/24/17 included, 5 mg [milligrams], give 1 tablet			behavior and mood monitoring, sleep assessments and documenting reason	1		

Facility ID: 29822

If continuation sheet Page 38 of 56

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				NG _			
		245626	B. WING _			02/10/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	ON AND LIVING CENTER			000 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 329	Continued From pa	age 38	F 32	29			
	by mouth one time augmentation." Review of Medicat	a day for mood			and non-pharmacological intervention prior to each PRN pain medication. Members of IDT have been educated the procedure for completing behave and mood reviews for residents reco	ed on rior	
		ry 2017 to February 2017, eived scheduled doses of ered.			psychotropic medications and their The DON or designee will monitor th	role.	
	R189's assessments were reviewed since admission on 1/24/17, and revealed an AIMS assessment had not been completed for R189.				corrective actions to ensure the effectiveness of these actions includ auditing all resident charts that perta antipsychotic medications for AIMS	ding:	
	1/24/17 to 2/8/17 a	otes were reviewed from nd there was no an AIMS assessment being			assessments, psychotropic medicat for behavior and mood documentati sleep medications for sleep assess and PRN pain medications for reaso non-pharmacologic interventions	ion, ments	
	nursing (DON) stat not completed for I four of a resident's	1:32 p.m. the director of ed an AIMS assessment was R189. The DON stated by day stay she expected an AIMS			documentation according to facility protocol for 2 weeks followed by ran weekly audits. Upon completion of audits, education will be completed	these timely	
	the AIMS assessm completed by the r there was not a nu The DON stated and	completed. The DON stated ent was assigned to be nurse manger and currently rse manager on R189's unit. nother nurse should have S assessment for R189.			based on outcome of the audits. Fa to adhere to these protocols will res re-training and/or corrective counse The results of the audits and compli rates (track, trend, analysis) will be reported to the facility QAPI Commi- monthly for the first 3 months. Upon	ult in ling. iance ttee	
	LACK OF SLEEP	ASSESSMENT:			review, system revisions and/or staf education will be implemented if ind via a prescribed corrective action pla	licated	
	the facility admission Minimum Data Ass indicated R189 wa	d to the facility on 1/24/17 per on record. R189'S admission essment dated 1/30/17, s cognitively intact, and had asleep, staying asleep, or			Facility DON will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indica March 22, 2017.	у	

Facility ID: 29822

If continuation sheet Page 39 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245626	B. WING	i		02/	10/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	by mouth one time	MG [milligrams], give 4 tablet a day for sleep."	F	329			
	(MAR) from Januar	on Administration Record y 2017 to February 2017, eived scheduled doses of ed.					
	admission on 1/24/	ep assessment had not been					
	1/24/17 to 2/8/17 ar	comprehensive sleep					
	nursing (DON) state not completed for F resident was on adu should be documen to be used to comp	:32 p.m. the director of ed a sleep assessment was 189. The DON stated when a mitted with melatonin there ated hours of sleep completed lete a comprehensive sleep ermine the effectiveness of the					
	comprehensive slee	0:45 a.m. the DON stated ep assessments were not r any residents in the building					
	FOR AN AS NEED	ENTED REASON FOR USE ED PAIN MEDICATION AND ARMACOLOGICAL BEING ATTEMPTED AND					

If continuation sheet Page 40 of 56

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245626	B. WING			02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BOCHES	TER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW		
nooneo				F	ROCHESTER, MN 55901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
F 329	Continued From pa	ao 40	- 	329			
. 020	DOCUMENTED PF	-	1.0	523			
		OF A AN AS NEEDED PAIN					
	MEDICATION:						
		to the facility on 1/24/17 per					
		on record. R189'S admission essment dated 1/30/17,					
	indicated R189 was						
	R189's medication	orders found on the					
	medication adminis	tration records (MAR) for					
		Eebruary 2017 included PRN					
	orders for the follow	ving pain medications:					
		ablet 500 MG [milligrams], Give very 6 hours. Order date					
	1/24/17. "						
		IG (TraMADol HCI) *Narcotic*					
	date ordered 1/24/1						
	for pain."	outh every 6 hours as needed					
		IG (TraMADol HCl) *Narcotic*					
	date ordered 2/1/17						
	for pain."	outh every 4 hours as needed					
		Tablet C MO there she's and a					
		Tablet 5 MG *Narcotic* order 1 tablet by mouth every 4					
		r pain rated greater than 3 or					
	comfort level AND (Give 2 tablet by mouth every 4					
	hours as needed fo	r pain rated greater than 6					
	Review of the Janu	ary 2017 MAR revealed:					
		Vacetaminophen 13 times					
		/17. The facility did not on for use 13 of the 13 times					

If continuation sheet Page 41 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING	à		02 / ⁻	10/2017
NAME OF	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CENTER			1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	facility failed to docu interventions attemp acetaminophen bein R189 received PRN times from 1/24/17 document the reason medication was addr facility failed to docu interventions attemp oxycodone being ad R189 received PRN times from 1/24/17 document the reason medication was addr facility failed to docu interventions attemp oxycodone being ad R189 received PRN 1/24/17 to 2/1/17. T the reason for use 2 medication was addr facility failed to docu interventions attemp oxycodone being ad R189 received PRN 1/24/17 to 2/1/17. T the reason for use 2 medication was addr facility failed to docu interventions attemp being administered. Review of the Febru R189 received PRN 2/1/17 to 2/8/17. Th reason for use 1 of was administered. I document non-phar	administered. In addition, the ument non-pharmacological pted prior to the PRN ng administered. Noxycodone, 5 MG, 1 tablet, 6 to 2/1/17. The facility did not on for use 6 of the 6 times the ministered. In addition, the ument non-pharmacological pted prior to the PRN dministered. Noxycodone, 5 MG, 2 tablet, 5 to 2/1/17. The facility did not on for use 5 of the 5 times the ministered. In addition, the ument non-pharmacological pted prior to the PRN dministered. Nature the the the ministered of the 20 times from the facility did not document 20 of the 20 times the ministered. In addition, the ument non-pharmacological pted prior to the PRN tramadol	F	329			

If continuation sheet Page 42 of 56

		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY
		245626	B. WING			02/	/10/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From pa administered.	.ge 42	F 3	29			
	times from 2/1/17 to document the reaso medication was adr facility failed to doc	N oxycodone, 5 MG, 1 tablet, 2 o 2/8/17. The facility did not on for use 2 of the 2 times the ministered. In addition, the ument non-pharmacological pted prior to the PRN dministered.					
	times from 2/1/17 to document the reaso medication was adr facility failed to doc	N oxycodone, 5 MG, 2 tablet, 2 o 2/8/17. The facility did not on for use 2 of the 2 times the ministered. In addition, the ument non-pharmacological pted prior to the PRN dministered.					
	every 6 hours, 2 tim facility did not docu the 2 times the med addition, the facility non-pharmacologic	N tramadol 50 MG, 1 tablet, nes from 2/1/17 to 2/8/17. The ment the reason for use 2 of dication was administered. In failed to document cal interventions attempted amadol being administered.					
	every 4 hours, 18 ti The facility did not of 18 of the 18 times t administered. In ad document non-phar	N tramadol 50 MG, 1 tablet, mes from 2/1/17 to 2/8/17. document the reason for use the medication was Idition, the facility failed to rmacological interventions he PRN tramadol being					
	[complaints of] pain	cluded, PAIN: Has c/o n to right knee, right arm and ort pain verbally. Did have					

If continuation sheet Page 43 of 56

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION		E SURVEY PLETED	
		245626	B. WING			02 / ⁻	10/2017	
	PROVIDER OR SUPPLIER	ON AND LIVING CENTER		19	TREET ADDRESS, CITY, STATE, ZIP CODE 900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 329	dx [diagnoses] of M affect perception of "give pain medication non-medication inter repositioning, ice/w effectiveness of any with CNP/MD if cor- relief not effective." R189 was observed during a medication a prn pain medication a gran pain medication a prn pain medication a staff and requested felt she needed to h had stated she had from staff to help w she would ask for a use one and staff w R189 stated staff d non-pharmacologic management when medication. On 2/8/17 at 9:11 a stated staff should non-pharmacologic administration of PI stated non-pharma should be documer RN-F stated knew f	arthroplasty. Has arthritis. Has Major depression that could pain. Interventions included, ons as indicated. ok to try erventions such as: arm packs. observe y intervention tried. consult neerns/present plan for pain d on 2/7/17, at 6:25 p.m., R189 n pass observation, to receive on. The nurse did not offer logical interventions prior to of the pain medication. wed on 2/08/2017, at 1:29 p.m., ommunicated her pain levels to I the PRN pain medication she help her with her pain. R189 just requested an icepack ith shoulder pain. R189 stated an icepack when she wanted to yould get an icepack for her. id not offer her cal options for pain she requested a prn pain , registered nurse (RN)-F offer and try cal interventions prior to RN pain medications. RN-F cological interventions tried ned in the medical record. this was an area of concern ion pass and completing	F3	329				

If continuation sheet Page 44 of 56

		AND HUMAN SERVICES				FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING			02/	10/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	ON AND LIVING CENTER			900 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	On 2/09/2017, at 11 nursing (DON) state with the non-pharm to the administratio The DON stated up with residents about interventions that h so we have their pr this assessment was stated a pain care p included non-pharm DON stated she ex non-pharmacologic what was tried prior PRN medication and document the rease was administered. LACK OF AIMS AS MONITORING OF R103 was admitted R103's diagnosis for dated 12/8/16, iden R103 medication on Summary Report ic one tablet by mouth depression with a s Seroquel 25 mg giv time a day for mood Orders for monitoring identifies behavior	1:32 a.m. the director of ed she expected staff start nacological interventions prior on of a PRN pain medication. Soon admission nursing visited at non-pharmacological ave worked for them for pain, references. The DON verified as completed for R189 and blan was developed that nacological interventions. The pected staff to offer cal interventions, document r to the administration of the nd stated she expected staff to on why PRN pain medication SESSMENT AND BEHAVIOR/MOOD: It to the facility on 12/8/16. Sound on the Admission Record diffies anxiety. rders found on the Order dentifies Lexapro 10 mg give n one time a day for start date of 12/8/16, and ve 0.25 tablet by mouth one d/insomnia dated 12/8/17. ng of anti-depressant and ications were entered on	F3	329			

	H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 03/10/2017 APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
	245626	B. WING			02/	10/2017
NAME OF PROVIDER OR SUPPLIEF	1	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER REHABILITATI	ON AND LIVING CENTER			900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329 Continued From p	age 45	F:	329			
on psychotropic m antipsychotic med to be for mood (re agitation/confusio seizure as husbar is result of seizure records, dose had up to 25 mg daily Was in ER in earli arrived her on an daily). Also unclea Hint of diagnosis of documentation ab 14". Treatment Admini February 2017, id effects of anti-dep 2/8/17. January 20 monitor for any sid Medication Admin February 2017, id Lexapro 10 mg da 0.25 tablet daily. M side effects of anti- monitoring of beh 2/8/17. MAR for J any monitoring of Progress note datt have a PHQ-9 sco moderate depress 12/15/16, identifie indicates mild dep	2/28/16, identifies R103 to be nedications. "Arrived here on lications (Seroquel). It appears ident history of n) and anxiety. It may help nd and record hint that insomnia es. Per hospital admission I been usually 12.5 mg daily and right before hospital admission. er November for anxiety. Also antidepressant (Lexapro 10 mg ar how long has been on this. of depression but no recent out it. Initial PHQ-9 score was stration Record (TAR) dated entifies to monitor for side ressant use with a start date of 017, TAR doesn't identify to de-effects of medications. istration Record (MAR) dated entifies R103 to have received ally and Seroquel 25 mg give MAR identifies monitoring for i-psychotic medications and aviors with a start date of anuary 2017, does not identify anti-psychotic behaviors. ed 12/8/16, identifies R103 to ore of 12 which indicates sion. Progress note dated s a PHQ-9 score of 5 which oression. Progress note dated a staff interview was completed					

Facility ID: 29822

If continuation sheet Page 46 of 56

STATEMENT	OF DEFICIENCIES DF CORRECTION	KANNER CALCULAR CALCULAR AND CALULAR AND CALCULAR AND CALCULAR AND CALCULAR AND CAL		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245626	B. WING _		02	/10/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIC	ON AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 329	completed which in Review of progress 2/9/17, identifies no behaviors or mood Review of assessm assessment had no Interview on 2/9/17 practical nurse (LP are directed toward gets angry and can agitated. LPN-A sta these behaviors in document every tin R103's behaviors v are why R103 ente Interview on 2/9/17 nursing (DON) stat to be an AIMS asse any resident receiv verified an AIMS asse completed for R100 managers are resp assessments. Interview on 2/9/17 assistant (NA)-A st have agitation and have conversations stated R103 has ag and others and car stated she is able t behaviors in point of but isn't able to exp	, identifies a staff interview was idicated no depression. Is notes from 12/8/16 through o mention of R103 having any concerns. Interst indicated an AIMS of been completed for R103. If, at 7:29 a.m. with licensed N)-A stated R103's behaviors as her husband and that she o be mean and also gets very ated that he had documented the past but stated he doesn't ne it happens. LPN-A stated veren't a new issue and they	F 32	29		

		AND HUMAN SERVICES				FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING _			02 / [.]	10/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			000 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa nurse.	.ge 47	F 3	29			
	manager (RN)-A sta any AIMS assessm unaware that she w the assessment and list or isn't alerted to required to complete Interview on 2/9/17, verified there was n monitoring docume completed for R103 is entered along wit nurses to monitor fo behaviors or mood, DON stated nurses	, at 1:58 p.m. with DON to behavior or mood entation that had been 3. DON stated usually an order th the medication to alert the or side effects and specific , but this was not completed. a should be documenting er they are occurring and ng mood to ensure					
	Gradual Dose Redu Abnormal Involunta will be performed o	noactive Medication use and uction" dated 8/2013, identifies ary Movement Scale (AIMS) n residents receiving cations to screen for tardive months.					
	dated 8/2013, ident will be monitored ev care team are to co mood/behavior obs click care and point systems) when a re behaviors. Commun and or social worke	/Behavior/Sleep Observation" ifies target mood/behaviors very shift. All members of the omplete the daily servation tool/ PCC POC (point t of care, online charting esident exhibits mood or nication to the licensed nurse er as appropriate. The licensed w documentation of the daily					

If continuation sheet Page 48 of 56

STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DAT	. 0938-039 E SURVEY IPLETED
	PROVIDER OR SUPPLIER	245626	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2017
		N AND LIVING CENTER		19	OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	completion and the documentation. A s mood/behavior/slee the monthly chartin of the interventions the resident's respond LACK OF AIMS AS R87's diagnosis fou- identifies Delusional hallucinations dated R87's medication o Summary Report d Seroquel 25 mg giv for behaviors, agita delusional/paranoid dose PRN when un Seroquel 25 mg giv times a day for beh outbursts, delusion Review of Medicatii (MAR) from Decem- indicates R87 recein needed) doses of S Care plan dated 1/- problem due to yell harm to wife. Has a Disrupts roommate staff at times also. with delusions. Hist Bonnet syndrome.	ervation/PCC POC for need for any additional ummary of the ep is to be completed during g cycle to include a summary used as well as a summary of onse. SESSMENT FOR R87: and on the Diagnosis Report al Disorders and Visual d 10/28/16. rders found on the Order ated 2/9/17, identifies /e 1 tablet by mouth as needed ted persistent d outbursts may give additional hable to redirect behaviors. /e one tablet by mouth two aviors: persistent paranoid	F 3	329			

		AND HUMAN SERVICES				FORM	03/10/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245626	B. WING _			02 / [.]	10/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CENTER			000 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa being completed. Review of assessm assessment had no Interview on 2/9/17, nursing (DON) state to be an AIMS asse any resident receivi verified an AIMS asse completed for R87. managers are resp assessments. Interview on 2/9/17, manager (RN)-A sta any AIMS assessm unaware that she w the assessment and list or isn't alerted to required to complet Policy titled, "Psych Gradual Dose Redu Abnormal Involunta will be performed o antipsychotic medic dyskinesia every 6 LACK OF SLEEP A R173 admitted to th 12/26/17 and readm facility admission re Minimum Date Asse R173 was cognitive falling asleep, stayin	ge 49 ents identified AIMS of been completed for R87. , at 8:40 a.m. with director of ed by day 4 there is supposed essment that is completed for ing an antipsychotic. DON esessment had not been DON stated the nurse onsible for completing the , at 12:15 p.m. with the nurse ated that she hadn't completed ents. RN- stated she was vas responsible for completing d stated she doesn't have a p what assessments she is re.	F 32	29			
	much. R173's physician or	rders dated 1/13/17 through					

If continuation sheet Page 50 of 56

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245626	B. WING			02/10/2017	
	PROVIDER OR SUPPLIER	ON AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 329	2/04/17 and reorde "Trazodone Tablet in in the evening for s after 1 hour AND G needed for sleep M awake after 1 hour Review of Medicati (MAR) from Januar indicated R173 rec trazodone nightly a 2/8/17. R173's assessmen admission on 1/12/ comprehensive sle completed for R173 R173's progress no 1/13/17 to 2/8/17 a documentation of a assessment being LACK OF AIMS AS MONITORING OF R173's diagnosis for dated 1/13/17, iden disorder. R173 medication o Summary Report in give one tablet by r depression, and Se by mouth twice dail times daily for depr 1/13/17. Orders fo	red on 2/4/17 included, 50 MG Give 1 tablet by mouth leep may repeat x1 if needed ive 1 tablet by mouth as lay take repeat dose if still " on Administration Record ty 2017 to February 2017, eived scheduled doses of long with prn dose given on ts were reviewed since 17, and revealed a ep assessment had not been 3. otes were reviewed from nd there was no a comprehensive sleep completed. SESSMENT AND BEHAVIOR/MOOD: ound on the Admission Record tifies severe major depressive rders found on the Order lentifies: mirtazapine 15 mg nouth one time a day for eroquel 25 mg give 0.25 tablet y , and Zoloft 100 mg two ession all with start dates of r monitoring of anti-depressant medications were entered on	F	329	29		

Facility ID: 29822

If continuation sheet Page 51 of 56

DEPARTMENT OF HEALTH A					FORM	03/10/2017 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245626	B. WING _			02/*	10/2017
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER REHABILITATION	AND LIVING CENTER			00 BALLINGTON BOULEVARD NW DCHESTER, MN 55901		
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329 Continued From pag	je 51	F 32	29			
Behavior monitoring identifies behavior mother behavior/mood Care plan dated 1/20 psychotropic medica has diagnosis of dep several psychiatric h antidepressant and a Treatment Administr February 2017, ident effects of anti-depres 2/8/17. January 2017 monitor for any side- Medication Administr February 2017, ident mirtazapine 15 mg d depression and once and Seroquel 25 mg daily and Zoloft 100 identifies monitoring anti-psychotic medic behaviors with a star January 2017, does anti-psychotic behav Progress note dated have a PHQ-9 score depression. Progres identifies a PHQ-9 score depression. Progres identifies a PHQ-9 score depression. Progres	p record for February 2017 nonitoring from MDS. No d monitoring identified. 0/17, identifies R173 is on ations. Indicates that R173 pression and history of nospitalizations. R173 takes antipsychotic medications. ration Record (TAR) dated tifies to monitor for side ressant, use with a start date of 7, TAR does not identify to -effects of medications. tration Record (MAR) dated tifies R173 to have received daily at bed time for e daily as needed for anxiety g give 0.25 tablet two times mg two times daily. MAR for side effects of cations and monitoring of rt date of 2/8/17. MAR for not identify any monitoring of					

Facility ID: 29822

If continuation sheet Page 52 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245626 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER REHABILITATION AND LIVING CENTER ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 53 of 56

		AND HUMAN SERVICES			FORM	03/10/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245626	B. WING	02 / ⁻	10/2017		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	STER REHABILITATIO	N AND LIVING CENTER		900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329 F 371 SS=E	non-pharmacologic prior to the PRN Dil Review of the Febru R189 received PRN to 2/1/17. The facilir reason for use 4 of was administered. If document non-phar attempted prior to the administered. 2/10/17 at 9:13 a.m sleep and AIMs asses already stated to ot AIMs assessment h residents. Also, sta medication requiring when the questions 483.60(i)(1)-(3) FOC STORE/PREPARE/ (i)(1) - Procure food considered satisfact authorities. (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and foc (iii) This provision do	al interventions attempted laudid being administered. Uary 2017 MAR revealed: N Dilaudid 4 times from 2/1/17 ty did not document the the 4 times the medication In addition, the facility failed to rmacological interventions he PRN Dilaudid being N. with DON when asked about sessments stated that she had her surveyors that no sleep or had been completed for any ated that she did an audit for g monitoring and added them a started. OD PROCURE, /SERVE - SANITARY d from sources approved or etory by federal, state or local	F 329			3/22/17	

If continuation sheet Page 54 of 56

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVE	
id plan c	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	COMPLETED		
		245626	B. WING		02/10/2017	
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER REHABILITATIC	N AND LIVING CENTER		1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	
F 371	Continued From pa	lge 54	F 37	1		
	(i)(2) - Store, prepa	re, distribute and serve food in ofessional standards for food				
	foods brought to re visitors to ensure s handling, and cons	regarding use and storage of sidents by family and other afe and sanitary storage, umption. NT is not met as evidenced				
	failed to prevent the borne illness, which 36 residents on the	tion and interview, the facility e potential spread of food n had the potential to affect all Rehab units also including no use ice from a portable ice		No specific residents were direct affected by this deficient practice. The dietary manager will impleme measures to ensure this deficient does not recur including: the pro- water pass and ice availability for	ent t practice cess for	
	cooler containing ic room/hallway. The allowed free access three/fourths full of inside the container	a.m. A metal cart with a plastic e was by rehab one dining cooler was unlocked and s to ice. The cooler was half to ice, with plastic scoop left r in contact with the ice. The		residents throughout each day wi changed to avoid ice chests. The residents will be able to obtain fre via ice machines. Dietary staff wi educated regarding the water pas procedure and ice availability cha avoid ice chests. Ice chests will b removed by 3/17/17.	II be esh ice iII be ss unge to	
	access. At 2:37 p.n scoop still in contact hallway, unlocked. cooler with scoop s Interview at this tim (RN)-C concerning residents and visito with the ice, stated, filling resident wate scoop though [look	n a location anyone had n. the plastic cooler with ice ct with ice, continues to be in Again at 3:56 p.m. the ice till in contact with ice. He with registered nurse the ice cooler accessible to all ors and the ice scoop in contact "Nursing staff use the ice for r cups." "I don't see any ing for scoop next to cooler]." top was inside ice container		The dietary manager or designee monitor the corrective actions to a the effectiveness of these actions including: auditing that there are chests put into place by checking per day for 2 weeks followed by r weekly audits. Upon completion audits, education will be complete immediately. Failure to adhere to protocols will result in corrective counseling. The results of the au	ensure no ice 2 times andom of these ed o these	

Facility ID: 29822

If continuation sheet Page 55 of 56

				PLE CONSTRUCTION G	()	(X3) DATE SURVEY COMPLETED	
		245626	B. WING		02/	10/2017	
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP			
ROCHES	STER REHABILITATIO	ON AND LIVING CENTER		1900 BALLINGTON BOULEVARD ROCHESTER, MN 55901	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE	
F 371	container to kitchen 02/08/17, 2:57 p.m containing ice note dining room. The c scoop inside again with RN-B concern and scoop in conta kitchen staff brings shown scoop which RN-B stated, "That to ice scoop in con this." At 3:05 p.m. t interviewed and sa from outside the kit with ice. Dietary ma container and the in Dietary manager st cart." "No, that is n reference to ice sco out what happened Received Hydration VOA-Rochester Red dated 2015. regard which indicates Cu and place on hydra Rehab unit kitchen staff to pick up. Nu coolers with remain between causal roo bringing to kitchen	A seded to return cart with ice h. the metal cart with ice cooler d in hallway on rehab two by ontainer was full of ice with in contact with ice. Interview ing the plastic ice container ict with ice, stated, "I think the out the ice." RN-B had been h was located inside ice chest. should not be there [reference tact with ice], I will check into the Dietary Manager was id that the aide gets the cart tchen door and fills the cooler anager observed cart with ice ce scoop touching the ice. The tated, "No, that is the wrong ot supposed to be there [in oop touching ice], I will figure t." n General Policies for ehabilitation & Living Center ling Water pass Procedure, linary staff to fill ice coolers atton carts then locate them by door for Nursing Assistant rsing assistant staff to leave hing ice on respective units om and dining room until for refilling with fresh ice. ot indicate that scoop should	F 37	1 Committee monthly for the then quarterly ongoing. U system revisions and/or st will be implemented if indi- prescribed corrective action dietary manager will be re- maintaining compliance. alleges that it will be in suf compliance with the stand March 22, 2017.	pon this review, aff education cated via a on plan. Facility sponsible for The facility ostantial		

If continuation sheet Page 56 of 56

CENTER	MENT OF HEALTH	& MEDICAID SERV	ICES		LE CONSTRUCTION	FORM OMB NO.	02/13/2017 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			6 01 - BUILDING 1	(X3) DATE SURVEY COMPLETED	
		245626		B. WING		02/09	9/2017
	ROVIDER OR SUPPLIER		1		TATE, ZIP CODE N BOULEVARD NW		
ROOHL			1	STER, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI F BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs		K 000			
	by the Minnesota D State Fire Marshal survey, (Rochesster in compliance with participation in Mec Subpart 483.70(a), 2012 edition of Nat Association (NFPA Code (LSC), Chapt The Facility is a 1 s basement. The fac and was determine construction. The building is prot system. The facility full corridor smoke spaces open to the	Initial Survey was co pepartment of Public Division. At the time er Rehab & Living) w the requirements for dicare/Medicaid at 42 Life Safety from Fire ional Fire Protection) Standard 101, Life ter 18 New Health C story building with a p lity was constructed to be of Type V(11 tected by a full fire sp has a fire alarm syst detection, resident re corridors that are m epartment notificatio	Safety - of this as found 2 CFR, e, and the Safety are. Dartial in 2015 1) prinkler stem with cooms and ponitored			æ	
		apacity of 56 certifie		1			
				8			
LABORATO	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Rochester Rehabilitation And Living Center February 28, 2017 Page 2

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		29822	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	TER REHABILITATIO	N AND LIVING CI	LINGTON BOTER, MN 559	OULEVARD NW 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE 03/09/17

Electronically Signed

If continuation sheet 1 of 57

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/10/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
OCHES	TER REHABILITATIO			ULEVARD NW		
		ROCHES	STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading the date your orders will be lectronically submitting to the ment of Health.				
	Department's staff, the following correct indicate in your electron	9, & 10, 2017, surveyors of this visited the above provider and ction orders are issued. Please ctronic plan of correction that these orders, and identify the be completed.	k			
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "II statute/rule out of of "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		29822	B. WING		02/10/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ROCHES	TER REHABILITATIO		LINGTON B TER, MN 55	OULEVARD NW 901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830		3/22/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.			
	by: Based on observati review, the facility f services to prevent	ent is not met as evidenced on, interview, and document ailed to provide care and further falls for 1 of 1 ho were reviewed for falls with		Corrected	
	Findings:				
	dated 1/27/17 revie (ADL)'s R101 requi	Minimum Data Set (MDS) wed for activities of daily living res one-person physical assist use, personal hygiene.			
	R101's care plan re	eviewed identifies at risk for			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/10/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE	_	
ROCHES	TER REHABILITATIO		LLINGTON BO TER, MN 559	ULEVARD NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 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 area on 1/7/17.	h injury to the left leg and groin				
	update dated 1/11/ two person for tran from a wheelchair t document dated 1/	Functional Mobility and ADL 17 read R101 is an assist of sfers and pivot transfer to and to the bathroom. Same 30/17 and 2/9/17 reads to with transfers and toileting.				
	on 2/10/17 at 8:23 bathroom, said get	01 on 2/9/17 at 7:13 a.m. and a.m. Coming out of her ting self-ready for the day. walker with no staff in room.				
	will use wheel chai	1 on 2/9/2017 1:37 p.m. Said r to get somewhere fast, and eeds help, resident stated that o call for help.				
	assistant (NA)-F was R101 need. NA-F s in her room, and do	at 1:22 p.m. With nursing as asked, what help does said R101 does not need help bes not need assistance going aff feel she knows when she				
	asked how thing ge	2:27 p.m. interview with NA-F et communicated about the g their cares. NA-F stated staff				
	Interview with Direct	ctor of nursing (DON) on				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/10/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 4	2 830			
	staff communicatio choices/preference the information place in the care plan and NA's to view. DON reviewed R10 verified that R101 A assist of one for tra hygiene. DON exp staff follow the care Policy review dated and Procedure read services to attain o	es and ADL's. DON said that ced in their computer system d then auto populates for the 01 care plan on computer and ADL's read that she is an ansfers, toilet use and persona pectation would be to have the	1			
	psychosocial wellbo	eing. to the facility on 12/19/16				
	identified Alzheime	nd on the Diagnosis Report r's Disease, unspecified behavioral disturbance and I 12/19/16.				
		rt dated 12/19/16, identifies Jular diet, regular texture, thin or General diet.				
		eport dated 12/19/16, indicates every Wednesday.	3			
	nutrition risk related recent cognitive an BMI (body mass in monitor intake, offe	8/17, identifies potential d to Alzheimer's dementia, d functional decline and low dex). Interventions include: er bedtime snack, offer aten foods, and provide diet as				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			E SURVEY PLETED
		29822	B. WING		02/10/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OCHES	TER REHABILITATIO		LLINGTON BC STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 5	2 830			
	ordered, regular. Observe changes in weight, notify physician, and weigh resident every Wednesday.					
	weight on 12/19/16 120.8 pounds. 1/18 weight loss and a	Summary identified R67 5, was 125.6 pounds. 1/11/17, 8/17, 115.8 pounds a 9.2 pound 9 percent decline in one month loss). No other weights were				
	practical nurse (LP weighed on Wedne order to complete r weight and it is a 3 5 pound difference prompt a message	7, at 7:10 a.m. with licensed N)-A stated everyone gets esday's unless they have an more often. If we enter a pound difference in a day or a in a week the computer will that indicates a weight loss is to notify the provider.				
	assistant (NA)-C st weekly. When ente system they are ab	7, at 7:26 a.m. with nursing tated residents are weighed ering weights into the computer ole to see the previously d are to alert the nurse if there				
	nursing (DON) stat completed at least otherwise. DON stat is identified the innu- meets to try and de weight loss. DON state interventions. DON documented weigh DON stated she wa	l verified R67 had only 3 Its during her stay in the facility as aware weight loss was a facility, including weights being				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/10/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	LACK OF FOLLOWING CARE PLAN IN REGARDS TO INTERVENTIONS TO PROMOTE HEALING OF PRESSURE ULCERS: R61's 14 day schedule assessment Minimum		Ξ			
	Data Set (MDS) da moderately impaire	ted 11/29/16 identifies R61's and requires extensive persons for bed mobility,				
	reviewed at risk for generally thin and f pressure ulcers bot reposition in chair e	th a target date of 12/6/16, skin breakdown as skin in ragile, R61 has history of th heels. Interventions every two hours, offload (to neels, administer treatments				
	3:07 p.m. observed on the end of her re placed properly to f	s on 2/8/17 from 12:50 p.m. to I R61 to have her heels resting ecliner no cushion or pillow float (offload) her heels as an care plan and had been in and 17 minutes.				
	7:11 a.m. and 8:48	servation on 2/9/17 between a.m. heels not floated (offload I. Feet resting directly on bed)			
		0:52 a.m. sitting in recliner, nd again heels not floated.				
	in bed and again he was notified and ob	7 at 8:16 a.m. R61 found lying er heels not floated. LPN-B pserved R61 in bed with : 8:21 a.m. her heels were not				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			-			
		29822	B. WING		02/	10/2017
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
OCHES	TER REHABILITATIC		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIV		(X5) COMPLE DATE
2 830	Continued From pa	age 7	2 830			
	2/09/17 at 12:02 p. in place to help pro ulcer. NA-F stated underneath feet in keep blankets off fe but socks only. NA	ing assistant (NA)-F on m. regarding R61 intervention mote healing of pressure that staff place a pillow chair and bed, a bar on bed to eet and do not place shoes, t-F gave a demonstration using should look when R61's heels	3			
	about the interventi to R61 left foot. LF are completed in th Mondays, feet elev and in bed, no sho	12:06 p.m. LPN-B was asked ion in place to promote healing PN-B stated dressing changes he evening, bath day are vated on pillow when in chair bes, but wears socks liked to keep warm and has lift in ths off feet.				
	reviewed of current	l on 2/9/17 at 2:59 p.m. had t care plan for R61 and verified positioned every 2 hours and to nes.				
	dated 11/2016, doe	Plan Policy and Procedure" esn't address following the care highest level of care for each				
	The Director of Nur policies and proced	THOD FOR CORRECTION: rsing could review and revise dures and educate staff to erventions and monitor for				
	TIME PERIOD FOI days.	R CORRECTION: Forty (21)				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
	29822	B. WING		02/10/2017	
ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	• • •	
TER REHABILITATIC					
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLET DATE
Continued From pa	age 8	2 900			
MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			3/22/17
comprehensive res of nursing services	ident assessment, the director must coordinate the				
without pressure s pressure sores unle condition demonstr	ores does not develop ess the individual's clinical rates, and a physician				
receives necessar promote healing, pr	y treatment and services to revent infection, and prevent				
by: Based on observat review, the facility f services to promote pressure ulcers from	ion, interview, and document ailed to provide pressure ulcer e healing and prevent further m developing for 1 of 1		Corrected		
Findings:					
(MDS) dated 11/22 severely impaired a assistance with two dressing and perso	/16 identifies R61's as and requires extensive persons for bed mobility, anal hygiene. Also has two				
	ROVIDER OR SUPPLIER TER REHABILITATIC SUMMARY STA (EACH DEFICIENC REGULATORY OR L Continued From pa MN Rule 4658.052 Ulcers Subp. 3. Pressure comprehensive res of nursing services development of a r provides that: A. a resident wh without pressure so pressure sores unle condition demonstr authenticates, that B. a resident wa receives necessar promote healing, p new sores from de This MN Requirem by: Based on observat review, the facility for pressure ulcers from resident (R61) with Findings: R61's significant ch (MDS) dated 11/22 severely impaired a assistance with two dressing and person stage 2 pressure ul-	29822 STREET AT TER REHABILITATION AND LIVING CI 1900 BA ROCHES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 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.	A BUILLING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, 1900 BALLINGTON BROCHESTER, MN 55 ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 A 900 SUBMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 A 2 900 SUBD. 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. 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 cu	A BUILING: B.WING STREET ADDRESS, CITY, STATE, ZIP CODE TER REHABILITATION AND LIVING CI SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC DENTFYING MFORMATION) ID PROVIDERS PLAN OF CODENCIES IN REGULATORY ON LSC DENTFYING MFORMATION) Continued From page 8 MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcars 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. Corrected This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide pressure ulcers services to promote healing and prevent further pressure ulcers from developing for 1 of 1 resident (R61) with a current heel pressure ulcer. Corrected 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 brea	29822 B. WING 02 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW TER REHABILITATION AND LIVING CI 1900 BALLINGTON BOULEVARD NW POVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY WAS TEP PRECEDED BY FULL RECH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE CRACH OFFICIENCY WAS TEP PRECEDED BY FULL REGULTORY OR USC IDENTIFYING INFORMATION) PD PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY WAS TEP PRECEDED BY FULL REGULTORY OR USC IDENTIFYING INFORMATION) PD PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY WAS TEP RECEDED BY FULL REGULTORY OR USC IDENTIFYING INFORMATION) PD PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY WAS TEP RECEDED BY FULL REGULTORY OR USC IDENTIFYING INFORMATION) PD PROVIDER'S PLAN OF CORRECTION (EACH OFFICENTY WAS TEP RECEDED BY FULL REGULTORY OR USC IDENTIFYING INFORMATION) PD PROVIDER'S PLAN OF CORRECTION (EACH OFFICENCY WAS TEP RECEDED BY FULL PECILICATORY OR USC IDENTIFYING INFORMATION) PD PROVIDER'S PLAN OF CORRECTION (EACH OFFICATION ACTION SHOULD BE CRACH OFFICIENT WAS TEP RECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (Increased and the one officient is contract assessment, the director of nursing services top romote healing, prevent infection, and prevent new sores from developing. 2 900 This MN Requirement is not met as evidenced by: Based on observation, interview, and document revident (R61) with a current heel pressure ulcers services to promote healing and prevent further pressure ulcers from developing for 1 of 1 resident (R61) with a current heel pressure ulcer. Corrected R61's significant change Minimum Data Set (MDS) dated 11/22/16 identities R61's as severely i

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING			
		29822			02/10/2017	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
OCHES	TER REHABILITATIO		STER, MN 559	OULEVARD NW 01		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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				DEFICIEN	JY)	
2 900	Continued From pa	age 9	2 900			
	generally thin and fragile, R61 has history of pressure ulcers both heels. Interventions reposition in chair every two hours, offload					
		re to area) heels, administer				
	completed dated 12	turn from hospital assessment 2/16/16 the day she return n the hospital for a urinary tract				
	infection. The asse heel pressure woul (cm) x 3 cm x 0.2 a	essment read that she has left nd measuring 3 centimeters and a right heel pressure 2 cm ure ulcers were open and a				
	Copy, Primary Care Limited Evaluation on her left great (bi cm and heel mease Orders read:	nt titled clinical Document e Internal Med Nursing Home, dated 12/6/16 noted wounds ig) toe measuring 1.5 cm x 1.2 uring 2 cm diameter. sol dressings to both areas				
	daily Nursing to mor weekly skin update	nitor area daily and perform				
	patient lying in bed Pillow to be pla extremities to ensu		ı			
	the bed					
	Copy, Primary Car Subsequent Visit d	nt titled clinical Document e Internal Med Nursing Home, ated 12/8/16 noted a follow up				
	reads that the facili heels, but did have	tervention orders. Document ity using cradle and elevating dressing in place.				
	Orders read: Nursing to cont on left foot	tinue treatments to both areas				

STATE FORM

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		29822	B. WING		02/10/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND LIVING CE	LINGTON BO TER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE
				DEFICIENC	ΥY)	
2 900	Continued From pa	ige 10	2 900			
	DON to monitor closely Continue bed cradle when resting in bed Ensure heels are floating when in bed as well in recliner.					
in rev Rev Rec resid heel wors 12/2 off k shift docu days Weo (TM ever in a	Record (ETAR) for Bed cradle to b resident is in bed. N heel wounds and n worsening or no im 12/20/16. Avoid sho off loaded at all tim Missing docum shift once in nine d documentation on t days. Wound docum Wednesday and Fr Missing docum were documented R (TMA) out of nine of Left heel and le evening shift. Missing wound	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				
	3:07 p.m. observed on the end of her re placed properly to f physician. R61 had in her recliner. Nurs to complete a bladd Surveyor asked ho repositioned NA-E time not sure. NA-	on 2/8/17 from 12:50 p.m. to I R61 to have her heels resting ecliner no cushion or pillow toat her heels as ordered by d not been repositioned while sing assistant (NA)-E entered der scan while in her recliner. w often R61 is to be stated does not work all the E was asked where do you n if needed, NA-E stated in the				

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2 900	Continued From pa	age 11	2 900			
		A. NA-E completed bladder get nurse stated will be placing procedure.				
	7:11 a.m. and 8:48 pressure removed	servation on 2/9/17 between a.m. feet not floated (all from heels) observed to be NA-B in room to get her				
		0:52 a.m. sitting in recliner, ot floated. 11:08 a.m. LPN-B sted foot floated.				
	in bed with heels in floated. LPN-B ver	7 at 8:16 a.m. R61 found lying contact with mattress and not ified at 8:21 a.m. through irveyor that R61's heels were pillow under legs.				
	2/09/17 at 12:02 p. plan intervention in NA-F stated that st feet in chair and be blankets of feet and only socks. NA-F g pillow on how it sho	ing assistant (NA)-F on m. regarding R61 skin care place to help promote healing aff place a pillow underneath ed, a bar on bed to keep d do not place shoes on her, gave a demonstration using the buld look when R61's heels are clude by saying that skin ed to the nurse.	9			
	asked about press to promote healing located on heels. changes are comp are Mondays, feet chair and in bed,	at 12:06 p.m. LPN-B was ure ulcer intervention in place to R61's pressure ulcers LPN-B stated dressing leted in the evening, bath day elevated on pillow when in no shoes, but wears socks on to keep warm and has lift kets off feet.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29822	B. WING		02/	10/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	ULEVARD NW 01		
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2 900	Continued From pa	age 12	2 900			
	stated interventions stage two pressure moisture to wound, use bed cradle and stated that R61 get hours. Reviewed of plan with DON white 2 hours and offload the dressing chang them. DON stated completed every da completed by an in and verified that the completed and the being completed w	I on 2/09/17 at 2:59 p.m. s to promote healing for R61's e ulcers on heels was to add d nothing heavy on feet. DON is repositioned every three-four f current pressure ulcer care ch included to reposition every I heals. DON was asked about the sand who can complete that the dressing are ay in the evening and is to be urse. DON reviewed the ETAF e dressing changes were not ones that were initialed as as by a TMA who can not changes or documentation on	r t			
	director of nursing in-service staff and physician orders co and treatment(s) and prompt repositioning	THOD OF CORRECTION: The and/or designee could monitor for compliance with oncerning pressure ulcer care nd in-service staff regarding ng, reviewing care plan and the to help promote healing of	3			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			3/22/17
	have a continuous management to rec	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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2 910	Continued From pa	age 13	2 910			
	home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	sident assessment, a nursing that: tho enters a nursing home ng catheter is not catheterized t's clinical condition indicates to was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.				
	by: Based on observat review, the facility f bladder assessmen corresponding toile improve urinary inc	ent is not met as evidenced ion, interview and record failed to ensure a bowel and nt had been completed with a eting schedule to maintain or continence after a decline in e for 1 of 1 resident (R99) y incontinence.		Corrected		
	Findings include:					
	identifies unspecified disturbance (9/14/1	und on the Admission Record, ed dementia without behaviora I6), hemiplegia and ing cerebral infarction affecting e (9/8/16).				
	identifies R99 to be toileting to achieve self-sufficiency. R9 to remove and ope to transfer and pos toilet, able to tear/u	nent (CAA) dated 9/19/16, e receiving treatment for the highest practical 9 was identified as being able in clothing in preparation, able ition self, able to void into the use toilet paper to cleanse self, ilet and able to adjust clothing				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		29822	B. WING		02/	10/2017	
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OCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01			
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2 910	Continued From pa	age 14	2 910				
		CAA summary identifies R99 inent of urine but less than 7 x					
	assessment compl occasionally incont dated 12/12/16, ide	linimum Data Set (MDS) leted on 9/15/16, identifies inent. Quarterly MDS review entifies R99 to be frequently vere impaired cognition.					
	been incontinent of able to tell need or toilet when caring f	2/22/16, identifies R99 to have f urine. Interventions include: urge to void, offer to take to or resident/when repositioning ist of 1 for toileting needs.					
	10/24/16, no menti	s notes from 9/8/16 to on of urinary incontinence. s notes from 12/1/16 to 2/8/17, ary incontinence.					
		nents from admission on nd bladder assessment					
	assistant (NA)-C. F unable to void. NA- able to tell staff who bathroom and othe Sometimes R99 is	0/17, at 7:24 a.m. with nursing R99 was toileted but was -C stated R99 is sometimes en needing to use the er times isn't able to. able to use the toilet and other inated) in the pad before being et.					
	nursing (DON) stat assessments are c quarterly. DON sta responsible for con	7, at 8:17 a.m. with director of eed bowel and bladder completed on admission and ted the floor nurses are npleting the assessment and thow much assistance the					

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ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	age 15	2 910			
	incontinent or conti DON stated that int complete the MDS MDS coordinator is the care plans base verified there was r assessment compl Interview on 2/10/1 assistant (NA)-D st	7, at 8:13 a.m. with nursing tated R99 is a one assist to				
	say when she need stated she offers R bathroom every 2-3	and every once in a while can ds to use the bathroom. NA-D 199 assistance with the 3 hours. 7, at 8:17 a.m. with licensed				
	tracking is complet aide tells nursing th	N)-C stated bowel and bladden ed on admission and also if an nat a resident has had a ence tracking can be initiated.				
	coordinator when a completed for urina nursing aides docu charting system) w or incontinent every to the bathroom. M looks at that inform MDS coordinator s and bladder assess completed for the r knew the informatic accurate, MDS coordinator	7, at 8:39 a.m. with MDS asked how the MDS is ary continence stated the ment in point click care (online thether the resident is continen y time the resident is assisted IDS coordinator stated that she nation to complete the MDS. tated she will look at the bowel sments if one has been resident. When asked how she on the aides documented was ordinator continued to state the off of the aides charting and	t •			
	also by reading the coordinator stated the residents when	e nurses notes. MDS she usually doesn't interview completing the bowel and the MDS. MDS coordinator				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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ROCHES	TER REHABILITATIC		LINGTON BO	OULEVARD NW 01		
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	unable to answer w care plan could be and bladder assess if there is missing in delegated to do the coordinator stated to the MDS and care not verify they were not a bowel and bla for R99 that could w schedule was suffice incontinence. Interview on 2/10/1 stated the MDS sho and clarifications w couldn't confirm the decline in urinary in and bladder assess for R99. DON state	ns are a group effort. MDS was when asked how an accurate completed without a bowel sment. MDS coordinator stated information the floor nurses are assessments. MDS that she would like to think that plan are both correct but could correct because there was adder assessment completed verify that a 2 hour toileting cient in preventing further 7, at 8:49 a.m. with DON build be based on assessments ith staff. DON stated she e MDS is accurate for the icontinence because a bowel sment had not been completed of there should have been a nt completed that we would				
	have based our car DON stated with R incontinence she w and bladder assess care plan revised to prevent further dec Facility policy titled, Screening dated 20	re plan interventions off of. 99's decline in urinary rould have expected a bowel sment be completed and the preflect the change and to line. Bowel and Bladder 3-Day 010, identifies a bowel and				
	admissions, readm reviews or new inco collection tool will b the resident's best or improve continent the resident has be time when toileted	will be completed on all new issions, annual and quarterly ontinence. This 72 hour data be used to assist in determining toileting schedule to maintain nce levels. Policy identifies if een incontinent most of the every two hours, change e and one-half hours. If more				

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ROCHES	STER REHABILITATIO		LLINGTON B STER, MN 55			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CO	RRECTION	(X5)
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2 910	Continued From pa	ge 17	2 910			
	data is needed, cor screening until	ntinue Bowel and Bladder				
	director of nursing of the need to follow in	HOD OF CORRECTION: The could in-service all employees ncontinence protocol ate licensing requirement. Also ince.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			3/22/17
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observati review, the facility f monitor weights to	ent is not met as evidenced ion, interview and document ailed to consistently obtain and prevent sever weight loss for 2 , R67) who had been reviewed s.	2	Corrected		
	Findings Include:					
	12-13-16, identified	inimum Data Set (MDS) dated diagnoses of Alzheimer's ntia. R22 needed assistance o				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
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				DEFICIENC	Y)	
2 965	Continued From pa	age 18	2 965			
		or eating and had severely This was a closed record				
	Review of R22's we documented as foll 12/2/16: 179 12/14/16: 180 12/21/16: 168 12/28/16: 168	eights in pounds was lows:				
		weight loss in the first 16 days nis was a 6 % weight loss and ss.	;			
	12/15/16, included, accompanied R22 be a poor historian most questions. [FI teeth with no troubl can feed himself at and has not had ar	n progress note dated , "[family member (FM)-A] during my visit. He appears to as he was unable to answer M-A] states he has his own le chewing or swallowing. He fter set up. He is a good eater hy recent weight loss. No d at home. No immediate ."				
	12/19/16, included, textures, thin liquid preferred dining loc eating self-perform Summary: R22 adr following a hospital urinary tract infection medical history] of multiple strokes. H is unable reply to q	utritional data collection dated , "Diet order of Regular, regula s Meal tray to room is cation. Limited assistance for ance Setup help only mitted for rehab [rehabilitation] I stay for a hip fracture and on. He has a PMH [personal Alzheimer's dementia and is [FM-A] is his historian as he uestions appropriately r/t re status. He appears normal				
nanata Di	weight, alert with p	eriods of somnolence and well with assistance in the dining				

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		29822	B. WING	B. WING		02/10/2017	
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2 965	Continued From pa	age 19	2 965	DEFICIENC	(Y)		
	giver. He has no tro and eats well with i daily. Fluid intake ~ records. Weight ha	His [FM-A] is his primary care puble chewing or swallowing ntake of >75% each meal 1500 ml/day per nursing task is remained stableContinue .Monitor intake/fluids daily and					
	included, "Diet: Reg liquids, Intake: dec average at each m Fluids: Declined to 179# [pounds], last 167.8# -11# (6%) s recorded this mont R22 has had a dec week. Most current issues with swallow 3-day trial of mech textures. This write [director of nursing a screening of his s recommendations. admission noted. F	~1100 ml .Weights: Admit wt. recorded wt [weight]12/21/16 ince admission. No weight h. rease in intake over the past tly the last few days he has had ving. Nursing has ordered a [mechanical soft] soft/pureed r notified DON/SLP/therapy /speech language therapist] for swallowing ability and Weight loss of 6% since Recommend weights be done 3 en decline in intake for closer ng up for SLP	4				
	included, "Potentia dementia AEB [as somnolence, forge	re plan printed 2/9/17, I nutrition risk related to evidenced by] periods of tfulness and confusion." ded: "Weigh resident every					
	(RD)-A stated when loss, she expected	p.m., registered dietician n a resident displayed weight staff to alert her to complete a oss. RD-A stated weights are					

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2 965	Continued From pa	age 20	2 965				
	clinical tab. RD-A s weighed R22, he d RD-A stated she w loss until she comp review and noticed RD-A stated every be weighed on We different order for n stated staff obtainin problem and that w order daily weights for residents to hel taken. RD-A verifie R22 should have w week as a part of h	eights and vital reports under stated since staff had not id not trigger for a weight loss. as unaware of R22's weight bleted the nutritional 30-day R22 was not being weighed. resident in the building was to dnesdays, unless they had a nore frequent weights. RD-A ng weights weekly had been a vas why she would sometimes or weights three times a week p ensure weights would be d this was why she indicated veights taken three times a ner 30-day nutritional review. spectation was staff to follow weigh residents on					
	stated staff try to ge Wednesdays. NA-A	a.m. nursing assistant (NA)-A et all resident weights on A stated sometimes based orkload weights do not always					
	aware of R22's wei was aware of the tr recommendations DON stated when weights and vitals a is an alert if there weights and residents weights stated she was award done weekly prior to	2 a.m., stated she was not ight loss. The DON stated she rial for mechanical soft and for swallowing evaluation. The weights are recorded under the section in the computer, there vas a weight change. The DON monitored the weights alerts hts in the computer. The DON are weights were not being to the identification by n audit on 2/2/17. The DON	1				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 965	Continued From pa	ige 21	2 965			
	computer system.	ht day and entered into the The DON stated expected staff lan for weekly weights.				
	dated 2006, include weighed and meas admission. Each re for the first four we thereafter unless an identified. Resident more often based u	ring - Nursing Services policy ed, "Each resident will be ured within 24 hours of sident will be weighed weekly eks of her/his stay, monthly n adverse trend has been s will be weighed weekly or upon ongoing assessment of uid retention, and other				
	identified Alzheimer Dementia without b	d on the Diagnosis Report r's Disease, unspecified behavioral disturbance and 12/19/16 (day of admission).				
		rt dated 12/19/16, identifies ular diet, regular texture, thin or General diet.				
	Order Summary Re R67 to be weighed	eport dated 12/19/16, indicates every Wednesday.				
	nutrition risk related recent cognitive an BMI (body mass in monitor intake, offe substitutes for unea ordered, regular. O	B/17, identifies potential d to Alzheimer's dementia, d functional decline and low dex). Interventions include: er bedtime snack, offer aten foods, and provide diet as bserve changes in weight, d weigh resident every				
	December 2016, id	stration Record (MAR) dated entifies R67 was weighted on 3/16. January 2017, MAR				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	·····	COM	FLEIED
		29822	B. WING		02/	10/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 965	Continued From pa	age 22	2 965			
	and 1/18/17. Howe Weights and Vitals weight on 12/19/16 120.8 pounds. 1/18 loss in one month of weight loss. No oth Meal Intake and Flu 12/19/16 to 1/18/17 consumed 76-1009 Nutritional Summan dated 12/27/16, ide diet with think liquid nutritional supplem having an admissio of 19.7. Summary i and well nourished weight loss and ide 130 pounds. Summ regular diet, monito weekly.	Summary identifies R67 6, was 125.6 pounds. 1/11/17, 8/17, 115.8 pounds a 9.2 pound or 9 percent which is a severe er weights identified. uids forms reviewed from 7, identifies R67 consistently				
	weight to be 120.8. entered a note reco accuracy. However	Registered Dietician had ommending a re-weigh for r, no indication this was information provided when				
	weight to be 115.8.	d 1/20/17, indicates R67's Registered Dietician's entered had discharged from the	ŀ			
	1/19/17, assessme	sing charting from 12/19/16 to onts include a section to Charting on 12/19/16, of 125.6. All other				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		29822	B. WING		02/	10/2017
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE	02/	10/2017
			LLINGTON BO	ULEVARD NW		
		ROCHES	STER, MN 559			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	age 23	2 965			
	assessments the solank.	ection for weight were left				
	weight loss, she ex complete a consult weights are to be c and stated she che reports under clinic resident in the build Wednesdays, unles for more frequent w obtaining weights w and that was why s daily weights or we residents to help er	ated when a resident displayed pected staff to alert her to for weight loss. RD-A stated ompleted every Wednesday ecked the weights and vital eal tab. RD-A stated every ding was to be weighed on ss they had a different order veights. RD-A stated staff veekly had been a problem the would sometimes order ights three times a week for nsure weights would be taken. pectation was staff to follow veigh residents on				
	practical nurse (LP weighed on Wedne order to complete r weight and it is a 3 5 pound difference prompt a message	r, at 7:10 a.m. with licensed N)-A stated everyone gets esday's unless they have an nore often. If we enter a pound difference in a day or a in a week the computer will that indicates a weight loss to notify the provider.				
	assistant (NA)-C st into the computer s	, at 7:26 a.m. with nursing ated when entering weights system they are able to see the weight and are to alert the change.				
	nursing (DON) stat completed at least	, at 10:43 a.m. with director of ed weights are to be once weekly unless ordered ated when a decline in weight				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OCHES	TER REHABILITATIC		LLINGTON BO STER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 965	Continued From pa	ge 24	2 965			
	meets to try and de weight loss. DON s the resident to dete interventions. DON documented weigh DON stated she wa	verified R67 had only 3 ts during her stay in the facility as aware weight loss was a facility, including weights being				
	Assessment Policy "Food and Nutrition	o policies, "Nutritional and Procedure" undated, and " dated 11/2016. Neither polic g and monitoring weights.				
	The director of nurse dietician (RD) could revise policies and system is in place to loss and to identify so interventions can and RD could educe policies/procedures	THOD OF CORRECTION: sing (DON) and the registered d develop, review, and/or procedures to ensure a o decrease the risk of weight weight loss in a timely manne n be implemented. The DON ate all appropriate staff on the s, and could develop s to ensure ongoing	r			
	TIME PERIOD FOI (21) Days.	R CORRECTION: Twenty On	e			
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			3/22/17
	procedures and co	conditions. Sanitary nditions must be maintained ir e dietary department at all				
	epartment of Health					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02 /	10/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ROCHES	TER REHABILITATIC		LLINGTON B STER, MN 55	OULEVARD NW 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	uge 25	21015			
	by: Based on observat failed to prevent the borne illness, which 36 residents on the	ent is not met as evidenced ion and interview, the facility e potential spread of food n had the potential to affect all Rehab units also including no use ice from a portable ice		Corrected		
	Findings include:					
	cooler containing ic room/hallway. The allowed free access three/fourths full of inside the container ice container was in access. At 2:37 p.m scoop still in contac hallway, unlocked. cooler with scoop s Interview at this tim (RN)-C concerning residents and visito with the ice, stated, filling resident wate scoop though [look RN-C informed sco and when shown, F shouldn't be there,	a.m. A metal cart with a plastic cooler was by rehab one dining cooler was unlocked and s to ice. The cooler was half to ice, with plastic scoop left r in contact with the ice. The n a location anyone had n. the plastic cooler with ice ct with ice, continues to be in Again at 3:56 p.m. the ice till in contact with ice. ie with registered nurse the ice cooler accessible to all ors and the ice scoop in contac , "Nursing staff use the ice for r cups." "I don't see any ing for scoop next to cooler]." oop was inside ice container RN-C stated, "Well, that I will take this back to the reded to return cart with ice n.				
	containing ice note dining room. The conscious scoop inside again with RN-B concerning	the metal cart with ice cooler d in hallway on rehab two by ontainer was full of ice with in contact with ice. Interview ing the plastic ice container ct with ice, stated, "I think the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		29822	B. WING		02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER REHABILITATIC		LLINGTON BO	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21015	Continued From pa	age 26	21015			
	shown scoop which RN-B stated, "That to ice scoop in cont this." At 3:05 p.m. t interviewed and sat from outside the kit with ice. Dietary ma container and the ic Dietary manager st cart." "No, that is no	out the ice." RN-B had been n was located inside ice chest. should not be there [reference tact with ice], I will check into he Dietary Manager was id that the aide gets the cart chen door and fills the cooler anager observed cart with ice ce scoop touching the ice. The rated, "No, that is the wrong of supposed to be there [in pop touching ice], I will figure l."	e			
	VOA-Rochester Re dated 2015. regard which indicates Cul and place on hydra Rehab unit kitchen staff to pick up. Nu coolers with remain between causal roc bringing to kitchen	n General Policies for ehabilitation & Living Center ing Water pass Procedure, linary staff to fill ice coolers tion carts then locate them by door for Nursing Assistant rsing assistant staff to leave ning ice on respective units om and dining room until for refilling with fresh ice. t indicate that scoop should ntact with the ice.				
	dietary manager/die staff on the need to environment for foo	THOD OF CORRECTION: The etician could in-service dietary o maintain a sanatary od storage, preperation and nitor for compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			3/22/17

STATE MENULY OF DEFICIENCIES AND PLANDAR CONTRECTOR (XI) PHONODERSUPPLIENCIAL IDENTIFICATION NUMBER 29822 (XI) MONODERSUPPLIENCIAL IDENTIFICATION NUMBER 29822 (XI) MONODERSUPPLIENCIAL IDENTIFICATION NUMBER 29822 (XI) MONODERSUPPLIENCIAL IDENTIFICATION IDENTIFICATION ROCHESTER REHABILITATION AND LIVING OF ROCHESTER REHABILITATION AND LIVING OF ROCHESTER REHABILITATION NUMBER INFORMATION INFORM	Minneso	ta Department of He	alth				
NAME OF PROVIDER OR SUPPLIE STREET ADDRESS, CITY, STATE, 2# CODE TOD BALLINGTON BOLLEVADD NW DOCHESTER REHABILITATION AND LIVING CI 1900 BALLINGTON BOULEVADD NW DOCHESTER, MN 5500 Out ID PTECK TAS SUMMARY STREEMST OF DEPICIPACIES BEDULATORY OR LSC IDENTIFYING INFORMATION, PECK BEDULATORY OR LSC IDENTIFYING INFORMATION, TAS ID PECK PROVIDERS PLAN OF COMBECTION BOLLEVADD NW DOCHESTER, MN 5500 21426 Continued From page 27 (a). A runsing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis lineCiton control guidelines issued by the United States Centre for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MWWR). This MN Requirement is not met as evidenced by: Based on interview and record review, facility failed to ensure tuberculosis states centre eregarding implementation of the guidelines. (b) Written 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. Corrected Findings include: S1 was hired on 8/16/16. Facility was unable to provide documentation of a tuberculosis symptom screening or a step 1 and step 2 Mantoux skin test being completed. Corrected	-						
BOOHESTER REHABILITATION AND LIVING 1900 BALLINGTON BOULEVARD WE ROCHESTER, NM 55901 IMALIO PRECIN TAG SUMMARY STATEMENT OF DEFICIENCIES REACH CORRECTIVE AUTION SHOULD BE REACH CORRECTIVE AUTION SHALE AUTION SHOULD BE REACH CORRECTIVE AUTION SHOULD BE R			29822	B. WING		02/1	0/2017
PRO-IDE STER HEHABLITATION AND LIVING CI BOCHESTER, MN 55901 PRIDING SUMMARY STATEMENT OF DEFICIENCIES. BECIL STRIPT, CONTREMENT OF DEFICIENCIES. BECIL STRIPT, CONTREMENT OF DEFICIENCIES. BECIL STRIPT, CONTREMENT OF DEFICIENCIES. BECIL STRIPT, CONTREMENT OF DEFICIENCIES. BECIL STRIPT, CONTREVENT OF DEFICIENCIES. Trac D PRETRY Trac PROVIDERS PLAN OF CONRECTION (EXCOMPTION OR LSO DENTIFYING INFORMATION) D PRETRY Trac D PROVIDERS PLAN OF CONRECTION (EXCOMPTION OR LSO DENTIFYING INFORMATION) D PRETRY Trac D PROVIDERS PLAN OF CONRECTION (EXCOMPTION OR LSO DENTIFYING INFORMATION) D PRETRY Trac D PROVIDERS PLAN OF CONRECTION (EXCOMPTION OR LSO DENTIFYING INFORMATION) D PRETRY Trac D PROVIDERS PLAN OF CONRECTION (EXCOMPTION OR LSO DENTIFYING INFORMATION) D PRETRY Trac D PRETRY Trac<	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
Prigrix Tag IEACH DEPICIENCY MUST BE PRECEDED BY FULL PRECULATORY OR LSCIDENTIFYING INFORMATION) Prigrix Tag IEACH CORPECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE Construint of the construction construction of the construction construction of the construction of the construction construction construction of the construction construction construction of the construction construction of the construction constructin the construction constructin construction co	ROCHES	TER REHABILITATIO	N AND LIVING CI				
 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Preventin (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 	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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.CorrectedFindings 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	 (a) A nursing home maintain a comprel infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement (b) Written complia 	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of te technical assistance intation of the guidelines.	21426			
innesota Department of Health		by: Based on interview failed to ensure tub was completed for skin tests were con S3) employed with for Tuberculosis. Findings include: S1 was hired on 8/ provide documenta screening or a step test being complete S2 was hired on 1/2	and record review, facility erculosis symptom screening 1 of 6 staff (S1) and Mantoux npleted for 3 of 6 staff (S1, S2, the facility who were reviewed 18/16. Facility was unable to tion of a tuberculosis symptom 1 and step 2 Mantoux skin ed.		Corrected		
	Minnesota D	epartment of Health					

If continuation sheet 28 of 57

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02 /	10/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO TER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ige 28	21426			
	with a step 1 Manto	completed on 1/3/17 along oux skin test. Documentation t receive a step 2 Mantoux				
	screening on 1/10/ [.] Mantoux skin test. step 1 Mantoux ski	16/17. S3 received a symptom 17, along with a step 1 Documentation identifies the n test was not read and a step t was not completed.				
	nursing (DON), stat hired they receive t screening and the s before they provide step 1 Mantoux skii Mantoux skin test is facilities human res all employee Tuber	, at 1:09 p.m. with director of ted once a staff member is he Tuberculosis symptom step 1 Mantoux skin test direct patient care. After the n test is read, the step 2 s scheduled. DON stated the sources department had kept culosis records in a binder. s are to be maintained in the e records.				
	"Infection Control T and "Infection Cont dated 2015. Neithe	o separate policies titled, B Control Plan" dated 2015 rol TB Exposure Control Plan" r policy addresses the steps Tuberculosis screening and				
	director of nursing of review policies and components of the monitoring program educated on the TE Mantoux process.	THOD OF CORRECTION: The (DON) and/or designee could procedures related to the infection control and TB n. Facility staff could be B regulations and the two step The director of nursing and/or relop a monitoring system to mpliance.				

	ta Department of He					E SURVEY
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		IPLETED
		29822	B. WING		02/	/10/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	TER REHABILITATIO			OULEVARD NW		
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	ge 29	21426			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one-				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary ral	21535			3/22/17
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Financ This standard is inc available through th	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan te Law Library. It is not				
	by: Based on observati review facility failed were completed for R87, R173): failed t monitoring was con	ent is not met as evidenced on, interview and record to ensure AIMS assessments 4 of 5 residents (R189, R103, to ensure behavior and mood npleted for 2 of 5 residents d to ensure comprehensive		Corrected		

H3H811

If continuation sheet 30 of 57

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29822	B. WING		02/	10/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 30	21535			
	residents (R189, R the reason for adm pain medications a non-pharmacologic prior to the adminis	were completed for 2 of 5 173): and failed to document inistration of as needed (PRN) nd failed to document cal interventions attempted stration of PRN pain of 5 residents (R189, R173) ation use.				
	Findings include:					
	LACK OF AIMS AS	SESSMENT:				
	R189 was admitted the facility admission	to the facility on 1/24/17 per on record.				
		rders dated 1/24/17 included, 5 mg [milligrams], give 1 tablet a day for mood				
	(MAR) from Janua	on Administration Record ry 2017 to February 2017, eived scheduled doses of red.				
	admission on 1/24/	its were reviewed since (17, and revealed an AIMS ot been completed for R189.				
	1/24/17 to 2/8/17 a	otes were reviewed from nd there was no an AIMS assessment being				
	nursing (DON) stat not completed for F four of a resident's	1:32 p.m. the director of ed an AIMS assessment was R189. The DON stated by day stay she expected an AIMS completed. The DON stated				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29822	B. WING		02/	10/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 31	21535			
	completed by the n there was not a nu The DON stated ar	ent was assigned to be nurse manger and currently rse manager on R189's unit. nother nurse should have S assessment for R189.				
	LACK OF SLEEP A	ASSESSMENT:				
	the facility admission Minimum Data Ass indicated R189 was	to the facility on 1/24/17 per on record. R189'S admission essment dated 1/30/17, s cognitively intact, and had asleep, staying asleep, or				
		rders dated 1/24/17 included, MG [milligrams], give 4 tablet a day for sleep."				
	(MAR) from Janua	on Administration Record ry 2017 to February 2017, eived scheduled doses of ed.				
	admission on 1/24/	its were reviewed since (17, and revealed a ep assessment had not been 9.				
	1/24/17 to 2/8/17 a	a comprehensive sleep				
	nursing (DON) stat not completed for F	1:32 p.m. the director of ed a sleep assessment was R189. The DON stated when a mitted with melatonin there				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
OCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 32	21535			
	to be used to comp	nted hours of sleep completed lete a comprehensive sleep ermine the effectiveness of the				
	comprehensive sle	0:45 a.m. the DON stated ep assessments were not r any residents in the building				
	FOR AN AS NEED LACK OF NON-PH INTERVENTIONS DOCUMENTED PF	ENTED REASON FOR USE ED PAIN MEDICATION AND ARMACOLOGICAL BEING ATTEMPTED AND RIOR TO THE OF A AN AS NEEDED PAIN				
	the facility admission	to the facility on 1/24/17 per on record. R189'S admission essment dated 1/30/17, s cognitively intact.				
	medication adminis	orders found on the stration records (MAR) for February 2017 included PRN ving pain medications:				
		ablet 500 MG [milligrams], Give very 6 hours. Order date	e			
	date ordered 1/24/	IG (TraMADol HCl) *Narcotic* I7, puth every 6 hours as needed				
	"Ultram Tablet 50 N	IG (TraMADol HCI) *Narcotic*				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		29822	B. WING		02/10/20	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• • •	
ROCHES			LLINGTON BO STER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 33	21535			
	date ordered 2/1/1 Give 1 tablet by me for pain."	7, outh every 4 hours as needed				
	date 1/24/17, Give hours as needed for comfort level AND	I Tablet 5 MG *Narcotic* order 1 tablet by mouth every 4 or pain rated greater than 3 or Give 2 tablet by mouth every 4 or pain rated greater than 6				
	Review of the Janu	uary 2017 MAR revealed:				
	from 1/24/17 to 2/1 document the reas the medication was facility failed to doo	N acetaminophen 13 times 1/17. The facility did not son for use 13 of the 13 times s administered. In addition, the cument non-pharmacological npted prior to the PRN ing administered.				
	times from 1/24/17 document the reas medication was ad facility failed to doo	N oxycodone, 5 MG, 1 tablet, 6 7 to 2/1/17. The facility did not son for use 6 of the 6 times the lministered. In addition, the cument non-pharmacological apted prior to the PRN administered.				
	times from 1/24/17 document the reas medication was ad facility failed to doo	N oxycodone, 5 MG, 2 tablet, 5 7 to 2/1/17. The facility did not son for use 5 of the 5 times the lministered. In addition, the cument non-pharmacological apted prior to the PRN administered.				
	1/24/17 to 2/1/17.	N tramadol, 20 times from The facility did not document 20 of the 20 times the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED
		29822	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
ROCHES	TER REHABILITATIO		LLINGTON BC STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 34	21535			
	facility failed to doc	ministered. In addition, the cument non-pharmacological upted prior to the PRN tramado d.	I			
	Review of the Febr	ruary 2017 MAR revealed:				
	2/1/17 to 2/8/17. The reason for use 1 of was administered. document non-pha	N acetaminophen 1 times from he facility did not document the f the 1 times the medication In addition, the facility failed to trmacological interventions the PRN acetaminophen being				
	times from 2/1/17 t document the reas medication was ad facility failed to doc	N oxycodone, 5 MG, 1 tablet, 2 to 2/8/17. The facility did not on for use 2 of the 2 times the ministered. In addition, the cument non-pharmacological opted prior to the PRN idministered.				
	times from 2/1/17 t document the reas medication was ad facility failed to doc	N oxycodone, 5 MG, 2 tablet, 2 to 2/8/17. The facility did not on for use 2 of the 2 times the ministered. In addition, the cument non-pharmacological opted prior to the PRN udministered.				
	every 6 hours, 2 tin facility did not docu the 2 times the me addition, the facility non-pharmacologic	N tramadol 50 MG, 1 tablet, nes from 2/1/17 to 2/8/17. The ument the reason for use 2 of dication was administered. In / failed to document cal interventions attempted amadol being administered.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 02/10/2017	
		29822	B. WING			
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	10/2011
NAME OF F	ROVIDER OR SUPPLIER			ULEVARD NW		
ROCHES	TER REHABILITATIO		STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	age 35	21535			
	every 4 hours, 18 t The facility did not 18 of the 18 times administered. In ac document non-pha	N tramadol 50 MG, 1 tablet, imes from 2/1/17 to 2/8/17. document the reason for use the medication was ddition, the facility failed to armacological interventions the PRN tramadol being				
	[complaints of] pair back. Is able to rep right total shoulder dx [diagnoses] of N affect perception o "give pain medicati non-medication inter repositioning, ice/w effectiveness of an	ncluded, PAIN: Has c/o in to right knee, right arm and port pain verbally. Did have arthroplasty. Has arthritis. Has Major depression that could f pain. Interventions included, ions as indicated. ok to try erventions such as: varm packs. observe by intervention tried. consult incerns/present plan for pain	5			
	during a medication a prn pain medicat any non-pharmaco	d on 2/7/17, at 6:25 p.m., R189 n pass observation, to receive ion. The nurse did not offer logical interventions prior to of the pain medication.	9			
	R189 stated she co staff and requested felt she needed to had stated she had from staff to help w she would ask for a					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LINGTON BC TER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 36	21535			
	medication.					
	stated staff should non-pharmacologic administration of P stated non-pharma should be docume RN-F stated knew and stated medica treatments were a On 2/09/2017, at 1 nursing (DON) stat with the non-pharm to the administratic The DON stated up with residents about interventions that h so we have their put this assessment w stated a pain care included non-pharm DON stated she ex non-pharmacologic what was tried prio PRN medication an	cal interventions prior to RN pain medications. RN-F acological interventions tried nted in the medical record. this was an area of concern tion pass and completing				
	LACK OF AIMS AS MONITORING OF	SESSMENT AND BEHAVIOR/MOOD:				
	R103 was admitted	d to the facility on 12/8/16.				
	R103's diagnosis for dated 12/8/16, ider	ound on the Admission Record ntifies anxiety.				
		rders found on the Order dentifies Lexapro 10 mg give				

STATE FORM

If continuation sheet 37 of 57

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	29822	B. WING	B. WING		10/2017
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OCHESTER REHABILITATIO		LLINGTON BC STER, MN 559	OULEVARD NW 01		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535 Continued From pa	age 37	21535			
 depression with a s Seroquel 25 mg giv time a day for moor Orders for monitorin anti-psychotic med 2/8/17, after enterin Behavior monitorin identifies behavior other behavior/moor Care plan dated 12 on psychotropic med antipsychotic medie to be for mood (rec agitation/confusion seizure as husband is result of seizures records, dose had up to 25 mg daily ri Was in ER in earlie arrived her on an a daily). Also unclear Hint of diagnosis of documentation abor 14". Treatment Adminis February 2017, ide effects of anti-deprin 2/8/17. January 20 monitor for any side Medication Adminis February 2017, ide 	g record for February 2017 monitoring from MDS. No od monitoring identified. 2/28/16, identifies R103 to be edications. "Arrived here on cations (Seroquel). It appears	k			

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29822	B. WING		02/	10/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 38	21535			
		nuary 2017, does not identify nti-psychotic behaviors.				
	have a PHQ-9 scor moderate depression 12/15/16, identifies indicates mild depression 1/11/17, identifies a as R103 was unable note dated 1/31/17, completed which in	d 12/8/16, identifies R103 to re of 12 which indicates on. Progress note dated a PHQ-9 score of 5 which ession. Progress note dated a staff interview was completed le to be interviewed. Progress , identifies a staff interview was idicated no depression.				
	2/9/17, identifies no behaviors or mood Review of assessm	s notes from 12/8/16 through o mention of R103 having any concerns. nents indicated an AIMS of been completed for R103.				
	Interview on 2/9/17 practical nurse (LP are directed toward gets angry and can agitated. LPN-A sta these behaviors in document every tim	, at 7:29 a.m. with licensed N)-A stated R103's behaviors Is her husband and that she be mean and also gets very ated that he had documented the past but stated he doesn't ne it happens. LPN-A stated veren't a new issue and they				
	nursing (DON) state to be an AIMS asse any resident receive verified an AIMS as completed for R103	, at 8:40 a.m. with director of ed by day 4 there is supposed essment that is completed for ing an antipsychotic. DON ssessment had not been 3. DON stated the nurse onsible for completing the				
	Interview on 2/9/17	, at 12:09 p.m. with nursing				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
AME OF F	PROVIDER OR SUPPLIER	1	DDRESS, CITY, ST	ATE, ZIP CODE		
OCHES	TER REHABILITATIO		LLINGTON BO	ULEVARD NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ^Y	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
21535	Continued From pa	age 39	21535			
	have agitation and have conversations stated R103 has ag and others and car stated she is able t behaviors in point of but isn't able to exp	ated R103 will occasionally times where she isn't able to s that are reality based. NA-A gitation towards her husband b be confused at times. NA-A o document only specific of care (online charting system blain the situation. NA-A stated ors or mood concerns to the				
	manager (RN)-A st any AIMS assessm unaware that she w the assessment an	, at 12:15 p.m. with the nurse ated that she hadn't completed ents. RN-A stated she was vas responsible for completing d stated she doesn't have a o what assessments she is te.				
	verified there was r monitoring docume completed for R103 is entered along winurses to monitor f behaviors or mood DON stated nurses					
	Gradual Dose Red Abnormal Involunta will be performed o	noactive Medication use and uction" dated 8/2013, identifies ary Movement Scale (AIMS) In residents receiving cations to screen for tardive months.				
		/Behavior/Sleep Observation" tifies target mood/behaviors				

TATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/10/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	• • •	
ROCHES	TER REHABILITATIO					
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 40	21535			
	care team are to co mood/behavior obs click care and point systems) when a re behaviors. Commu and or social worke nurses are to review mood/behavior obs completion and the documentation. A s mood/behavior/slee the monthly chartin of the interventions the resident's respo LACK OF AIMS AS R87's diagnosis for	ervation tool/ PCC POC (point to f care, online charting esident exhibits mood or nication to the licensed nurse er as appropriate. The licensed w documentation of the daily ervation/PCC POC for need for any additional ummary of the ep is to be completed during g cycle to include a summary used as well as a summary of onse. SESSMENT FOR R87: and on the Diagnosis Report al Disorders and Visual				
	R87's medication o Summary Report d Seroquel 25 mg giv for behaviors, agita delusional/paranoic dose PRN when un Seroquel 25 mg giv times a day for beh outbursts, delusion Review of Medicatii (MAR) from Decem indicates R87 recei needed) doses of S	rders found on the Order ated 2/9/17, identifies re 1 tablet by mouth as needed ted persistent d outbursts may give additional table to redirect behaviors. re one tablet by mouth two aviors: persistent paranoid s. on Administration Record taber 2016 to February 2017, ved scheduled and PRN (as Seroquel as ordered.				
	problem due to yell	14/17, identifies a behavior ing and making threats of ambivalent family relationships.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29822	B. WING		02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ROCHES	TER REHABILITATIC		LLINGTON BO STER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 41	21535			
	staff at times also.	e which is his wife. Will yell at Has diagnosis of psychosis tory of hallucinations/Charles				
		s notes dated 12/5/16 through of any AIMS assessment				
		nents identified AIMS ot been completed for R87.				
	nursing (DON) stat to be an AIMS asse any resident receiv verified an AIMS as completed for R87.	, at 8:40 a.m. with director of ed by day 4 there is supposed essment that is completed for ing an antipsychotic. DON essessment had not been . DON stated the nurse ionsible for completing the				
	manager (RN)-A st any AIMS assessm unaware that she w the assessment an	r, at 12:15 p.m. with the nurse ated that she hadn't completed rents. RN- stated she was vas responsible for completing d stated she doesn't have a o what assessments she is te.	1			
	Gradual Dose Red Abnormal Involunta will be performed o	noactive Medication use and uction" dated 8/2013, identifies ary Movement Scale (AIMS) on residents receiving cations to screen for tardive months.				
	LACK OF SLEEP A	ASSESSMENT:				
		ne facility on initially on nitted on 1/12/17 per the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 42	21535			
	Minimum Date Ass R173 was cognitive	ecord. R173 admission essment 1/20/17 indicated ely intact and was trouble with ing asleep or sleeping too				
	2/04/17 and reorde "Trazodone Tablet in the evening for s after 1 hour AND G	rders dated 1/13/17 through ered on 2/4/17 included, 50 MG Give 1 tablet by mouth eleep may repeat x1 if needed tive 1 tablet by mouth as lay take repeat dose if still				
	(MAR) from Janual indicated R173 rec	on Administration Record ry 2017 to February 2017, eived scheduled doses of long with prn dose given on				
	admission on 1/12/	ep assessment had not been				
	1/13/17 to 2/8/17 a	a comprehensive sleep				
	LACK OF AIMS AS MONITORING OF	SESSMENT AND BEHAVIOR/MOOD:				
		ound on the Admission Record tifies severe major depressive				
	Summary Report ic	rders found on the Order dentifies: mirtazapine 15 mg nouth one time a day for				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/10/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER REHABILITATIC		LLINGTON BO STER, MN 559	ULEVARD NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 43	21535			
	by mouth twice dail times daily for depr 1/13/17. Orders fo and anti-psychotic in 2/8/17, after enterin Behavior monitoring identifies behavior other behavior/mod Care plan dated 1/2 psychotropic medic has diagnosis of de several psychiatric antidepressant and Treatment Adminis February 2017, ide	eroquel 25 mg give 0.25 tablet ly, and Zoloft 100 mg two ression all with start dates of r monitoring of anti-depressan medications were entered on ng the facility. g record for February 2017 monitoring from MDS. No od monitoring identified. 20/17, identifies R173 is on cations. Indicates that R173 epression and history of hospitalizations. R173 takes I antipsychotic medications. tration Record (TAR) dated ntifies to monitor for side essant, use with a start date of	t			
	monitor for any side Medication Adminis February 2017, ide mirtazapine 15 mg depression and one and Seroquel 25 m daily and Zoloft 100	17, TAR does not identify to e-effects of medications. stration Record (MAR) dated ntifies R173 to have received daily at bed time for ce daily as needed for anxiety g give 0.25 tablet two times 0 mg two times daily. MAR				
	anti-psychotic med behaviors with a sta January 2017, does anti-psychotic beha Progress note date	d 1/27/17, identifies R173 to				
	depression. Progre identifies a PHQ-9	re of 4 which indicates no ess note dated 1/20/16, score of 9 which indicates mild ess note dated 1/06/17,	t			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO TER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 44	21535			
	depression, Progre	score of 3 which indicates no ss noted dated 12/27/16 score of 5 which indicates mild	I			
		notes from 12/8/16 through o mention of R173 having any concerns.				
		nents indicated an AIMS ot been completed for R173.				
	FOR AN AS NEED LACK OF NON-PH INTERVENTIONS DOCUMENTED PF	ENTED REASON FOR USE ED PAIN MEDICATION AND IARMACOLOGICAL BEING ATTEMPTED AND RIOR TO THE I OF A AN AS NEEDED PAIN				
	medication adminis	orders found on the stration records (MAR) for February 2017 included PRN wing pain medications:				
	R173 stated they w would to try ice first	n 02/09/2017, at 11:15 a.m. yould asked periodically if she t. R173 indicated that she ecause it does not work for				
	Give 0.5 tablet by r for pain rated <5/10	IG (HYDROmorphone HCI) nouth every 4 hours as needed 0 AND Give 1 tablet by mouth eeded for pain rated >5/10	1			
	Administration Rec R173 received PR	ary 2016 Medications ord (MAR) revealed: N (as needed) Dilaudid lication 17 times from				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SUF COMPLET	
			-			
		29822	B. WING		02/10/2017	
AME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, S			
OCHES	TER REHABILITATIC		TER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From pa	ige 45	21535			
	facility did not docu 17 times the medic addition, the facility non-pharmacologic prior to the PRN Di Review of the Febr R189 received PRN to 2/1/17. The facili reason for use 4 of was administered. document non-pha	f 1/13/17 to 1/31/17. The ment the reason for use 17 of ation was administered. In failed to document cal interventions attempted laudid being administered. uary 2017 MAR revealed: N Dilaudid 4 times from 2/1/17 ty did not document the the 4 times the medication In addition, the facility failed to rmacological interventions he PRN Dilaudid being				
	sleep and AIMs ass already stated to ot AIMs assessment H residents. Also, sta	a. with DON when asked about sessments stated that she had her surveyors that no sleep or had been completed for any ated that she did an audit for g monitoring and added them s started.				
	director of nursing develop systems to regimens are thoro unnecessary medic could educate all a unnecessary medic could develop a mo ongoing complianc Quality Assurance	cations. The DON or designee ppropriate staff on cations. The DON or designee onitoring system to ensure e and report the findings to the Committee.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C	DER'S PLAN OF CORRECTION (X5) ORRECTIVE ACTION SHOULD BE COMPL
Subscription Image: Subscription of the section of the section 253C-01 Image: Subscription 253C-01 <t< th=""><th>DER'S PLAN OF CORRECTION (X5) ORRECTIVE ACTION SHOULD BE COMPL</th></t<>	DER'S PLAN OF CORRECTION (X5) ORRECTIVE ACTION SHOULD BE COMPL
ROCHESTER REHABILITATION AND LIVING CI 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 PROV (EACH O PREFIX PROV (EACH O CROSS-RE 21800 Continued From page 46 21800 21800 21800 21800 MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights 21800 21800 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	DER'S PLAN OF CORRECTION (X5) ORRECTIVE ACTION SHOULD BE COMPL
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG PROV (EACH C CROSS-RE 21800 Continued From page 46 21800 21800 21800 MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights 21800 21800 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	ORRECTIVE ACTION SHOULD BE COMPL
TAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-RE21800Continued From page 462180021800MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights21800Subd. 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	
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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 Corrected	

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21800	Continued From pa	age 47	21800			
	skilled services for	rmination of Medicare Part A of 4 of 4 residents (R113, R35 ved for liability and beneficiary	,			
	Findings Include:					
	10/22/16, used 8 d facility. The facility her legal represent for Medicare and M (CMS)-10055 to int	form her of potential liability for ces and of her right to appeal				
	10/27/16, used 6 d facility. The facility legal representative Medicare and Med inform her of poten	ed from Medicare Part A on ays and remained in the did not provide R35 and/or her e with a SNFABN/Centers for icaid Services (CMS)-10055 to ntial liability for non-covered r right to appeal the denial to				
	12/8/16, used 35 d facility. The facility legal representative Medicare and Med inform her of poten	ed from Medicare Part A on ays and remained in the did not provide R40 and/or her e with a SNFABN/Centers for icaid Services (CMS)-10055 to itial liability for non-covered r right to appeal the denial to				
	8/27/16 used 43 da The facility did not representative with Medicare and Med	ged from Medicare Part A on ays and remained in the facility provide R120 and/or her legal a SNFABN/Centers for icaid Services (CMS)-10055 to ntial liability for non-covered				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 48	21800			
	services and of her Medicare.	right to appeal the denial to				
	stated in response they provide the SN "We have not been	8/17, at 4:10 p.m. Administrator to a question regarding when NFABN form to the residents, giving these out. We will e and will be starting to give	r			
	director of nursing	THOD OF CORRECTION: The could designate and educate ment to give demand notice	•			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			3/22/17
	Subd. 10. Particip notification of famil	bation in planning treatment; y members.				
	in the planning of the includes the opport alternatives with inco- opportunity to requi- care conferences, a family member or co- both. In the event for present, a family me chosen by the resident conferences. (b) If a resident we unconscious or cor communicate, the for-	Il have the right to participate heir health care. This right sunity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be sember or other representative dent may be included in such who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify				

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		1900 BAL	LINGTON BC	ULEVARD NW		
ROCHES	TER REHABILITATIO	N AND LIVING CI ROCHES	TER, MN 559	01		
(X4) ID					(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
21830	Continued From pa	ige 49	21830			
	either a family merr	ber or a person designated in				
		ent as the person to contact in				
		the resident has been				
		lity. The facility shall allow the				
	,	articipate in treatment				
		e facility knows or has reason				
		ent has an effective advance				
		trary or knows the resident has that they do not want a family				
		n treatment planning. After				
		ember but prior to allowing a				
		articipate in treatment				
	planning, the facility	/ must make reasonable				
		vith reasonable medical				
	•	ne if the resident has				
		ce directive relative to the				
		re decisions. For purposes of asonable efforts" include:				
		e personal effects of the				
		e medical records of the				
		session of the facility;				
		ny emergency contact or				
		tacted under this section thas executed an advance				
		her the resident has a				
		the resident normally goes for				
	care; and					
	(4) inquiring of th	e physician to whom the				
		oes for care, if known,				
		nt has executed an advance				
		y notifies a family member or				
		ency contact or allows a family				
		ate in treatment planning in is paragraph, the facility is not				
		r damages on the grounds that				
		ne family member or				
		or the participation of the				
		s improper or violated the				
	,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
AME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
OCHES	TER REHABILITATIO		LINGTON B	OULEVARD NW 901		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
21830	Continued From pa	age 50	21830			
	family member or of the facility shall atter members or a desi examining the pers and the medical re- possession of the f to notify a family m emergency contact admission, the faci social service ager agency that the res the facility has bee member or design county social service enforcement agence identifying and noti designated emerge service agency or I that assists a faciliti subdivision is not li damages on the gr the family member participation of the or violated the patie This MN Requirem by: Based on observat review, the facility f	asonable efforts to notify a designated emergency contact, empt to identify family ignated emergency contact by sonal effects of the resident cords of the resident in the facility. If the facility is unable ember or designated t within 24 hours after the lity shall notify the county ney or local law enforcement sident has been admitted and n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in fying a family member or ency contact. A county social local law enforcement agency ty in implementing this able to the resident for rounds that the notification of or emergency contact or the family member was improper		Corrected		
	reviewed for choice Findings include:					
	the facility admission					

STATE FORM

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
BOOD BALLING TON BOULEVARD NY DCHESTER, MN 55901 (X4) ID TRG SUMMARY STATEMENT OF DEFICIENCES ID HEFIX TAG DROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE AUTOR SHOULD BE OROSS-REFERENCED TO TULE APROPRIATE DEFICIENCY) OX 21830 Continued From page 51 21830 0n 2/07/17, 2:06 p.m. R188 stated she had been asking for 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. R188's Nursing Day 1 of Admission/Readmission assessment dated 2/3/16 included, "REOUIRED 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 Nursing Day 1 of Admission/Readmission assessment 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 assignent. NA-A stated residents are assigned their bath day stated can baked ble to come change to reflect a resident specific noce. Deschar a schedule change to reflect a resident specific noce.			29822	B. WING		02/	10/2017
ROCHESTER HEHABLITATION AND LIVING CI ROCHESTER, MN 55901 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EEP PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) IO CONTROL TAGE 21830 21830 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. 21830 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 staff can make a schedule change to reflect a resident's preference in the change to reflect a resident's preference in the	NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
INCLIFIESTER, MN 35901 IMAL ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIAL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21830 Continued From page 51 21830 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 if a resident sare 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	BUCHES	TER REHARII ITATIC		LINGTON BO	ULEVARD NW		
PHÈFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRÉFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CON 21830 Continued From page 51 21830 Continued From page 51 21830 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 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			ROCHES	TER, MN 559	01		
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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		shower today. R188 for a shower since stated she had bee shower would be all she would like a sh was given a showe R188's Nursing Da assessment dated QUESTION: Ask th for bathing and pas for their plan of car addressed bathing not answered and w R188's progress no "Resident would pro- week and on day sh On 2/09/17, at 7:35 (NA)-A stated baths and as requested. I assigned their bath assignment. NA-A different bath day s change to reflect a computer and upda On 2/09/17, 11:32 a (DON) stated she e the bathing prefere admission assess the assessment ha R188. The DON sta assessment was co	8 stated she had been asking admission on 2/3/17. R188 en unware of when her next nd stated she was not asked if ower or a bath today when she r. y 1 of Admission/Readmission 2/3/16 included, "REQUIRED he resident their preferences st routine mark answers here e." The questions that frequency or preferences were were left blank. ote dated 2/10/17, indicated, efer a bath x2 [two times] a hift." 6 a.m., nursing assistant s were scheduled once a week NA-A stated residents are day based on their room stated if a resident requested a taff can make a schedule resident's preference in the ate the bath sheet. a.m. the director of nursing expected the nurse to complete nce questions on the nursing nent and verified this portion of d not been completed for ated at the time the completed nursing should be				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	STER REHABILITATIO		LLINGTON BO STER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21830	day of week and tin accommodate bath The DON stated nu with R188 her bathi bathing and prefere admission. On 2/10/17, at 10:1 had assigned a stat about her bathing p she would provide t assessment once th On 2/10/2017, at 10 today was the first t staff regarding her h had requested a bat day shift. A bathing choices a requested and not p R81's quarterly Min 10/25/16; identified impairment and nee dressing and bed m During the initial int R81 was asked abo morning. R81 had tell us when to get u tell us we need to g During an interview p.m. R81 had been morning she stated breakfast. Surveyo	 and of day to try to ing their bathing preferences. arsing should have reviewed ng schedule, frequency of ence for type of bathing upon 9 a.m. the DON stated she ff member to speak to R188 references today and stated his writer a copy of the ne nurse had completed it. b. 248 a.m., the DON stated ime R188 was interviewed by bathing preferences. R188 th two times a week on the and preferences policy was provided. anum Data Set (MDS) dated R81 had severe cognitive eded extensive assistance for nobility. erview on 2/7/17 at 3:37 p.m., put her choice to get up in the said, when girls come in they up, we cannot sleep in, staff et up to go get breakfast. with R81 on 2/08/17 at 12:40 asked when she got up this that she got up in time for r asked if ready to get up she turned her head up, and 	21830			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21830	Continued From pa	age 53	21830			
		m. R81 observed to be rising Surveyor asked if getting up ated, "I guess so."				
	assistant (NA)-B w or if she usually ge R81 is woke up, do up NA-B stated tha time she wants to g Surveyor asked ho preferences. NA-E kardex (a reference information). NA-E	Y at 7:52 a.m. with nursing hen asked if R81 gets woke up ts up on own. NA-B stated bes not know R81 time to get at R81 has not told staff what get up in the morning. w staff know the residents 8 stated that they look in the e tool for staff for resident's 8 went to computer to review bt able to find any wake times				
	practical nurse (LP wake time LPN-B and varies between sometimes woke u gets up on her own where to find the pu like. LPN-B stated	Y at 12:12 p.m. with licensed N)-B asked if she knew R81 stated R81 is not an early riser n 7:45 am-8:20 a.m. R81 is p by staff and other times she n. LPN-B was asked about references residents would , "We do not have a lot of float nit and the staff just know their				
	been asked who co when residents wa LPN-B stated that admission papers on the unit. LPN-B or choices were as	Y at 1:27 p.m. with LPN-B had ompletes the admission paper s admitted to the facility. the floor nurses complete the with each resident that comes B asked when the preferences sked of the residents LPN-B ask their preferences or ion.				
		at 2:50 p.m. with director of lated the nurse on the floor				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ROCHES	TER REHABILITATIC		LLINGTON BO STER, MN 559	OULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21830	Continued From pa	age 54	21830			
	information is place populates to other bedtime are asked a program in place expectation would l prefers to sleep. R173 admitted to th nursing day one ad	ission on the residents then ed in the computer that auto areas. Questions on wake and on admission. Facility also has to wake at will. DON be not wake up R81 if she he facility on 12/26/16. A Imission/readmission				
	resident prefer sho R173 (per nursing hospital on 1/9/17 a 1/13/17. Progress r nursing day 1 admi	vas completed indicating that wers and one time per week. notes) admitted back to and readmitted to facility on note dated 1/13/17, title: ission/readmission note, there bathing preferences.				
	p.m. R173 had indi	vith R173 on 2/7/17, at 3:45 cated that she takes a shower but would be ok with every they are so busy.				
	asked everyday if s	p.m. R173 stated she had she could get a shower and they would look into it but it				
		a.m. R173 she stated that she assistant and they will tell her o her.				
	R173 asked for any	n. NA-A stated I do not recall if y extra showers. However, ly, if I was scheduled a shower would want more.				
	RN-D, regarding re	p.m. Interview with RN-B and sident preferences regarding neither RN-B nor RN-D				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29822	B. WING		02/	10/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER REHABILITATIO		LLINGTON BO STER, MN 559	ULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	ige 55	21830			
	preference or that s have an additional nurses stated, "Eve shower weekly, but one nurse here mo difficult to give ther On 2/10/17, at 9:15 DON, she stated th an extra shower that attempt to accomm On 2/10/17, at 10:1 someone (staff) hat regarding her bathi	a.m. during interview with at if resident requests to have at staff should make every odate the request. 6 a.m. R173 said that d come in to talk with her				
	dated reads; Open wake-at-will and re informed about the reviewed at care co SUGGESTED MET The administrator of on the need for sel	breakfast is served to facilitate sidents and family are importance of sleep and	3			
21915	MN St. Statute 144 Residents of HC Fa Subd. 27. Adviso their families shall maintain, and partie family councils. Ea assistance and spa	.651 Subd. 27 Patients & ac.Bill of Rights ry councils. Residents and nave the right to organize, cipate in resident advisory and ich facility shall provide ice for meetings. Council afforded privacy, with staff or	21915			3/22/17

H3H811

If continuation sheet 56 of 57

Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		29822	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCHES	TER REHABILITATIC		LINGTON B TER, MN 55	OULEVARD NW 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21915	visitors attending of	nly upon the council's	21915			
	invitation. A staff p responsibility of pro responding to writte council meetings.	erson shall be designated the oviding this assistance and en requests which result from Resident and family councils d to make recommendations				
	by: Based on interview facility failed to mal	ent is not met as evidenced and document review, the ke a good faith attempt to ouncil in the past calendar		Corrected		
	Findings include:					
	Worker at 2:00 p.m that they only had p the facility in regarc council. There wa mail notices or pho	th the facility's Licensed Social on 2/10/17, LSW-A verified posted a notice on the walls in its to developing a family is no other attempts such as ne calls made to encourage orm a committee at the facility.				
	Administrator could and procedures to establish a family c could document an	of Correction: The I review and revise policies ensure annual attempts to ouncil. The Administrator d keep record of forming a identify when the attempt had endar year.				
Minnesota D	Time Period for Co days. epartment of Health	rrection: Twenty-one (21)				