Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 31, 2025

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: April 22, 2025

Dear Administrator:

On May 14, 2025, we notified you a remedy was imposed.

On September 25, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 18, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 29, 2025, be discontinued as of September 18, 2025. (42 CFR 488.417 (b))

In our letter of May 14, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 22, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 31, 2025

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, Mn 55901

Re: Reinspection Results
Event ID: LBPL-H3

Dear Administrator:

On July 11, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 22, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
May 14, 2025

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: April 22, 2025

Dear Administrator:

On April 22, 2025, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On April 21, 2025, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 29, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 29, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 29, 2025, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 22, 2025. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Rochester Rehabilitation And Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 22, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 22, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly

Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 04/22/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/14/25 to 4/22/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/14/25 to 4/22/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H56262740C (MN00104633) H56262738C (MN00104940) H56266460C (MN00105275) H56262739C (MN00107393) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

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

Electronically Signed | 05/22/2025

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

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(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. §483.10(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. §483.10(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. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow up on a resident	F 561	Plan of Correction F561 SS=D Allegation of Compliance: This plan of	5/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 561	Continued From page 2 requested medication change in a timely manner for 1 of 1 residents (R138) reviewed for choices. Findings include: R138's quarterly Minimum Data Set (MDS) assessment was not completed at time of survey. R138 had intact cognition and had no rejection of cares. R138 had a diagnosis of right knee prosthesis infection and inflammatory response requiring intravenous (IV) antibiotic therapy. R138 required ongoing limited assistance for dressing and limited assist for hygiene. R138's medication orders included: Ertapenem (medication for infection) 1 gram IV infusion over one hour every day for infection of right knee prosthetic with a start date of 3/28/25. The first dose available at the facility was administered at 11pm. During interview on 4/14/25 at 6:32 p.m., R138 stated she would like to have the Ertapenem infusion done earlier in the evening around 7 or 8 p.m. R138 stated the nurses must wake her up at 11 p.m. to start the infusion and then again in an hour when the infusion is complete. She has asked the nursing staff to change this or request to change this, but the change has not been made. During interview on 4/14/25 7:00 p.m., licensed practical nurse (LPN)-E stated R138 had previously asked him to administer the Ertapenem dose sooner; he had stated to her that the medication could not be done sooner. LPN-E confirmed a situation background assessment recommendation (SBAR) report had not been	F 561	correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. F561 SS=D: Based on observation, interview, and documentation review, the facility failed to follow up on a resident requested medication change in a timely manner for 1 of 1 residents (R138) reviewed for choices. Self Determination: the resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified, such as choosing activities, schedules, health care, and providers. Affected Resident(s): R138 discharged on 5/2/2025 Potential Affected Resident(s): All residents with IV medications will be interviewed to confirm medication administration times meet resident preferences. Measures/Systematic Changes: Morning Daily Clinical meeting has been enhanced to include review of change of condition, medication changes, critical labs, falls, resident concerns and grievances. This includes a review of the 24-hour nursing report to ensure all	

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F 561	Continued From page 3 completed for this request. During interview on 4/16/25 at 9:07 a.m., registered nurse (RN)-A stated the resident had previously told her she wanted medication to be given during the day but told the resident the medication time could only be changed by a provider or a pharmacist. RN-A stated she had not completed a SBAR report to submit the request to the provider. During interview on 4/16/25 at 10:29 a.m., nurse practitioner (NP)-A stated the antibiotic could be moved to any time R138 preferred. NP-A confirmed she was unaware R138 wanted to change the time of the antibiotic administration. NP-A confirmed she would expect this kind of request to come on the standard SBAR communication. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated medication change requests are completed on a SBAR document. DON confirmed anyone can fill out the SBAR on the resident's behalf. DON confirmed R138 did not have an SBAR note requesting medication administration times. R138 medication administration time for Ertapenem continues to be administered late and was given on 4/17/25 at 12:04 a.m. A policy regarding resident choices was requested and not provided.	F 561	resident requests related to medication changes are responded to appropriately. Policies were reviewed for “Change of condition, Identification, Communication and Response”, “Resident Rights”, and “Person Centered Medication Administration” and remain current. Education of Licensed Nurses has been initiated to ensure that any resident who requests to change Medication Administration times will be followed up on in a timely manner. Monitoring: Audit will be completed to ensure appropriate resident medication administration preferences are being met. Audit will take place 2x week for 3 weeks and then weekly x 9 weeks. Results of monitoring will be reported at QAPI meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee will be responsible for compliance Date of Alleged Compliance: 5/29/2025	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		5/29/25

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F 580	Continued From page 4 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify resident representative following provider order changes in a timely manner for 1 of 1 residents (R18) who received an order for antibiotics for a urinary tract infection (UTI). Findings include: R18's quarterly Minimum Data Set (MDS) assessment dated 2/11/25, indicated R18 was severely cognitively impaired with no behaviors and was incontinent of bladder and bowel. R18's care plan for incontinence/altered elimination indicated R18 had ongoing incontinence and could not communicate the need to void. Interventions included: assist perineal hygiene after toileting, encourage fluid intake, observe for signs/symptoms of UTI (difficulty with urination, frequency, urgency, lower abdominal pain and discomfort, back pain, blood in the urine and report to medical doctor/nurse practitioner (MD/NP), offer toileting upon rising, before and after meals and bedtime and as needed (PRN). R18's medication administration record included: cefdinir 300 mg take 1 capsule by mouth two times a day for UTI for 5 days. Take before	F 580	F580 Notification of Changes Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. F580 SS=D: Based on interview and record review, the facility failed to notify resident representative following provider order changes in a timely manner for 1 of 1 residents (R18) who received an order for antibiotics for a urinary tract infection. A facility must immediately inform the resident, consult with the residents physician, and notify the residents representative when there is an accident with injury and has potential for requiring physician intervention, significant change in the residents physical, mental, or psychosocial status, a need to alter treatment, or transfer to the hospital.	

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	245626	A. BUILDING _____ B. WING _____	C 04/22/2025

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F 580	Continued From page 6 morning and evening meals dated 4/11/25 and in/out catheter to get UA (urine analysis) sample dated 4/9/25. R18's provider progress notes indicated the following: -4/8/25 "family is noting increased confusion since 4/7/25 and is concerned of UTI. Family is requesting UA". -4/9/2025 indicated order for urine specimen to be sent to lab. -4/11/25 indicated positive urinalysis (test to check for infection) and order for cefdinir 300 mg take 1 capsule by mouth twice a day before morning and evening meal x 5 days. -4/13/25 indicated sensitivities confirming continued use of cefdinir. R18's progress notes lacked resident representative was notified after UA results and R18 was diagnosed with a urinary tract infection, or changes to medication orders. During interview on 4/17/25 at 4:39 p.m., R18's family member (FM)-A reported requesting staff to obtain a urinalysis on 4/4/25 due to R18 having increased vocalizations, however the urine sample was not obtained until 4/10/25. FM-A arrived at the facility on 4/14/25 and still had not heard any updates regarding R18's urine status. At the time FM-A was told R18 "was on something for 5 days". FM-A stated it causes "so much stress having to dig for information about [R18]." During interview on 4/18/25 at 11:40 a.m., the director of nursing (DON) stated resident representatives should be notified of any change in condition, medication changes, and "anything abnormal", or for clarification of anything. All nurses can update resident representatives of	F 580	Affected Resident: R18s care plan has been reviewed and remains accurate. Records of residents with order changes in the last 30 days have been reviewed to ensure resident representative notification occurred and found to be appropriate. Daily Clinical Meeting now includes a review of all residents who have a change of conditions, medication changes, critical labs, falls, and other clinical changes to ensure proper notifications take place. The facility policy on Notification of Changes has been reviewed and updated. RRLC nursing staff are to notify the resident and the residents representative (if appropriate) on all medication changes or changes in a residents condition or plan of care. Nurses and nursing assistants will receive education will be completed regarding notification of changes to the appropriate parties. Education will also include the policy of Notification of changes. DON or designee will perform audits on Notification of Changes in progress notes 2x week for 3 weeks and then weekly x 9 weeks. DON is responsible for compliance. Date Certain: 5/29/2025	

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F 580	Continued From page 7 changes. The DON stated occasionally, the provider will update the resident or representative regarding recommendations however, it is expected staff would document notification of representative in a progress note. The DON reported, staff have been updated regarding notifying families and have seen improvement, however this instance "must have been missed". A facility policy titled "Notification of changes" dated 12/2016, indicated immediate notification of the resident and/or representative is to be done in situations including " a need to alter treatment/plan of care significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form or treatment)." It continues, "document, in the resident's medical record, the time called, the person spoken with, what was reported, and their response if any."	F 580		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		5/29/25

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F 636	Continued From page 8 (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,	F 636		

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F 636	Continued From page 9 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately complete comprehensive assessment of a resident's needs, strengths, goals, life history and preferences to determine a resident's functional capacity. In addition, the facility failed to ensure Minimum Data Set (MDS) was completed in a timely and/or in a comprehensive manner to facilitate accurate evaluation of resident' conditions for 5 of 5 residents (R6, R24, R194, R199, and R201) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the MDS as an assessment tool which facilities are required to use. The manual directed comprehensive assessments, "include the completion of both the MDS and the CAA process, as well as care planning." The CMS RAI manual also identified the RAI process (i.e., MDS) was completed to help evaluate resident' strengths and areas for care-planning. The manual listed all types of assessments to be completed along with corresponding timeframe's for them via a graph labeled, "RAI OBRA-required Assessment Summary." This directed a quarterly MDS should be completed (i.e., signed) within, "ARD + 14 calendar days." R6	F 636	F636 Comprehensive Assessments & Timing Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. Care plans for R6, R24, and R201 care plans have been reviewed and are accurate. MDS assessments dates have been reviewed for R6, R24, and R201 and are accurate. R194 and R199 have since discharged from the facility. Care plans were reviewed and they were accurate. Discharge MDS assessment dates were reviewed and were completed timely. All residents in the facility have been reviewed for MDS assessment dates and timely completion and they are accurate. MDS nurse has been included in the Daily Clinical Meeting, bringing forward any	

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F 636	Continued From page 10 R6's quarterly MDS, dated 3/10/25, identified R6 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R6's diagnoses included progressive neurological condition, multiple sclerosis, neurogenic bladder, paraplegia, anxiety and depression. Each resident electronic medical record (EMR) listed a section labeled, "MDS," which listed MDS's assessments to date for each resident. R6's quarterly MDS, with an assessment reference date (ARD) dated 3/10/25, although was listed and indicated completed on 4/14/25. R6's medical record was reviewed and lacked reason why the MDS was not completed timely. R24 R24's MDS list indicated "Medicare 5 day" was completed on 11/29/24 with no assessments listed after that date. R24's medical record was reviewed and lacked why the MDS had not been completed timely. R194 R194's admission MDS, dated 3/28/25, identified the MDS was "In progress". R194's admission MDS, with an assessment reference date (ARD) 4/10/25, was listed but categorized as, "In Progress." The MDS was not completed with multiple sections being red-colored and having little or no data entered and being labeled, "In Progress." The uncompleted sections included, "Hearing, Speech and Vision," and "Behavior," and "Bladder and Bowel," among several others.	F 636	needs are brought to the clinical team to ensure assessments are completed to ensure MDS are completed timely. The facility policy on the Resident Assessment Instrument (RAI) was reviewed and is current. RRLC staff are to ensure completion of the comprehensive assessments and the MDS assessments according to the RAI manual. Nurses and nursing assistants will be educated on following the MDS schedule and ensuring all comprehensive assessments are completed in a timely manner. Staff education will also include the policy on the Minimum Data Set (MDS)/Resident Assessment Instrument (RAI). Education on the RAI Policy and Process including assessments, CAA and care plan and care plan review for the interdisciplinary team. DON or designee will perform audits to ensure timely completion of MDS assessments 2x week for 3 weeks and then weekly x 9 weeks. DON is responsible for compliance. Date Certain: 5/29/2025	

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F 636	Continued From page 11 R194's medical record was reviewed and lacked reason why the MDS had not been completed timely. R199 R199's admission MDS, dated 3/17/25, identified the MDS was "In progress". R199's admission MDS, Medicare 5 day assessment, "Discharge return anticipated" assessment and "Medicare 5-day" assessment was listed but categorized as, "In Progress." All above MDS assessments were not completed with multiple sections being red-colored and having little or no data entered and being labeled, "In Progress." The uncompleted sections included, "Hearing, Speech and Vision," and "Behavior," and "Bladder and Bowel," among several others. R199's medical record was reviewed and lacked evidence why the MDS had not been completed timely. R201 R201's admission MDS, dated 4/14/25, identified the MDS was "In progress". R201's Medicare 5 day assessment, Discharge return anticipated assessment and Medicare 5-day assessment, Admission/Medicare 5 day, Discharge return anticipated were listed but categorized as, "In Progress." All above MDS assessments were not completed with multiple sections being red-colored and having little or no data entered and being labeled, "In Progress."	F 636		

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F 636	Continued From page 12 The uncompleted sections included, "Hearing, Speech and Vision," and "Behavior," and "Bladder and Bowel," among several others. R201's medical record was reviewed and lacked evidence why the MDS had not been completed timely per the RAI manual. During interview on 4/21/25 at 3:22 p.m., MDS-A stated she was a consultant and was asked to assist facility with completing MDS assessments last week. MDS stated she received access and started on 4/17/25 but was off on 4/18/25. MDS-A verified they help complete the MDS for the campus. MDS-A confirmed the above noted assessments were not finished and or reported timely. During interview on 4/21/25 at 4:49 p.m., administrator confirmed MDS assessment were behind and/ or had not been completed. Administrator stated they had just hired an external company to help with the MDS process. The facility Minimum Data Set (MDS)/Resident Assessment Instrument (RAI) policy, dated 5/18/23, identified the resident assessment process is completed by the interdisciplinary team (IDT) in accordance with the federal requirements to provide a baseline of the resident's functional status on admission with scheduled assessments to determine ongoing functional status and changes.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		5/29/25

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F 656	Continued From page 13 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 14 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement person-centered interventions for cardiac diagnosis for 1 of 1 residents (R194) reviewed for care plans. R194's admission Minimum Data Set (MDS) assessment was not completed in full at time of survey. R194's cognitive function was noted to be intact. R194 admitted on 3/28/25, following surgical repair of spinal stenosis (condition that narrows the space in the spine, putting pressure on the spinal cord or nerves). R194 diagnosis included atrial fibrillation (irregular heart rhythm), early ventricular depolarization (electrical signal in the heart come from lower chambers instead of upper chambers), atherosclerosis of the aorta (plaque buildup in the heart), bilateral carotid artery stenosis (partial or full blockage of the carotid artery located on each side of the neck), and hypertensive heart disease (develops due to prolonged high blood pressure, causing heart failure and abnormal heart muscle thickening). R194's admission care area assessment (CAA) report dated 3/28/25 identified a cardiac diagnosis requiring monitoring, medications, and treatments without specific person-centered interventions R194's CAA also identified R194 had a pacemaker requiring monitoring, medication, and treatments on an ongoing basis; no specific person-centered interventions were	F 656	F656 Comprehensive Care Plan Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. R194 has since discharged. Residents care plan was reviewed and it was accurate. Residents with cardiac diagnoses residents care plans have been reviewed and updated with person-centered interventions. Weekly all resident interdisciplinary team review meeting now includes a review of care plans to ensure person centered interventions are implemented. The facility policy on Comprehensive Care Plans was reviewed and is current. RRLC staff are to ensure each resident has a person-centered care plan.	

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F 656	Continued From page 15 noted. R194's goals of evaluation for the cardiac diagnosis included R194 would be free of signs and symptoms of complications related to cardiac condition. R194's goals of evaluation for the pacemaker diagnosis included R194's pacemaker checks will be within normal limits. R194's goal of pain management diagnosis was R194 would demonstrate minimal discomfort or absence of acute pain and identify positive coping behaviors for chronic pain. During interview on 4/15/25 1:32 p.m., licensed practical nurse (LPN)-A stated the admission assessment is completed by a health unit coordinator (HUC) or the nurse assessment coordinator. Once the admission assessment entry is complete, the electronic medical record (EMR) will auto-populate a generic care plan. Within 48 hours the nurse assessment coordinator will enter the specific person-centered interventions. LPN-A confirmed R194 had a completed admission assessment, performed on 3/28/25. LPN-A confirmed R194 record did not have person-centered interventions. LPN-A confirmed R194 should have resident specific interventions due to his significant cardiac history and recent surgical procedure which would require pain monitoring and management. During interview on 4/16/25 at 7:27 a.m., RN-A confirmed R194 did not have specific resident-centered interventions. RN-A confirmed R194 should have interventions to include ongoing blood pressure monitoring, vital sign parameters, medication parameters in relation to the current vital signs, and interventions to address cardiac symptoms of dizziness and	F 656	Nurses and nursing assistants will be educated on ensuring each resident has a person-centered care plan created. Education will also include a review of the Comprehensive Care Plan policy. DON or designee to audit care plans for all new admissions 2x week for 3 weeks and then weekly x 9 weeks. Audit results will be reviewed monthly at QAPI meetings for further recommendations. DON is responsible for compliance. Date Certain: 5/29/2025	

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F 656	Continued From page 16 lightheadedness. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated each resident should have an admission assessment completed when they arrive. DON confirmed R194 had an admission assessment upon arrival on 3/28/25. DON confirmed an initial generic care plan was generated for R194 on 3/28/25. DON confirmed R194 did not have a resident-specific care plan with interventions completed within 48 hours of admission. A facility policy titled Comprehensive Care Plan dated 10/2022 stated, the interdisciplinary team (IDT) will create an individual resident-specific care plan with individual interventions to communicate the resident's individual care within 48 hours of admission.	F 656		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to follow physician orders, complete assessments, monitor or input appropriate interventions and recognize changes in condition, for 6 of 6 residents (R31, R201, R21,	F 684	Plan of Correction F684 SS=J Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit	5/29/25

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F 684	Continued From page 17 R194, R6, R18) reviewed for quality of care. As a result of the facility's failures, an immediate jeopardy (IJ) situation was identified for R31 who had displayed respiratory distress with labored breathing, increased anxiety and required additional medication, R201 who had displayed signs of a UTI and was transferred to the ER for treatment, R21 who had displayed signs of a urinary tract infection (UTI) and was transferred to the hospital ER for treatment. The immediate jeopardy began on 4/12/25, when R31's daily weight were not completed as ordered and facility was not monitoring, which led to R31's respiratory distress, and failed to identify, monitor and assess R201 and R21 for change of condition related to blood in the catheters led to kidney/bladder infections. The administrator, assistant administrator, director of nursing (DON), regional vice president was notified of the immediate jeopardy at 5:47 p.m. on 4/18/25. The immediate jeopardy was removed on 4/21/25 at 1:07 p.m., but noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R31 was admitted on 4/11/25 and admission Minimum Data Set (MDS) assessment dated 4/17/25, identified the MDS was "In progress" with no information completed. R31's electronic medical record (EMR), included diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure with hypercapnia (increased levels of carbon dioxide in the blood)	F 684	that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. R31, R201, R21, R6, and R18s care plans and orders have been reviewed and are current. R194 has since discharged. Care plan was reviewed and it was current. All residents care plans have been reviewed and are accurate. The facility policies Interact, Change of Condition Notification, Change of Condition Protocol have all been reviewed and found to be current. RRLC staff are to notify a physician if a resident is experiencing a change of condition. Daily Clinical Meeting has been enhanced to include review of change of conditions, medication changes, critical labs and falls. It also includes monitoring of critical resident weights, dressing changes, and resident outputs. The enhanced daily clinical monitoring allows clinical leaders to ensure resident care and monitoring is taking place with in-person verification. Nursing and nursing assistants will receive education regarding change of	

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F 684	Continued From page 18 and hypoxia (insufficient oxygen at the tissue level), Cor pulmonale (enlargement and failure of the right ventricle of the heart as a response to increased vascular resistance or high blood pressure in the lungs), essential hypertension, anxiety disorder, shortness of breath, and was dependent on supplemental oxygen. R31's physician orders, dated 4/11/25, included the following: Oxygen via nasal cannula 2 L/min (liters per minute) at rest while awake, 4 L via nasal cannula with exercise or activity and 2 L via BiPAP when BiPAP is on; and daily fasting weight for edema and to notify the provider of a two (2) pound weight gain in two days or five (5) pound gain in seven days. Lasix 20 mg (milligrams) daily for edema. R31's post hospital follow up visit note dated 4/11/25, nurse practitioner (NP), indicated R31 had presented to the ER on 3/28/25 for shortness of breath and was found to be in hypoxic respiratory failure, and tachypneic (abnormally rapid and shallow breathing). R31's was admitted to the intensive care on 3/28/25 to 4/3/25 and was treated for volume overload, pneumonia, and COPD exacerbation. While in the Intensive Care Unit (ICU), R31 was aggressively diuressed (the excretion of a large amount of fluid). R31 required supplemental oxygen via nasal cannula 2 L at rest while awake, 4 L via nasal cannula with exercise or activity and 2 L via BiPAP while sleeping and medications. NP continued the current order of Lasix 20 milligrams (mg) daily and asked nursing to complete daily standing fasting weights and to notify provider of weight gain of two (2) pounds in two (2) days or five pounds in seven days and will follow up the following week to determine dry weight goal.	F 684	condition signs in a resident. Education will include SBAR forms and the stop and watch tool. Staff education will include review of the policies Interact, Change of Condition Notification, Change of Condition Protocol. DON or designee will perform audits on quality of life/change of condition 2x week for 3 weeks and then weekly x 9 weeks. Audit results will be reviewed monthly at QAPI meetings for further recommendations. DON is responsible for compliance. Date Certain: 5.29.2025	

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F 684	Continued From page 19 R31's care plan dated 4/11/25, included R31 respiratory diagnosis with abnormal lung sound and shortness of breath. Interventions were identified to administer medications as prescribed by physician, give nebulizer treatment and oxygen therapy as ordered, and to notify physician if increased coughing occurs. The care plan also indicated R31 was at nutritional risk related to diagnoses of COPD, respiratory failure, oxygen dependence, altered skin integrity and recent weight loss with low body weight. Interventions were identified to observe changes in weight and to notify physician. R31's daily weight record from 4/11/25 to 4/18/25 revealed R31 had not been weighed 6 of the 7 days: -4/11/25, wt. (weight) 142.56 lbs. -4/12/25, wt. not taken -4/13/25, wt. not taken -4/14/25, wt. not taken -4/15/25, wt. not taken -4/16/25, wt. not taken -4/17/25, wt. not taken -4/18/25, wt. not taken During observation on 4/16/25 at 10:42 a.m., R31 was sitting in his room with oxygen on. R31 was observed to have labored breathing. During observation on 4/18/25 at 11:32 a.m., R31 was laying in bed with oxygen on. R31 was observed to have labored breathing. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A stated residents who have an order for daily weights should have their weight obtained in the morning before breakfast.	F 684		

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F 684	Continued From page 20 RN-A stated any staff can obtain a weight and document the weight in the electronic medical record (EMR). RN-A said whoever obtains the weight are responsible for charting it. During interview on 4/18/25 at 12:09 a.m., NP stated R31 was extremely complicated and fragile. NP stated R31 was experiencing labored breathing, had diminished lung sounds and was on the incorrect oxygen setting while lying in bed during the visit. NP stated R31's oxygen orders were for two liters at rest although was found to be set at four liters while lying in bed. NP stated she had wanted R31 to go to the ER for evaluation although R31 refused. NP stated she had also offered R31 Dilaudid (medication that reduces respiratory rate and reduces breathing difficulties) to help with his breathing and hydroxyzine for anxiety, NP indicated R31 refused. NP stated she was not sure if the Lasix (newly added medication from hospital) was effective or if R31 was having fluid buildup because she did not know what R31's weights were due to facility not following orders to obtain daily weights. NP stated she expected facility to obtain daily weight and to record them and follow any parameters in order to initiate interventions/treatments to help prevent resident from fluid buildup which can make breathing difficult. R31's weight obtained per NP on 4/18/25, was 156.6 lbs, a 14.1 pound increase. During a follow up interview on 4/18/25 at 3:11 p.m., NP stated R31 had slightly improved from the first visit and an action plan was made with R31 and R31's son. NP stated she obtained R31's weight today of ~157 pounds. NP stated	F 684		

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F 684	Continued From page 21 R31's dismissal weight from the hospital was 142 pounds. R31 had a 14.4-pound weight gain in the past week. NP stated she was going to increase R31's Lasix. NP stated she felt like R31 could have been in respiratory failure this morning upon her initial assessment. NP stated oxygen orders were not initiated or started over the weekend from 4/11/25 (date of admission) to 4/14/25 and staff were administering the oxygen at whatever liter per minute R31 told them to put it on or whatever they felt was appropriate. NP stated son was very concerned as he noted a change in R31's breathing over the weekend. NP stated she notified the facility of this and that is when the facility initiated and entered the oxygen orders in R31's EMR. NP stated she expected staff to obtain a full set of vitals on residents every day to monitor for any changes in condition. During interview on 4/18/25 at 3:22 p.m., occupational therapist (OT) stated R31 had slowed down while in therapy over the past couple of days and did not have therapy today due to the NP holding therapy services until further notice. During interview on 4/17/25 at 12:03 p.m., licensed practical nurse (LPN)-G stated if there was a change in condition with a resident, she would notify the charge nurse, or the provider and document change in a progress note in the resident's chart. LPN-G stated if a resident had an order for daily weights, it would be reflected on the medication/treatment administration record. LPN-G stated the nursing assistants (NA)'s obtain the weight and would notify a nurse with weight results, who would then document weight in the EMR. LPN-G stated there is not a good system in place regarding weights as weights are missed.	F 684		

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F 684	Continued From page 22 LPN-G reviewed R31's chart and confirmed R31 had an order for fasting daily weights and the last recorded weight was on 4/11/25. LPN-G stated it was important to get the daily weights on R31 due to his fragile health concerns and that the provider needed to be notified of any weight change to allow for immediate intervention to be done. During interview on 4/17/25 at 3:02 p.m., RN-C stated when a resident has an order for daily weights, she obtains the daily weight as it is needed and important due to condition and respiratory failure. During interview on 4/18/25 at 2:44 p.m., LPN-A stated the NA's obtain the daily weights but if the nurse noticed it was not completed the nurse should obtain the weight. LPN-A stated daily weights should be done by 10:00-10:30 a.m. but could be delayed due to other factors that may arise. NA's know what weights to be obtained by looking in the EMR under their tasks. LPN-A stated if a daily weight does not get done then she would expect that resident to be the first one obtained the following day. During interview on 4/18/25 at 2:47 a.m., NA-B stated the nurse lets her know and she would write down which residents need weights. Once she got the weight, she would then give it to the nurse who would document. During interview on 4/18/25 at 3:11 p.m., NA-C stated the nurse gives her a paper log at the beginning of the shift, which is where she would write the weights on it and would return it to the nurse to document at the end of the shift.	F 684		

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F 684	Continued From page 23 During interview on 4/17/25 at 2:00 p.m., director of nursing (DON) stated the admissions nurse, health unit coordinator (HUC), nurse manager and herself are responsible for processing and entering orders. DON stated the floor nurses are allowed to process orders if order was received "after hours". DON stated all orders are verified by another nurse to ensure it was correct. During a follow-up interview on 4/18/25 at 4:25 p.m., DON stated daily weights are to be completed in the morning and if there are parameters in place for a resident and the weight is outside the parameter, she would expect staff to notify the provider of any change. DON confirmed R31 had an order, with parameters for fasting daily weights and the order was not followed. DON stated daily weights are important to be done for a person with any cardiac issues in order to identify immediately. DON confirmed the oxygen order was received on 4/11/25 although was not entered until 4/14/25. R201 R201's was admitted on 3/3/25 and admission MDS assessment dated 4/14/25, identified the MDS was "In progress" with no information completed. R201's EMR, included diagnoses of acute pyelonephritis (kidney infection), urinary tract infections, and chronic kidney disease (stage 4). R201's physician orders, dated 4/11/25, included the following: right nephrostomy (tube inserted into the kidney to drain urine directly into a collection bag outside the body) site care -	F 684		

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F 684	Continued From page 24 cleanse with normal saline daily, pat dry and cover with split gauze and paper tape daily every evening shift. R201's care plan dated 4/7/25, indicated R201 had altered elimination and would need treatment/monitoring/cares due to weakness and immobility. Interventions identified R201 had a nephrostomy. Care plan also indicated R201 had an alteration in skin integrity related to surgical incision. Intervention identified staff to observe site daily for signs of infection or poor healing: drainage, odor, redness, warmth of incision line and to notify physician of any signs of infection. The care plan lacked location of surgical incision. During observation and interview on 4/14/25 at 6:28 p.m., R201's nephrostomy bag contained dark red urine. R201 stated she was informed by staff she had an "episode" this morning where R201 became unresponsive and lethargic. During observation on 4/15/25 at 11:27 a.m., R201 just returned from therapy and nephrostomy bag contained dark red urine. During observation on 4/16/25 at 8:49 a.m., R201 was lying in bed with nephrostomy bag with dark red urine present. R201's EMR lacked documentation of monitoring of urine output (change in urine color), nor notification to provider of any changes in condition. During interview on 4/14/25 at 6:44 p.m., R201's family member (FM-B) stated they were not notified of an event related to unresponsiveness and when she went to the nursing station to	F 684		

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F 684	Continued From page 25 inquire about the event, FM-B was told that R201 went unresponsive for a few seconds, was ashen (pale gray color) in color and was lethargic following event. During interview on 4/14/25 at 6:47 p.m., RN-C stated she was told in report R201 was hard to wake up that morning and became lethargic. RN-C confirmed there was no documentation in R201's EMR regarding event. R201's progress note, dated 4/16/25 at 4:16 p.m., indicated R201 was sent to ER by provider for further evaluation. During interview on 4/17/25 at 9:26 a.m., FM-B stated when the NP came to R201's room for a regular visit, during her assessment she noticed the urine in R201's nephrostomy bag was red. NP recommended R201 be sent to the ER for further evaluation. FM-B stated R201 had been hospitalized for a kidney and bladder infection and was having a stent exchanged in the morning. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A stated standard catheter, nephrostomy care consisted of ensuring urine is flowing appropriately and monitoring the amount and color of the urine. RN-A stated if there was something abnormal, she would document in the EMR and notify the provider. RN-A stated she did not receive a lot of training on nephrostomies and had only one observation of a nephrostomy. During interview on 4/17/25 at 12:03 p.m., licensed practical nurse (LPN)-G stated NA's empty nephrostomy bag and would notify her of any changes or concerns such as flowing of	F 684		

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F 684	Continued From page 26 urine, dark colored urine. LPN-G stated she would notify the charge nurse and would encourage resident to drink more fluids. LPN-G stated she would assess urine for odor, assess resident for change in cognition and would monitor. LPN-G stated she would document abnormal findings in a progress note. LPN-G stated nephrostomy bag is emptied once to twice per shift. LPN-G stated she had not received any training regarding nephrostomies. During interview on 4/17/25 at 2:00 p.m., DON stated if there was a skill, task, or diagnosis not cared for in the facility, we would complete in person training for staff. DON stated the admission nurse would inform the DON prior to admission with what cares may need training on. This will allow the facility to initiate education ahead of time. During interview on 4/17/25 at 2:26 p.m., RN-D stated there were no specific training related to nephrostomies. During interview on 4/17/25 at 3:02 p.m., RN-C stated NA's empty R201's nephrostomy bag and write down the urine output which she would then document in the EMR. RN-C stated NAs notify her of any changes. RN-C stated she would go and assess the abnormality (such as blood in the bag) and would call the provider to obtain an order. RN-C stated she was not notified of the dark red urine in R201's nephrostomy bag by any NA's. During a follow up interview on 4/18/25 at 11:40 a.m., DON stated if a resident is suspected to have a UTI or is displaying symptoms of a UTI, she would expect staff to monitor vital signs and	F 684		

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F 684	Continued From page 27 symptoms, update the provider, increase fluids, enter progress note with information and initiate a nursing order on the MAR (medication administration record) for monitoring. During interview on 4/18/25 at 12:03 p.m., NP confirmed she was not notified R201's urine output was red. NP stated when she went to check in on R201 on 4/16/25, she had noticed red urine and had staff send R201 to the ER for further evaluation. NP confirmed when the resident previously had blood in her urine, it was an indication of a kidney, bladder infection. NP confirmed if she had been notified, she may have been able to prevent the visit to the emergency room by ordering a urine test to test for infection. During interview on 4/18/25 at 2:47 p.m., NA-B stated she emptied nephrostomy/catheter bags in the beginning of her shift and again at the end of her shift, document the amount drained. NA-B stated if she noticed a change in the urine, such as blood, she would let the nurse know immediately. During interview on 4/18/25 at 4:25 p.m., DON stated she expected there to be an order to obtain and monitor output for a resident with a nephrostomy/catheter. DON stated monitoring should consist of checking for redness around the insertion site, urine output and characteristics of the output, and any signs of drainage. DON stated she would expect staff to notify the provider immediately of any changes. DON stated staff should have notified the provider immediately when blood was noticed for direction from the doctor on what to do. DON confirmed there was no documentation of notification to the provider regarding dark red urine.	F 684		

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F 684	Continued From page 28 R21 R21's MDS assessment dated 1/15/25, indicated intact cognition. R21 had a functional impairment of both lower extremities. R21 required substantial assistance with toileting and hygiene. R21 had an indwelling catheter requiring substantial assistance for care. R21's medical diagnosis included benign prostatic hyperplasia (overgrowth of cells causing organ enlargement) with lower urinary tract symptoms causing urinary retention. This diagnosis is further complicated by obstructive and reflux uropathy (blockage preventing urine from flowing normally). R21's care plan for Foley Catheter dated 9/13/23 included R21 will be free of signs and symptoms of urinary tract infections, will receive catheter cares per order, have catheter emptied every shift, monitor and record output every shift, and monitor/record/request/report to provider change in amount, color, consistency, or odor. R21's physician orders include catheter change every month on the 11th, routine catheter care twice daily, change urinary drainage bag once a week on Mondays, and flush catheter with 30 ml (milliliters) of normal saline every shift as needed. During observation on 4/14/25 at 1:49 p.m., R21 had a leg bag for catheter drainage of urine. The drainage in the leg bag was red in color and filled approximately three quarters of the leg bag. R21 stated he was not in pain, did not recall if the drainage was new, and was unsure when staff had changed the catheter or the drainage bag.	F 684		

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F 684	Continued From page 29 During observation on 4/14/25 at 6:09 p.m., R21 continued to have dark red urine in the catheter leg bag. R21's progress note dated on 4/15/2025 at 7:20 a.m., indicated R21 had approximately 600 ml's of blood in his urinary leg bag. The progress note lacked indication if staff notified a provider about the amount or color of the drainage in the urinary leg bag. R21's TAR indicated R21 had routine catheter care performed twice a day for the last seven days. R21's progress note dated on 4/15/2025 at 4:15 p.m., indicated R21 was sent to the emergency department and his son was notified. R21 returned to the facility after emergent evaluation; was diagnosed with a urinary tract infection and started on an oral antibiotic. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A could not state what routine catheter care entailed. RN-A stated she just looked to make sure the catheter was still flowing, what the output looked like, and if the catheter might need to be flushed. RN-A stated she charts the amount of urine output, not the characteristics. RN-A stated if the urine looked abnormal, such as redness, she would enter a progress note and notify the provider via a situation/background/assessment/recommendation (SBAR) note. RN-A confirmed a progress note and SBAR notification was not charted for R21. During an interview on 4/16/25 at 10:33 a.m., the nurse practitioner (NP)-A indicated an	F 684		

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F 684	Continued From page 30 unawareness of R21's output included blood. NP-A confirmed when the resident previously had blood in his urine, it was an indication of a urinary tract infection. NP-A confirmed if she had been notified, she would have been able to help prevent the visit to the emergency room by ordering a urine test to test for infection and would start oral antibiotics. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) identified the facility charting does not have a location to document urine characteristics such as color, clarity, and odor. The DON indicated if a provider was notified about a change the staff are expected to input a progress note. The DON confirmed staff communicate these components of urine output via word of mouth or a progress note. DON identified a progress note of R21's urine characteristics dated 4/15/2025 at 7:20 a.m., although DON would have expected a progress note of R21's urine characteristics and notification to the provider when the blood was identified on 4/14/25. The Immediate Jeopardy was removed on 4/21/25, at 1:07 p.m. when it was determined the facility provided re-education and competency testing to licensed nursing staff on the facility's policies/procedures pertaining to change of condition, notification of changes, physician's orders, congestive heart failure, nephrostomy, COPD and catheters to include standards of documentation. In addition, the facility developed and implemented an auditing system for monitoring. R194	F 684		

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F 684	Continued From page 31 R194's admission Minimum Data Set (MDS) assessment was not completed in full at time of survey. R194's cognitive function was noted to be intact. R194 admitted on 3/28/25, following surgical repair of spinal stenosis (condition that narrows the space in the spine, putting pressure on the spinal cord or nerves). R194 diagnosis included atrial fibrillation (irregular heart rhythm), early ventricular depolarization (electrical signal in the heart come from lower chambers instead of upper chambers), atherosclerosis of the aorta (plaque buildup in the heart), bilateral carotid artery stenosis (partial or full blockage of the carotid artery located on each side of the neck), and hypertensive heart disease (develops due to prolonged high blood pressure, causing heart failure and abnormal heart muscle thickening). R194's care plan dated 3/28/25, identified a cardiac diagnosis and a pacemaker requiring monitoring, medications, and treatments. R194 care plan did not include person-centered interventions. R194's admission medication orders on 3/28/25 included amiodarone 200 mg each morning (used for irregular heart rate), metoprolol tartrate 75 mg twice per day (used for irregular heart rate and high blood pressure), apixaban 5 mg twice per day (used as a blood thinner), nitroglycerin 0.4 mg sublingual tablet every 5 minutes for 4 doses as needed (used for acute chest pain), and torsemide 10 mg every morning (used to treat fluid retention).	F 684		

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F 684	Continued From page 32 During an interview on 4/14/25 at 1:47 p.m., R194 stated he fell earlier this morning due to low blood pressure (a condition called hypotension). R194 stated he started to feel dizzy in physical therapy (PT) and the physical therapist was assisting him back to his room. R194 stated he felt dizzy and thinks he might have passed out in the hall on his way back to his room. R194 stated he had been given all his normally scheduled cardiac medications. R194's medication administration record (MAR) identified R194 was administered his scheduled medications. R194's blood pressure summary indicated he had not had his blood pressure (BP) checked before administering the cardiac medications. R194's fall report dated 4/14/25 at 10:45 a.m., included vital signs of a BP result of 83/40, heart rate (HR) of 83, and an oxygen saturation of 89%. At 11:09 am., upon returning to his room BP was 115/49. R194's post fall progress note dated 4/14/25 at 11:30 a.m., read the appropriate staff were notified, provider and family. R194's follow-up blood pressure was not documented until 4/14/25 at 5:06 p.m., with results being 123/52. R194 vital signs dated 4/15/25 at 10:56 a.m., included a BP of 86/64, a subsequent BP at 10:57 a.m., was noted to be 69/33. During an interview on 4/15/25 at 11:11 a.m., R194 was in his room with his wife and stated he was at PT this morning when he became dizzy	F 684		

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F 684	Continued From page 33 again and not able to complete PT. The results of his BP was low and R194 was returned to his room. R194 stated he had been given his normally scheduled BP medications this morning and indicated the staff did not take his blood pressure prior to administering the medications. R194 and his wife were uncertain whether the provider had been notified of R194's recent low BP's. During an interview on 4/15/25 at 11:20 a.m., registered nurse (RN)-A said staff would need an order to check a BP, blood sugar, or oxygen level before administering some medications. RN-A indicated she was aware R194 had an episode of low BP the previous day. RN-A confirmed she did not check the BP prior to giving the scheduled medications this morning. RN-A indicated some of the medications given could potentially have lower 194's BP. RN-A confirmed she did not check R194's BP due to the last results were with in normal range and because there was no order to check vital signs prior to administering medications. RN-A stated she would hold a BP medication if the systolic (first number) BP was less than 90. RN-A stated she would hold a BP medication if the resident was experiencing symptoms such as dizziness, weakness, or falling. RN-A stated she would call an ambulance if the BP was less than 80 and the resident had symptoms of dizziness, weakness, or falling. RN-A confirmed the resident had a BP less than 80 and he has had episodes of dizziness and falling. RN-A stated she had notified licensed practical nurse (LPN)-B (position as a nurse manager) about R194's low BP from this morning. RN-A stated LPN-B would fill out a situation background assessment recommendation (SBAR) report and send to the	F 684		

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F 684	Continued From page 34	F 684		

provider. RN-A reviewed R194's vitals and verified last charted BP was 69/33.

During interview on 4/15/25 at 11:35 a.m., physical therapist (PT)-A stated she worked with R194 on 4/14/25 and today (4/15/25). PT-A stated today they were monitoring R194's BP closely. At approximately 10:50 a.m., R194's BP was within normal limits while on the stationary bike, however, when he sat down in a regular chair, he stated he felt like his BP was low again. PT-A stated she called the nursing staff who assisted R194 back to his room.

During observation on 4/15/25 at 11:48 a.m., R194 was seated in his room, leaning towards the left; his appearance pale and R194 stated when he gets up, he has a lot of pressure in his head.

During observation and interview on 4/15/25 at 1:02 p.m., R194 confirmed he has not had his BP checked since he returned from therapy. He stated he is feeling ok, although felt his BP was still low. R194 confirmed he had not seen a provider.

During observation and interview on 4/15/25 at 1:07 p.m., RN-A confirmed there was no follow up BP checks after R194's last results were 69/33 and had not been directed by a physician to retake. Surveyor encouraged RN-A to verify R194's BP, taken manually the results were 120/72. RN-A confirmed she had not heard back from the provider and had not attempted to reach out to the provider regarding the recent low blood pressures.

During an interview on 4/15/25 1:32 p.m., LPN-A

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F 684	Continued From page 35 and LPN-B stated an SBAR report was sent to the provider regarding R194's low blood pressures although had not received any new orders. LPN-A stated SBAR's are faxed to the providers for less emergent issues and phone calls are made for concerns with urgent situations to include a change in alertness, multiple falls, vital signs are abnormal or passing out. LPN-B confirmed R194 had experienced abnormal vital signs, two falls, and an episode of passing out and confirmed the provider was not phoned. During an interview on 4/15/25 1:55 p.m., director of nursing (DON) stated she was aware R194 experienced recent low blood pressures with two episodes of lightheadedness and dizziness which resulted in falls. DON confirmed the provider had been sent an SBAR report 4/15/25. DON stated she would consider anything less than 100/60 as low and anything less than 50/30 to be emergent, requiring a call to the provider or a call to 911. DON verified R194's documented BP of 69/33. DON confirmed no call was made to the provider. DON's expectation would be to continue monitoring R194 given his status and his cardiac history. DON stated she would expect a complete set of vital signs to include BP, heart rate, respiratory rate, and oxygen saturation prior to giving additional cardiac medications. DON also included their procedure for post-fall monitoring included vitals sign monitoring every 8 hours for 24 hours, notify provider, and document in a progress note. DON confirmed lack of post-fall documentation or provider notification for 4/14/25 or 4/15/25 falls. During interview and observation on 4/15/25 at 3:42 p.m., Medical Doctor (MD)-C visited R194 in the physical therapy room accompanied by the	F 684		

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F 684	Continued From page 36 DON. PT-A and DON provided a brief update about R194. During this update, R194 stated he had experienced another fall at approximately midnight. The DON stated she was unaware of the 2nd fall on 4/14/25. MD-C instructed staff to return R194 to his room and complete a full set of orthostatic blood pressures and notify his regular provider with the results and encouraged R194 to remain in his room until seen by his normal provider on 4/16/25. During an observation on 4/16/25 at 7:20 a.m., LPN-C completed R194's necessary orthostatic BP levels without documenting the correlating heart rate. LPN-C stated an unawareness orthostatic BPs required a heart rate. During an interview on 4/16/25 at 7:56 a.m., MD-B confirmed an unawareness of R194's condition and incidents from 4/14/25 and 4/15/25 and would expect staff to notify a provider by phone immediately when there is a significant change in BP readings. MD-B stated staff could call 911 for immediate attention with symptoms of dizziness, falls, or general unwellness like R194 experienced. During an interview on 4/16/25 at 10:13 a.m., nurse practitioner (NP)-A stated she was notified of R194's falls and very low BP's upon arriving to the facility. NP-A stated she would have expected to be notified when a resident's BP is less than 90, and not just a receipt of an SBAR report being faxed. NP-A confirmed 911 should have been called for a BP less than 80 with symptoms such as falling, dizziness, and lightheadedness. NP-A confirmed the expectation is to complete a full set of vital signs prior to administering more than one cardiac medication,	F 684		

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F 684	Continued From page 37 NP-A confirmed R194 received more than one cardiac medication. NP-A confirmed the expectation was to monitor vital signs, including a blood pressure, frequently after a fall that was suspected to be due to low blood pressure. NP-A confirmed the process for completing orthostatic BP's included laying, sitting, standing-waiting 3-5 minutes in between position changes with a correlating heart rate. During interview on 4/16/2025 at 12:48 p.m., DON stated it is the expectation to complete a full set of vital signs after a fall; to include BP, pulse, temperature, respirator rate and oxygen saturation. DON confirmed R194 had a BP completed although lacked the remainder of vital signs after his falls. DON confirmed the late entry in the medical record regarding the fall at midnight on 4/15/25. DON confirmed the fall should have been documented at the time of the fall. DON stated an orthostatic blood pressure is completed at laying, sitting, standing positioning, waiting 3-5 minutes between positions with a correlating heart rate. DON confirmed R194 did not receive accurate orthostatic BP's. DON confirmed R194 had fallen 3 times, had not received post-fall follow up in accordance with facility policy. DON confirmed the provider had not been accurately updated about R194's change in status. R6 R6's quarterly Minimum Data Set (MDS) assessment, dated 3/10/25 indicated R6 had severe cognitive impairment with no behaviors, is dependent on staff for all activities of daily living	F 684		

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F 684	Continued From page 38 (ADLs) and has an indwelling catheter and ostomy. MDS also included R6 had diagnoses of multiple sclerosis (a progressive disease of the nervous system), neurogenic bladder (disease where the bladder does not function properly), and history of recurrent urinary tract infections. A catheter/urostomy/nephrostomy care plan indicated R6 would remain free of signs and symptoms (s/sx) of urinary tract infections. Interventions included: catheter bag cover at all times in bed and wheelchair, change catheter as ordered by physician, empty catheter every shift and record output, keep catheter tubing free of kinks, keep drainage bag below bladder level, secure catheter to leg to avoid tension on urinary meatus (opening). Monitor/record/request/report to medical doctor (MD) change in amount, color, consistency, or odor, UTI s/sx, chills, fever, nausea/vomiting, and pain. R6's medication administration record included: -cefdinir (antibiotic) twice a day for infection x 7 days ordered 3/19/25 and discontinued 3/24/25. Medication was given 3/19/25-3/24/25. -Amoxicillin-potassium clavulanate (antibiotic) twice a day for bacterial infection x 7 days ordered 3/22/25 and given 3/22/25-3/29/25. -suprapubic catheter (a tube inserted into the bladder through the abdomen) 18f change the 28th of every month -suprapubic catheter change drainage bag weekly -routine catheter care every day and evening shift -suprapubic catheter check tubing for proper positioning and cath care every shift -suprapubic catheter monitor intake and output every shift	F 684		

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F 684	Continued From page 39 A provider "telephone encounter" form dated 3/18/25 at 3:55 p.m., indicated staff called from facility stating her the end of her tube feeding broke and will be sending R6 to the emergency department (ED) to get it replaced. Please send order to send to ED" A provider telephone order dated 3/18/25 at 4:08 p.m., indicated "ok to send to the ER". R6's hospital emergency room progress note dated 3/19/25 indicated R6 was sent to the emergency room due to her PEG tube (tube in stomach to for liquid feeding) was broken and needed replacing. R6 was also found to have a urinary tract infection and acute cystitis (inflammation of the bladder) and would return to the facility with orders for antibiotics. R6's hospital after visit summary (AVS) report dated 3/18/25, R6 was sent to the emergency room due to "complication mechanical gastrostomy [feeding tube]". It included results from a urinalysis indicating bacteria present. Cefdinir was ordered. R6's hospital orders dated 3/21/25, indicated prescription for amoxicillin-pot clavulanate 875-125 twice a day for 7 days starting 3/21/25 and ending 3/28/25. It also included orders to discontinue previously ordered cefdinir. R6's clinical assessment screen indicated two separate entries for "nursing skilled services data collection" from 3/18/25-3/29/25. Both entries occurred on 3/24/25 at 6:51 a.m. and 11:14 a.m. On both entries, "urinary tract infection monitoring" was left blank.	F 684		

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F 684	Continued From page 40 R6's progress notes lacked documentation R6 returned from the emergency room, monitoring of urinary symptoms related to the UTI, or side effects of antibiotic as indicated by: -3/18/25 8:30 p.m., hosp -3/21/25 10:02 a.m.,"cefdinir capsule 300 mg Give 1 capsule by mouth two times a day for infection for 7 days-Awaiting delivery" -3/21/25 10:07 a.m. had vitals documented due to R6 having an emesis the previous evening. -3/23/25 6:59 a.m., indicated cefdinir was held due to antibiotic change -3/23/25 4:50 p.m., indicated cefdinir was "unavailable" R18 Quarterly MDS assessment dated 2/11/25, indicated R18 was severely cognitively impaired with no behaviors and was incontinent of bladder and bowel. An incontinence/altered elimination care plan indicated R18 had ongoing incontinence and cannot communicate the need to void. Interventions included: assist perineal hygiene after toileting, encourage fluid intake, observe for signs/symptoms of UTI (dysuria, frequency, urgency, nocturia, suprapubic pain and discomfort, back pain, hematuria and report to MD/NP, offer toileting upon rising, before and after meals and bedtime and PRN. R18's medication administration record included:	F 684		

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F 684	Continued From page 41 cefdinir 300 mg take 1 capsule by mouth two times a day for UTI for 5 days. Take before morning and evening meals dated 4/11/25 and in/out catheter to get UA sample dated 4/9/25. It lacked symptom monitoring or antibiotic side effect monitoring. R18's provider progress notes indicated the following on date: -4/8/25 "family is noting increased confusion since 4/7/25 and is concerned of UTI. Family is requesting UA". -4/9/2025 indicated order for urine specimen to be sent to lab. -4/11/25 indicated positive urinalysis (test to check for infection) and order for cefdinir 300 mg take 1 capsule by mouth twice a day before morning and evening meal x 5 days. -4/13/25 indicated sensitivities confirming continued use of cefdinir. R18's clinical assessment screen lacked monitoring for urinary tract infection, vital signs lacked vitals taken during time frame antibiotics administered, progress notes lacked indication of urinary symptoms, why UA was obtained, symptom monitoring, or antibiotic side effect monitoring. During interview on 4/16/25 at 2:09 p.m., licensed practical nurse (LPN)-F stated if a resident is exhibiting signs or symptoms of a urinary tract infection, communication is faxed to the nurse line. If after hours or on weekends, a phone call is placed to an on-call provider. Documentation is made in progress notes. LPN-F reviewed R18's progress notes and confirmed there is no documentation of urinary symptoms. LPN-F also confirmed R18 started on antibiotics 4/11/25 and	F 684		

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F 684	Continued From page 42	F 684		

the record lacked documentation of vital monitoring, symptom monitor, or antibiotic monitoring.

During interview on 4/17/25 at 12:04 p.m., registered nurse (RN)-B stated residents diagnosed with a urinary tract infection should be monitored for symptoms on the treatment administration record (TAR). If it is not documented on the TAR, a progress note is made.

During interview on 4/17/2025 at 1:06 p.m., the medical director (MD)-B stated daily nursing assessments for urinary tract infection should follow whatever the protocol is.

During interview on 4/17/25 at 3:05 p.m., LPN-B stated R18 is normally not very verbal but had recently been singing a lot, prompting staff to obtain a urine sample. The urine sample tested positive for bacteria and resident was started on antibiotic. R18 has not had any aggressive behaviors and typically is not able to express symptoms. LPN-B stated R18 has not had any fevers. LPN-B stated, "I don't know what we ended up doing with her [R18] to be honest." Staff monitor residents diagnosed with urinary tract infection by obtaining temperature, monitoring for signs of infection, and side effects of antibiotics. Results are documented on the electronic medical record. Any abnormal findings are documented in a separate progress note.

During interview on 4/18/25 at 11:40 a.m., the director of nursing (DON) confirmed facility progress notes lacked documentation R6 was sent to the emergency room, returned to the facility, and monitored related to the urinary tract

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F 684	Continued From page 43 infection and antibiotic use. The DON confirmed the hospital AVS is the only record R6 was sent to the emergency room. The director of nursing stated she is automatically notified of newly ordered antibiotics by the facility charting system and does not recall receiving notification of antibiotic ordered. Regarding R18, the DON stated R18's family member reported R18 had been singing lately which is abnormal behavior. The family member questioned if R18 had an infection due to talking more. R18 did not exhibit any other symptoms. The DON stated she would expect some sort of documentation when a urine sample is obtained. If a resident is suspected of having a urinary tract infection, the expectation is to have monitoring put in place for vitals and symptoms. The provider should be updated, fluids increased, and cognition monitored. Monitoring should be entered as a progress note or a nursing order on the medication administration record. A resident on antibiotic should be monitor for signs and symptoms of the infection being treated, side effects of the antibiotics, and temperature. This monitoring may also be placed on the medication administration record	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		5/29/25

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F 690	Continued From page 44 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper management of indwelling urinary devices for 1 of 1 residents (R6) reviewed for catheter care. R6's quarterly Minimum data Set (MDS) assessment dated 3/10/25 indicated R6 had severe cognitive impairment with no behaviors, is dependent on staff for all activities of daily living (ADLs) and has an indwelling catheter and ostomy. MDS also included R6 had diagnoses of multiple sclerosis (a progressive disease of the	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all	

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F 690	Continued From page 45 nervous system), neurogenic bladder (disease where the bladder does not function properly), and history of recurrent urinary tract infections. R6's care plan for catheter/urostomy/nephrostomy indicated R6 would remain free from signs and symptoms of urinary tract infections. Interventions included: catheter bag cover when in bed and wheelchair, change catheter as ordered by physician, empty catheter every shift and record output, keep catheter tubing free of kinks, keep drainage bag below bladder level, secure catheter to leg to avoid tension on urinary meatus (opening). Monitor, record, report to MD change in amount, color, consistency, or odor, infection signs and symptoms, chills, fever, nausea/vomiting, and pain. R6's medication administration record included: -suprapubic catheter (a tube inserted into the bladder through the abdomen) 18f change the 28th of every month -suprapubic catheter change drainage bag weekly -routine catheter care every day and evening shift -suprapubic catheter check tubing for proper positioning and cath care every shift -suprapubic catheter monitor intake and output every shift During observation on 4/15/25 at 10:43 a.m., R6 was sitting in common dining area for an activity with catheter drainage bag hanging on the armrest of the wheelchair at a level equal to resident's pelvis. During interview on 4/16/25 at 10:42 a.m., nursing assistant (NA)-B stated, "sometimes I put	F 690	deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. R6 care plan has been reviewed and is accurate. R6s catheter orders have been reviewed and are accurate. Residents with catheters care plans and orders have been reviewed and are accurate. All residents with an indwelling urinary devices that have a drainage bag will have drainage bag location checks added to the treatment administration record daily. The facility policy on Catheter Care has been reviewed and is current. RRLC staff are to ensure all catheters are cared for properly. Drainage bags are to be below the level of the bladder. Nurses and nursing assistants will receive education regarding appropriate catheter care. Education will include proper location for catheter bags on wheelchairs and while in bed. Education will include the Catheter Care Policy. DON or designee will perform audits 2x week for 3 weeks and then weekly x 9 weeks. Audit results will be reviewed monthly at QAPI meetings for further recommendations. DON is responsible for compliance. Date Certain: 5/29/2025	

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F 690	Continued From page 46 the catheter bag under the chair and sometimes I hang it on the side". NA-B reported the catheter bag continues to drain properly if hanging on the side of the wheelchair. During observation on 4/16/25 at 1:41 p.m., R6 was sitting in wheelchair in the room with catheter bag hooked to arm rest of wheelchair at a level equal to resident's pelvis. During interview on 4/17/25 at 10:04 a.m., NA-D indicated catheter bags are clipped under the wheelchair so the bag does not drag. During interview on 4/17/25 at 1:06 p.m., the medical director (MD)-B stated drainage bags should be placed "where gravity works" to allow for proper drainage. During interview on 4/17/53 at 1:53 p.m., the director of nursing (DON) stated catheter drainage bags should be placed under the wheelchair to allow for proper drainage, otherwise staff should utilize a leg bag. Catheter bags should remain below the level of the bladder to prevent urine reflux and damage to the bladder. The DON stated drainage bags should not be placed on the arm of a wheelchair. A facility policy titled "Indwelling urinary catheter (Foley) care and management" dated November 18, 2024 indicated: "Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI [catheter-associated urinary tract infection]"	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h)	F 694		5/29/25

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F 694	Continued From page 47 § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) (enters a peripheral vein and extends to the supervisor vena cava of the heart) was appropriately managed based on professional standards of practice and in accordance with physician orders for 2 of 2 residents (R138, R140) reviewed for intravenous (IV) medications. Findings include: R138 quarterly Minimum Data Set (MDS) assessment dated 4/3/25 was incomplete at the time of survey; cognitive function was intact. R138 was receiving IV antibiotic infusions. R138 was admitted on 3/28/25 with a diagnosis of right knee prosthesis infection and inflammation. R138 had a PICC line inserted into a peripheral vein in the upper right chest. R138's orders dated 3/31/25 lacked orders to change the PICC line dressing. Medication orders stated to administer ertapenem (IV antibiotic) 1 gram every 24 hours starting 3/28/25 at 11pm. During observation and interview on 4/14/25 at 6:32 p.m., R138 stated she was concerned because her PICC dressing had not been	F 694	F694 Parenteral/IV Fluids Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. R138 and R140 have since discharged. Care plans were reviewed and they were appropriate. All residents with PICC lines and IV antibiotics care plans have been reviewed and are appropriate. Orders have been reviewed in relation to IV antibiotics and PICC line management. PICC dressing changes are now monitored as part of the daily clinical monitoring review meeting to ensure professional standards are following in accordance with physician orders, with	

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F 694	Continued From page 48 changed since 4/4/25. The written date on the PICC line dressing was found to be 4/4/25; the top left corner of the dressing was peeling away from the skin. Resident was also concerned the PICC line medication tubing looked old. PICC line tubing lacked a date as to when it was placed. R138's medication administration record (MAR) indicated ertapenem was administered on 4/14/25 at 12:20 a.m. and 4/15/25 at 12:03 a.m. R138's treatment administration record (TAR) reflected the PICC site care was completed on 4/16/25. R138's quarterly Minimum Data Set (MDS) assessment for R140 dated 4/8/25 was incomplete at the time of survey; cognitive function was intact. R140 was receiving IV antibiotic infusions. R140 was admitted on 3/31/25 with a diagnosis of left knee prosthesis infection. R140 had a PICC line inserted into a peripheral vein in the right upper arm. R140 R140's orders dated 3/31/25 included changing PICC line dressing every 7 days and as needed if dressing was loose, soiled, or wet. Medication orders stated to administer ceftriaxone (IV antibiotic) 2 grams every 24 hours starting on 3/31/25 at 9pm. During observation and interview on 4/14/25 at 1:16 p.m., R140 stated he is on IV antibiotics for post-operative knee infection. Confirmed the PICC site dressing was undated. PICC site dressing is peeling up on the top left corner and down towards the bottom left corner. The PICC line tubing did not have a date. R140's MAR reflected the ceftriaxone was	F 694	follow up on completion of dressing changes by a nurse. The facility policies Central Vascular Access Device Dressing Change and Administration of an Intermittent Infusion have been reviewed and are current. Education will be completed with licensed nurses regarding the appropriate timeline to change PICC dressings. It will include the timing of changing IV tubing. Education will include date, time, and initials to all PICC dressings. Education will also include a competency to ensure all nurses are competent with PICC dressing changes. Nurse education will also include review of the Central Vascular Access Device Dressing Change and Administration of an Intermittent Infusion policies. DON or designee will perform audits 2x week for 3 weeks and then weekly x 9 weeks. Audit results will be reviewed monthly at QAPI meetings for further recommendations. DON is responsible for compliance.	

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F 694	Continued From page 49 administered on 4/14/25 at 9:54 p.m. and 4/15/25 at 8:19 p.m. R140's TAR reflected the PICC site care was completed on 4/16/25. During interview on 4/15/25 at 11:20 a.m., RN-A stated PICC site care should be done once per week and PICC line medication IV tubing should be replaced every 24 hours. RN-A stated if she encountered a PICC line dressing without a date, if there was an order, she would change the dressing. If there wasn't an order to change the PICC line dressing, she would submit a situation background assessment recommendation (SBAR) report to ask the provider for an order. During interview on 4/16/25 at 10:29 a.m., nurse practitioner (NP)-A stated it is an expectation that PICC site dressing changes are done every 7 days. NP-A confirmed it is an expectation PICC line medication IV tubing is replaced every 24 hours. NP-A confirmed she had instructed nursing staff on 4/11/25 the PICC site dressing needed to be changed on 4/11/25. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated the general parameters, and expectation is PICC site dressing changes are done every 7 days. DON confirmed the expectation is to date the dressing with the date it was changed. DON stated she would expect staff to change the PICC site dressing if it was due even if there was not an order to do so. DON would expect staff to change the PICC site dressing if it was undated. Staff can fill out an SBAR to request an order after the PICC site dressing has been changed. DON confirmed the expectation is to change PICC line medication IV tubing every 24 hours.	F 694		

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F 694	Continued From page 50 Per facility policy titled Central Vascular Access Device Dressing Change dated 6/1/24 a PICC line site care should be changed every 7 days from the date on the dressing label or more frequently if integrity of the dressing is compromised (wet, loose, or soiled). Per facility policy title Administration of an Intermittent Infusion dated 6/1/21 a PICC line medication IV tubing is replaced every 24 hours.	F 694		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and treat pain for 1 of 1 residents R194 reviewed for pain management. Findings include: R194's resident admission assessment was not completed at time of survey. R194's cognitive function was intact. R194 was admitted 3/28/25 following surgical repair of spinal stenosis. His past medical history included: pain in right hip, pain in left hip, lower back pain related to surgery and post-surgical treatment.	F 697	F 697 Pain Management Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. R194 has since been discharged. R194s care plan was reviewed and it was	5/29/25

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F 697	Continued From page 51 R194's care plan dated 3/28/25 indicated he could have post-surgical pain, and the intervention was to administer pain medication as ordered. R194's orders stated R194 should have pain monitoring every shift using the pain scale of 0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-8=severe pain, and 9-10=very severe/horrible pain. Non-pharmacological pain interventions should be documented for individualized pain as 1=ice, 2=relaxation/distraction, 3=repositioning, 4=re-medicating, 5=notify MD, 6=diversional activities, 7=music, 8=re-repositioning, 9=warm blanket, 10=stretching, 11=massage, 12=rest, 13=reduce stimuli, and 14=other. R194's active medication orders did not include any medication for pain. R194's medication administration record (MAR) dated 4/1/2025 to 4/15/2025 did not show pain medication was given. R194's treatment administration record (TAR) dated 4/1/2025 to 4/15/2025 did not show non-pharmacological treatments were given. The TAR also indicates R194 did not have pain assessed on 4/14/25 for the morning shift. The TAR indicated pain was assessed for the morning shift on 4/16/25 to be 5/10 indicating moderate pain. The MAR indicated no pain medications were given on this day and no non-pharmacological interventions were performed. The TAR indicated pain was assessed for the morning shift on 4/17/25 to be 7/10 indicating severe pain. The MAR indicated no pain medications were given on this day and no non-pharmacological interventions were performed. During observation and interview on 4/14/25 at	F 697	accurate. All residents will be interviewed to ensure their pain is being managed adequately. If their pain is not being managed adequately, a full clinical assessment will be completed. The facility has established a Pain Committee that meets weekly that will focus on all residents to ensure residents pain is managed appropriately and through using pharmacological and non-pharmacological l interventions. Pain assessments and interviews are located in the electronic medical record in assessment tab. Staff are aware of interventions through the care plan. The facility policy Pain Evaluation and Management was reviewed and is current. RRLC staff are to monitor and manage residents acute and chronic pain. Nurses and nursing assistants will receive education regarding management of pain in residents. Staff education will include the need to do a pain assessment to determine location and pain descriptors. Staff education will include review of the Pain Evaluation and Management Policy. DON or designee will perform audits 2x week for 3 weeks and then weekly x 9 weeks. Audit results will be reviewed monthly at QAPI meetings for further recommendations.	

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F 697	Continued From page 52 01:41 p.m., R194 stated his pain was doing ok until late last week, now he is having increased back pain with movement. R194 showed slight facial grimaces when repositioning, stating he doesn't have anything for pain relief. Record review showed R194 did not have any pain medications actively ordered. During observation and interview on 4/15/25 at 11:17 a.m., R194 stated he has 3/10 pain with movement today, he stated he told the nurse today but hasn't heard back from her if he can have something. During interview on 4/15/25 at 11:20 a.m., registered nurse (RN)-A stated R194 did tell her he had 3/10 pain. RN-A stated the resident does not have any active pain medication orders. RN-A stated she could give him a dose of Tylenol from the nursing standing orders. RN-A confirmed R194 has non-pharmacological interventions ordered; she has not offered him any of these medications or interventions. During observation and interview on 4/16/25 at 7:23 a.m., R194 stated he continued to have pain yesterday afternoon and into the evening. R194 stated he had not been asked about his pain and he had not been offered any medications or non-pharmacological pain interventions. R194 stated he must breathe through the pain of getting up, further stating physical therapy (PT) has gotten harder as his pain continues to increase. R194 stated he fears not being able to complete PT since his pain keeps increasing. During interview on 4/16/25 at 7:27 a.m., RN-A stated she was aware the resident was rating his pain a 5/10. RN-A stated again R194 could have	F 697	DON is responsible for compliance. Date Certain: 5/29/2025	

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	245626	A. BUILDING _____ B. WING _____	C 04/22/2025

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F 697	Continued From page 53 Tylenol from the standing orders since he still did not have anything ordered for his pain. RN-A stated she did not notify the provider about his increasing pain yesterday, and she had not notified the provider about the continued increase in pain today. During interview on 4/17/25 at 2:49 p.m., RN-A stated she assessed R194's pain around 2pm and he told her when he gets up it is 7. RN-A stated she had given R194 Tylenol, an ice pack, and sent a situation background assessment response (SBAR) report to the provider. RN-A stated she completed a progress not about this interaction so others would know she acted upon R194's pain. R194 progress note dated on 4/17/25, reflects the Tylenol was offered, although did not included the Tylenol was given. The TAR does not reflect the ice was given. During interview on 4/16/2025 at 12:48 p.m., the director of nursing (DON) stated it is an expectation staff contact a provider for pain management medication if resident stated they have pain, but no pain medication is ordered. DON confirmed the R194 did not receive pain medication or non-pharmacological pain interventions. DON confirmed she could not locate the SBAR report notification to the provider to order pain medications. DON confirmed R194 could have prolonged treatment if his pain continued to go untreated. Per facility policy titled Pain Evaluation and Management, dated 10/24/2022, stated If the resident has a diagnosis which could cause pain or discomfort, and they show no sign or	F 697		

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F 697	Continued From page 54 symptoms of pain or discomfort, continue to reassess for indicators of pain and behavioral changes. Staff should notify provider of any pain management change needed. Ensure non-pharmacological pain interventions have been included in the resident's pain management plan of care. Facility standing orders were requested but not received.	F 697		
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure clinical laboratory (lab) reports were filed into the medical record for 1 of 3 residents (R237) reviewed for laboratory reports. R237's face sheet dated 4/22/25, identified diagnoses of osteomyelitis (bone infection) and pyelonephritis (kidney infection). Review of R237's hospital discharge summary dated 3/11/25, identified R237 received intravenous (IV) antibiotics until 3/26/25 and was to have weekly bloodwork tests performed. Review of R237's clinic laboratory reports dated 3/14/25 and 3/21/25, identified R237 had labs completed.	F 775	Plan of Correction F775 SS= D Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. R237 has since discharged. Previous labs have been updated to residents chart. Care plan was reviewed and was current.	5/29/25

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F 775	Continued From page 55 Review of R237's medical record from 3/11/25 through 4/21/25 did not identify any laboratory results in chart or notification of laboratory results were faxed to infectious disease. During an interview on 4/21/25 at 12:26 p.m., director of nursing (DON) stated R237's had an order to receive weekly bloodwork while taking IV antibiotics from 3/11/25 through 3/26/25, however, the labs performed on 3/14/15 and 3/21/25 had not been received from the outside laboratory and had not been filed into R237's medical record. Review of the facility's laboratory Services Policy dated 8/14/23, identified that when qualified laboratory services must be performed out of the facility, the facility will: -Schedule the laboratory services. -When appropriate, obtain the laboratory specimen or have the resident prepared for the laboratory services to obtain the specimen. -Be responsible to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges. -File in the resident's clinical record laboratory reports dated and contain the name and address of the testing laboratory.	F 775	Residents with IV medications requiring routine lab analysis have been reviewed and labs are in charts and care plans are appropriate. The facility policy Laboratory Services has been reviewed and is current. RRLC staff are to ensure labs are completed per physician orders and results uploaded to the residents chart. New process implemented for care coordinators where they will record all lab orders, monitor for results, and upload resident lab results in electronic medial record. Nurse and nursing assistants will receive education on documentation of labs and ensuring all lab results get uploaded to the residents chart. Staff education will include review of the Laboratory Services policy. DON or designee will perform audits on lab service documentation 2x week for 3 weeks and then weekly x 9 weeks. Audit results will be reviewed monthly at QAPI meetings for further recommendations. DON is responsible for compliance.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		5/29/25

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F 880	Continued From page 56 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 57 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) for 2 of 2 (R138, R140) residents reviewed for infection prevention related to presence of peripherally inserted central catheter (PICC) line (enters a peripheral vein and extends to the supervisor vena cava of the heart). Findings include: R138 quarterly Minimum Data Set (MDS) assessment dated 4/3/25 was incomplete at the time of survey; cognitive function was intact. R138 was receiving IV antibiotic infusions. R138 was admitted on 3/28/25 with a diagnosis of right	F 880	Plan of Correction F880 SS=E Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency.	

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F 880	Continued From page 58 knee prosthesis infection and inflammation. R138 had a PICC line inserted into a peripheral vein in the upper right chest. R138's orders dated 3/31/25 did not include orders to change the PICC line dressing. Medication orders stated to administer ertapenem (IV antibiotic) 1 gram every 24 hours starting 3/28/25 at 11pm. R138's orders did not include orders for enhanced barrier precautions. During observation on 4/14/25 at 6:32 p.m., a PICC line was noted in R138's peripheral vein in the upper right chest. R138's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 4/15/25 at 13:56 p.m., registered nurse (RN)-A was observed entering R138's room to administer medication, RN-A did not put on PPE. R140 quarterly Minimum Data Set (MDS) assessment dated 4/8/25 was incomplete at the time of survey; cognitive function was intact. R140 was receiving IV antibiotic infusions. R140 was admitted on 3/31/25 with a diagnosis of left knee prosthesis infection. R140 had a PICC line inserted into a peripheral vein in the right upper arm. R140's orders dated 3/31/25 included changing PICC line dressing every 7 days and as needed if dressing was loose, soiled, or wet. Medication orders stated to administer ceftriaxone (IV antibiotic) 2 grams every 24 hours starting on 3/31/25 at 9pm. R140's orders did not include orders for enhanced barrier precautions.	F 880	Affected Resident(s): R138 discharged on 5.2.25 and R140 discharged on 4.22.25. Potential Affected Resident(s): All residents have been reviewed to ensure enhanced barrier precautions are implemented in accordance with infection control guidelines. Measures/Systematic Changes: Admission Coordinator will review all admission orders with DON or designee to ensure proper infection control guidelines are followed. If enhanced barrier precautions are needed, Admission Coordinator or designee will implement appropriate infection control protocols under the direction of the infection control nurse. At the Daily Clinical Meeting, all new orders requiring enhanced barrier precautions will be reviewed and DON or Infection Control Nurse will proper interventions are put into place. Policy for Infection Control-Transmission Based Precautions was reviewed and remains current. Admission Coordinator will review all admission orders with DON or designee to ensure proper infection control guidelines are followed. Education of Licensed nurses has been initiated to ensure that all residents with a PICC line will have Enhanced Barrier Precautions (EBP) implemented with	

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F 880	Continued From page 59 During observation on 4/14/25 at 1:16 p.m., a PICC line was noted in R140's peripheral vein in the right upper arm. R140's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 4/15/25 at 9:48 a.m., RN-A was observed entering R140's room to administer medications, RN-A did not put on PPE. During interview on 4/16/25 10:24 a.m., nurse practitioner (NP)-A stated both R138 and R140 should have been placed in EBP precaution upon admission due to both having PICC lines placed prior to admission at facility. During interview on 4/15/25 at 11:20 a.m., RN-A stated it is common to use EBP for residents with urinary catheters, indwelling lines, ostomies, or other things coming out of the body. RN-A stated if a resident required EBP then they should have and EBP sign placed on the door. RN-A stated the health unit coordinator (HUC) or admission nurse would place the EBP signs on the doors. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated EBP precautions are used for residents who have open wounds, catheters, PICC lines, or a known infection. DON confirmed R138 and R140 did not have enhanced barrier precautions initiated at admission. Per undated facility policy titled IPC Manual Chapter 8 Transmission Based Precautions, EBP precautions are initiated for residents with PICC lines, urinary catheters, and feeding tubes. Further, clear signage should be hung on the door with an isolation cart containing PPE placed	F 880	appropriate order, signage and PPE Monitoring: All residents on infection control precautions will be audited 2x week for 3 weeks and then weekly x 9 weeks to ensure all infection prevention guidelines are met. Results of monitoring shall be reported at the facility QAPI meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee are responsible for compliance. Date of Alleged Compliance: 5.29.2025	

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F 880	Continued From page 60 outside the room.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 883		5/29/25

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F 883	Continued From page 61 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R194 and R199) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 11/21/24, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer, after 5 years, the Pneumococcal 20-valent Conjugate Vaccine (PCV20) or	F 883	Plan of Correction F883 SS=E Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. Affected Resident(s): R 194 discharged 5/6/25, and R199 Discharged 5/13/25	

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F 883	Continued From page 62 Pneumococcal 21-valent Conjugate Vaccine (PCV21) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. This also identified an adult over 50 years old, who received one dose of PPSV23 at any age should be offered either option A (PCV20 or PCV21) or option B (PCV15) after one year. R194's face sheet dated 4/22/25, indicated he admitted to the facility 3/28/25 and was 86 years old. The immunization record dated 4/18/25, indicated he received a PPSV23 on 11/02/06 and a PCV13 on 12/19/14. The record lacked evidence of shared clinical decision making with his physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R5 was offered or received PCV20. R199's face sheet dated 4/21/25, indicated she admitted to the facility 3/10/25 and was 84 years old. The immunization record dated 4/18/25, indicated she received a PPSV23 on 5/5/10 and a PCV13 on 3/9/15. The record lacked evidence of shared clinical decision making with her physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R5 was offered or received PCV20. During interview on 4/21/25 at 2:34 p.m., the director of nursing (DON) stated she was responsible for the facility infection control program including ensuring resident eligibility for and offering routine vaccinations. The DON stated the facility procedure and expectation was to determine each resident's vaccine history and eligibility for vaccines upon admission. The DON acknowledged R194 and R199 had been eligible	F 883	Potential Affected Resident(s): All residents immunization records have been reviewed for pneumococcal immunization and vaccination has been offered. Measures/Systematic Changes: Infection prevention nurse has implemented a new process by using the CDC recommended app, PneumoRecs Vax Advisor, for all new admissions. The Pneumococcal Vaccine Program Policy reviewed and continues to be current. Education completed for clinical coordinators for Infection Control regarding CDC recommendations on vaccinations. Records will reflect the Pneumococcal Immunization has been offered and/or provided as recommended by the CDC. Monitoring: DON or designee will verify each new admission will be offered and/or provided the Pneumococcal vaccination series as recommended by CDC 2x week for 3 weeks and then weekly x 9 weeks. Results of monitoring will be reported at the facility QAPI meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee are responsible for	

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F 883	Continued From page 63 for the PCV20 however had not been educated on the risk and benefit or offered the PCV20 vaccine per CDC guidelines. The facility Pneumococcal Vaccine Program Policy dated 5/17/23, indicated residents will be offered immunizations again pneumococcal disease in accordance with CDC recommendation on vaccinations. Pneumococcal disease is a serious illness that can cause sickness and even death. Adults 65 years and older: CDC recommends pneumococcal vaccination for all adults 65 years or older. The tables below provide detailed information. For adults 65 years or older who have not previously received any pneumococcal vaccine, CDC recommends you: *Give 1 dose of PCV15 or PCV20. o If PCV15 is used, this should be followed by a dose of PPSV23 at least 1 year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. o If PCV20 is used, a dose of PPSV23 is NOT indicated. For adults 65 years or older who have only received PPSV23, CDC recommends you: *Give 1 dose of PCV15 or PCV20. o The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. o Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults 65 years or older who have only	F 883	compliance. Date of Alleged Compliance: 5.29.2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 04/22/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 64 received PCV13, CDC recommends you either: *Give 1 dose of PCV20 at least 1 year after PCV13 Or *Give 1 dose of PPSV23 at least 1 year after PCV13.	F 883		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 14, 2025

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard N
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: LBPL11

Dear Administrator:

The above facility was surveyed on April 14, 2025, through April 22, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 04/22/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/14/25 to 4/22/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with NO citations were issued: H56262740C (MN00104633) H56262738C (MN00104940) H56266460C (MN00105275) H56262739C (MN00107393) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. 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.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately complete comprehensive assessment of a resident's needs, strengths, goals, life history and preferences to determine a resident's functional capacity. In addition, the facility failed to ensure Minimum Data Set (MDS) was completed in a timely and/or in a comprehensive manner to facilitate accurate evaluation of resident' conditions for 5 of 5 residents (R6, R24, R194, R199, and R201) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid (CMS)	2 545	Acknowledged	5/29/25

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2 545	Continued From page 3 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the MDS as an assessment tool which facilities are required to use. The manual directed comprehensive assessments, "include the completion of both the MDS and the CAA process, as well as care planning." The CMS RAI manual also identified the RAI process (i.e., MDS) was completed to help evaluate resident' strengths and areas for care-planning. The manual listed all types of assessments to be completed along with corresponding timeframes for them via a graph labeled, "RAI OBRA-required Assessment Summary." This directed a quarterly MDS should be completed (i.e., signed) within, "ARD + 14 calendar days." R6 R6's quarterly MDS, dated 3/10/25, identified R6 had severe cognitive impairment and required assistance with all activities of daily living (ADLs). R6's diagnoses included progressive neurological condition, multiple sclerosis, neurogenic bladder, paraplegia, anxiety and depression. Each resident electronic medical record (EMR) listed a section labeled, "MDS," which listed MDS's assessments to date for each resident. R6's quarterly MDS, with an assessment reference date (ARD) dated 3/10/25, although was listed and indicated completed on 4/14/25. R6's medical record was reviewed and lacked reason why the MDS was not completed timely. R24 R24's MDS list indicated "Medicare 5 day" was completed on 11/29/24 with no assessments listed after that date. R24's medical record was reviewed and lacked	2 545		

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2 545	Continued From page 4 why the MDS had not been completed timely. R194 R194's admission MDS, dated 3/28/25, identified the MDS was "In progress". R194's admission MDS, with an assessment reference date (ARD) 4/10/25, was listed but categorized as, "In Progress." The MDS was not completed with multiple sections being red-colored and having little or no data entered and being labeled, "In Progress." The uncompleted sections included, "Hearing, Speech and Vision," and "Behavior," and "Bladder and Bowel," among several others. R194's medical record was reviewed and lacked reason why the MDS had not been completed timely. R199 R199's admission MDS, dated 3/17/25, identified the MDS was "In progress". R199's admission MDS, Medicare 5 day assessment, "Discharge return anticipated" assessment and "Medicare 5-day" assessment was listed but categorized as, "In Progress." All above MDS assessments were not completed with multiple sections being red-colored and having little or no data entered and being labeled, "In Progress." The uncompleted sections included, "Hearing, Speech and Vision," and "Behavior," and "Bladder and Bowel," among several others. R199's medical record was reviewed and lacked	2 545		

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2 545	Continued From page 5 evidence why the MDS had not been completed timely. R201 R201's admission MDS, dated 4/14/25, identified the MDS was "In progress". R201's Medicare 5 day assessment, Discharge return anticipated assessment and Medicare 5-day assessment, Admission/Medicare 5 day, Discharge return anticipated were listed but categorized as, "In Progress." All above MDS assessments were not completed with multiple sections being red-colored and having little or no data entered and being labeled, "In Progress." The uncompleted sections included, "Hearing, Speech and Vision," and "Behavior," and "Bladder and Bowel," among several others. R201's medical record was reviewed and lacked evidence why the MDS had not been completed timely per the RAI manual. During interview on 4/21/25 at 3:22 p.m., MDS-A stated she was a consultant and was asked to assist facility with completing MDS assessments last week. MDS stated she received access and started on 4/17/25 but was off on 4/18/25. MDS-A verified they help complete the MDS for the campus. MDS-A confirmed the above noted assessments were not finished and or reported timely. During interview on 4/21/25 at 4:49 p.m., administrator confirmed MDS assessment were behind and/ or had not been completed. Administrator stated they had just hired an external company to help with the MDS process.	2 545		

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2 545	Continued From page 6 The facility Minimum Data Set (MDS)/Resident Assessment Instrument (RAI) policy, dated 5/18/23, identified the resident assessment process is completed by the interdisciplinary team (IDT) in accordance with the federal requirements to provide a baseline of the resident's functional status on admission with scheduled assessments to determine ongoing functional status and changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other	2 555		5/29/25

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2 555	Continued From page 7 appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement person-centered interventions for cardiac diagnosis for 1 of 1residents (R194) reviewed for care plans. R194's admission Minimum Data Set (MDS) assessment was not completed in full at time of survey. R194's cognitive function was noted to be intact. R194 admitted on 3/28/25, following surgical repair of spinal stenosis (condition that narrows the space in the spine, putting pressure on the spinal cord or nerves). R194 diagnosis included atrial fibrillation (irregular heart rhythm), early ventricular depolarization (electrical signal in the heart come from lower chambers instead of upper chambers), atherosclerosis of the aorta (plaque buildup in the heart), bilateral carotid artery stenosis (partial or full blockage of the carotid artery located on each side of the neck), and hypertensive heart disease (develops due to prolonged high blood pressure, causing heart failure and abnormal heart muscle thickening). R194's admission care area assessment (CAA) report dated 3/28/25 identified a cardiac diagnosis requiring monitoring, medications, and treatments without specific person-centered interventions R194's CAA also identified R194 had a pacemaker requiring monitoring, medication, and treatments on an ongoing basis;	2 555	Acknowledged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 555	Continued From page 8 no specific person-centered interventions were noted. R194's goals of evaluation for the cardiac diagnosis included R194 would be free of signs and symptoms of complications related to cardiac condition. R194's goals of evaluation for the pacemaker diagnosis included R194's pacemaker checks will be within normal limits. R194's goal of pain management diagnosis was R194 would demonstrate minimal discomfort or absence of acute pain and identify positive coping behaviors for chronic pain. During interview on 4/15/25 1:32 p.m., licensed practical nurse (LPN)-A stated the admission assessment is completed by a health unit coordinator (HUC) or the nurse assessment coordinator. Once the admission assessment entry is complete, the electronic medical record (EMR) will auto-populate a generic care plan. Within 48 hours the nurse assessment coordinator will enter the specific person-centered interventions. LPN-A confirmed R194 had a completed admission assessment, performed on 3/28/25. LPN-A confirmed R194 record did not have person-centered interventions. LPN-A confirmed R194 should have resident specific interventions due to his significant cardiac history and recent surgical procedure which would require pain monitoring and management. During interview on 4/16/25 at 7:27 a.m., RN-A confirmed R194 did not have specific resident-centered interventions. RN-A confirmed R194 should have interventions to include ongoing blood pressure monitoring, vital sign parameters, medication parameters in relation to the current vital signs, and interventions to address cardiac symptoms of dizziness and	2 555		

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2 555	Continued From page 9 lightheadedness. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated each resident should have an admission assessment completed when they arrive. DON confirmed R194 had an admission assessment upon arrival on 3/28/25. DON confirmed an initial generic care plan was generated for R194 on 3/28/25. DON confirmed R194 did not have a resident-specific care plan with interventions completed within 48 hours of admission per facility policy. A facility policy titled Comprehensive Care Plan dated 10/2022 stated, the interdisciplinary team (IDT) will create an individual resident-specific care plan with individual interventions to communicate the resident's individual care within 48 hours of admission. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		

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2 875	Continued From page 10	2 875		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to follow physician orders, complete assessments, monitor or input appropriate interventions and recognize changes in condition, for 6 of 6 residents (R31, R201, R21, R194, R6, R18) reviewed for quality of care. As a result of the facility's failures, an immediate jeopardy (IJ) situation was identified for R31 who had displayed respiratory distress with labored breathing, increased anxiety and required additional medication, R201 who had displayed signs of a UTI and was transferred to the ER for treatment, R21 who had displayed signs of a urinary tract infection (UTI) and was transferred to the hospital ER for treatment. The immediate jeopardy began on 4/12/25, when R31's daily weight were not completed as ordered and facility was not monitoring, which led to R31's respiratory distress, and failed to identify, monitor and assess R201 and R21 for change of condition related to blood in the catheters led to kidney/bladder infections. The administrator, assistant administrator, director of nursing (DON), regional vice president was notified of the	2 875	Acknowledged	5/29/25

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

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2 875	Continued From page 11 immediate jeopardy at 5:47 p.m. on 4/18/25. The immediate jeopardy was removed on 4/21/25 at 1:07 p.m., but noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R31 was admitted on 4/11/25 and admission Minimum Data Set (MDS) assessment dated 4/17/25, identified the MDS was "In progress" with no information completed. R31's electronic medical record (EMR), included diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure with hypercapnia (increased levels of carbon dioxide in the blood) and hypoxia (insufficient oxygen at the tissue level), Cor pulmonale (enlargement and failure of the right ventricle of the heart as a response to increased vascular resistance or high blood pressure in the lungs), essential hypertension, anxiety disorder, shortness of breath, and was dependent on supplemental oxygen. R31's physician orders, dated 4/11/25, included the following: Oxygen via nasal cannula 2 L/min (liters per minute) at rest while awake, 4 L via nasal cannula with exercise or activity and 2 L via BiPAP when BiPAP is on; and daily fasting weight for edema and to notify the provider of a two (2) pound weight gain in two days or five (5) pound gain in seven days. Lasix 20 mg (milligrams) daily for edema. R31's post hospital follow up visit note dated 4/11/25, nurse practitioner (NP), indicated R31 had presented to the ER on 3/28/25 for shortness	2 875		

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2 875	Continued From page 12 of breath and was found to be in hypoxic respiratory failure, and tachypneic (abnormally rapid and shallow breathing). R31's was admitted to the intensive care on 3/28/25 to 4/3/25 and was treated for volume overload, pneumonia, and COPD exacerbation. While in the Intensive Care Unit (ICU), R31 was aggressively diuressed (the excretion of a large amount of fluid). R31 required supplemental oxygen via nasal cannula 2 L at rest while awake, 4 L via nasal cannula with exercise or activity and 2 L via BiPAP while sleeping and medications. NP continued the current order of Lasix 20 milligrams (mg) daily and asked nursing to complete daily standing fasting weights and to notify provider of weight gain of two (2) pounds in two (2) days or five pounds in seven days and will follow up the following week to determine dry weight goal. R31's care plan dated 4/11/25, included R31 respiratory diagnosis with abnormal lung sound and shortness of breath. Interventions were identified to administer medications as prescribed by physician, give nebulizer treatment and oxygen therapy as ordered, and to notify physician if increased coughing occurs. The care plan also indicated R31 was at nutritional risk related to diagnoses of COPD, respiratory failure, oxygen dependence, altered skin integrity and recent weight loss with low body weight. Interventions were identified to observe changes in weight and to notify physician. R31's daily weight record from 4/11/25 to 4/18/25 revealed R31 had not been weighed 6 of the 7 days: -4/11/25, wt. (weight) 142.56 lbs. -4/12/25, wt. not taken -4/13/25, wt. not taken -4/14/25, wt. not taken	2 875		

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2 875	Continued From page 13 -4/15/25, wt. not taken -4/16/25, wt. not taken -4/17/25, wt. not taken -4/18/25, wt. not taken During observation on 4/16/25 at 10:42 a.m., R31 was sitting in his room with oxygen on. R31 was observed to have labored breathing. During observation on 4/18/25 at 11:32 a.m., R31 was laying in bed with oxygen on. R31 was observed to have labored breathing. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A stated residents who have an order for daily weights should have their weight obtained in the morning before breakfast. RN-A stated any staff can obtain a weight and document the weight in the electronic medical record (EMR). RN-A said whoever obtains the weight are responsible for charting it. During interview on 4/18/25 at 12:09 a.m., NP stated R31 was extremely complicated and fragile. NP stated R31 was experiencing labored breathing, had diminished lung sounds and was on the incorrect oxygen setting while lying in bed during the visit. NP stated R31's oxygen orders were for two liters at rest although was found to be set at four liters while lying in bed. NP stated she had wanted R31 to go to the ER for evaluation although R31 refused. NP stated she had also offered R31 Dilaudid (medication that reduces respiratory rate and reduces breathing difficulties) to help with his breathing and hydroxyzine for anxiety, NP indicated R31 refused. NP stated she was not sure if the Lasix (newly added medication from hospital) was effective or if R31 was having fluid buildup because she did not know what R31's weights	2 875		

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2 875	Continued From page 14 were due to facility not following orders to obtain daily weights. NP stated she expected facility to obtain daily weight and to record them and follow any parameters in order to initiate interventions/treatments to help prevent resident from fluid buildup which can make breathing difficult. R31's weight obtained per NP on 4/18/25, was 156.6 lbs, a 14.1 pound increase. During a follow up interview on 4/18/25 at 3:11 p.m., NP stated R31 had slightly improved from the first visit and an action plan was made with R31 and R31's son. NP stated she obtained R31's weight today of ~157 pounds. NP stated R31's dismissal weight from the hospital was 142 pounds. R31 had a 14.4-pound weight gain in the past week. NP stated she was going to increase R31's Lasix. NP stated she felt like R31 could have been in respiratory failure this morning upon her initial assessment. NP stated oxygen orders were not initiated or started over the weekend from 4/11/25 (date of admission) to 4/14/25 and staff were administering the oxygen at whatever liter per minute R31 told them to put it on or whatever they felt was appropriate. NP stated son was very concerned as he noted a change in R31's breathing over the weekend. NP stated she notified the facility of this and that is when the facility initiated and entered the oxygen orders in R31's EMR. NP stated she expected staff to obtain a full set of vitals on residents every day to monitor for any changes in condition. During interview on 4/18/25 at 3:22 p.m., occupational therapist (OT) stated R31 had slowed down while in therapy over the past couple of days and did not have therapy today due to the NP holding therapy services until	2 875		

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2 875	Continued From page 15 further notice. During interview on 4/17/25 at 12:03 p.m., licensed practical nurse (LPN)-G stated if there was a change in condition with a resident, she would notify the charge nurse, or the provider and document change in a progress note in the resident's chart. LPN-G stated if a resident had an order for daily weights, it would be reflected on the medication/treatment administration record. LPN-G stated the nursing assistants (NA)'s obtain the weight and would notify a nurse with weight results, who would then document weight in the EMR. LPN-G stated there is not a good system in place regarding weights as weights are missed. LPN-G reviewed R31's chart and confirmed R31 had an order for fasting daily weights and the last recorded weight was on 4/11/25. LPN-G stated it was important to get the daily weights on R31 due to his fragile health concerns and that the provider needed to be notified of any weight change to allow for immediate intervention to be done. During interview on 4/17/25 at 3:02 p.m., RN-C stated when a resident has an order for daily weights, she obtains the daily weight as it is needed and important due to condition and respiratory failure. During interview on 4/18/25 at 2:44 p.m., LPN-A stated the NA's obtain the daily weights but if the nurse noticed it was not completed the nurse should obtain the weight. LPN-A stated daily weights should be done by 10:00-10:30 a.m. but could be delayed due to other factors that may arise. NA's know what weights to be obtained by looking in the EMR under their tasks. LPN-A stated if a daily weight does not get done then she would expect that resident to be the first one	2 875		

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2 875	Continued From page 16 obtained the following day. During interview on 4/18/25 at 2:47 a.m., NA-B stated the nurse lets her know and she would write down which residents need weights. Once she got the weight, she would then give it to the nurse who would document. During interview on 4/18/25 at 3:11 p.m., NA-C stated the nurse gives her a paper log at the beginning of the shift, which is where she would write the weights on it and would return it to the nurse to document at the end of the shift. During interview on 4/17/25 at 2:00 p.m., director of nursing (DON) stated the admissions nurse, health unit coordinator (HUC), nurse manager and herself are responsible for processing and entering orders. DON stated the floor nurses are allowed to process orders if order was received "after hours". DON stated all orders are verified by another nurse to ensure it was correct. During a follow-up interview on 4/18/25 at 4:25 p.m., DON stated daily weights are to be completed in the morning and if there are parameters in place for a resident and the weight is outside the parameter, she would expect staff to notify the provider of any change. DON confirmed R31 had an order, with parameters for fasting daily weights and the order was not followed. DON stated daily weights are important to be done for a person with any cardiac issues in order to identify immediately. DON confirmed the oxygen order was received on 4/11/25 although was not entered until 4/14/25. R201	2 875		

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2 875	Continued From page 17 R201's was admitted on 3/3/25 and admission MDS assessment dated 4/14/25, identified the MDS was "In progress" with no information completed. R201's EMR, included diagnoses of acute pyelonephritis (kidney infection), urinary tract infections, and chronic kidney disease (stage 4). R201's physician orders, dated 4/11/25, included the following: right nephrostomy (tube inserted into the kidney to drain urine directly into a collection bag outside the body) site care - cleanse with normal saline daily, pat dry and cover with split gauze and paper tape daily every evening shift. R201's care plan dated 4/7/25, indicated R201 had altered elimination and would need treatment/monitoring/cares due to weakness and immobility. Interventions identified R201 had a nephrostomy. Care plan also indicated R201 had an alteration in skin integrity related to surgical incision. Intervention identified staff to observe site daily for signs of infection or poor healing: drainage, odor, redness, warmth of incision line and to notify physician of any signs of infection. The care plan lacked location of surgical incision. During observation and interview on 4/14/25 at 6:28 p.m., R201's nephrostomy bag contained dark red urine. R201 stated she was informed by staff she had an "episode" this morning where R201 became unresponsive and lethargic. During observation on 4/15/25 at 11:27 a.m., R201 just returned from therapy and nephrostomy bag contained dark red urine. During observation on 4/16/25 at 8:49 a.m., R201	2 875		

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2 875	Continued From page 18 was lying in bed with nephrostomy bag with dark red urine present. R201's EMR lacked documentation of monitoring of urine output (change in urine color), nor notification to provider of any changes in condition. During interview on 4/14/25 at 6:44 p.m., R201's family member (FM-B) stated they were not notified of an event related to unresponsiveness and when she went to the nursing station to inquire about the event, FM-B was told that R201 went unresponsive for a few seconds, was ashen (pale gray color) in color and was lethargic following event. During interview on 4/14/25 at 6:47 p.m., RN-C stated she was told in report R201 was hard to wake up that morning and became lethargic. RN-C confirmed there was no documentation in R201's EMR regarding event. R201's progress note, dated 4/16/25 at 4:16 p.m., indicated R201 was sent to ER by provider for further evaluation. During interview on 4/17/25 at 9:26 a.m., FM-B stated when the NP came to R201's room for a regular visit, during her assessment she noticed the urine in R201's nephrostomy bag was red. NP recommended R201 be sent to the ER for further evaluation. FM-B stated R201 had been hospitalized for a kidney and bladder infection and was having a stent exchanged in the morning. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A stated standard catheter, nephrostomy care consisted of ensuring urine is	2 875		

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2 875	Continued From page 19 flowing appropriately and monitoring the amount and color of the urine. RN-A stated if there was something abnormal, she would document in the EMR and notify the provider. RN-A stated she did not receive a lot of training on nephrostomies and had only one observation of a nephrostomy. During interview on 4/17/25 at 12:03 p.m., licensed practical nurse (LPN)-G stated NA's empty nephrostomy bag and would notify her of any changes or concerns such as flowing of urine, dark colored urine. LPN-G stated she would notify the charge nurse and would encourage resident to drink more fluids. LPN-G stated she would assess urine for odor, assess resident for change in cognition and would monitor. LPN-G stated she would document abnormal findings in a progress note. LPN-G stated nephrostomy bag is emptied once to twice per shift. LPN-G stated she had not received any training regarding nephrostomies. During interview on 4/17/25 at 2:00 p.m., DON stated if there was a skill, task, or diagnosis not cared for in the facility, we would complete in person training for staff. DON stated the admission nurse would inform the DON prior to admission with what cares may need training on. This will allow the facility to initiate education ahead of time. During interview on 4/17/25 at 2:26 p.m., RN-D stated there were no specific training related to nephrostomies. During interview on 4/17/25 at 3:02 p.m., RN-C stated NA's empty R201's nephrostomy bag and write down the urine output which she would then document in the EMR. RN-C stated NAs notify her of any changes. RN-C stated she would go	2 875		

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2 875	Continued From page 20 and assess the abnormality (such as blood in the bag) and would call the provider to obtain an order. RN-C stated she was not notified of the dark red urine in R201's nephrostomy bag by any NA's. During a follow up interview on 4/18/25 at 11:40 a.m., DON stated if a resident is suspected to have a UTI or is displaying symptoms of a UTI, she would expect staff to monitor vital signs and symptoms, update the provider, increase fluids, enter progress note with information and initiate a nursing order on the MAR (medication administration record) for monitoring. During interview on 4/18/25 at 12:03 p.m., NP confirmed she was not notified R201's urine output was red. NP stated when she went to check in on R201 on 4/16/25, she had noticed red urine and had staff send R201 to the ER for further evaluation. NP confirmed when the resident previously had blood in her urine, it was an indication of a kidney, bladder infection. NP confirmed if she had been notified, she may have been able to prevent the visit to the emergency room by ordering a urine test to test for infection. During interview on 4/18/25 at 2:47 p.m., NA-B stated she emptied nephrostomy/catheter bags in the beginning of her shift and again at the end of her shift, document the amount drained. NA-B stated if she noticed a change in the urine, such as blood, she would let the nurse know immediately. During interview on 4/18/25 at 4:25 p.m., DON stated she expected there to be an order to obtain and monitor output for a resident with a nephrostomy/catheter. DON stated monitoring should consist of checking for redness around the	2 875		

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2 875	Continued From page 21 insertion site, urine output and characteristics of the output, and any signs of drainage. DON stated she would expect staff to notify the provider immediately of any changes. DON stated staff should have notified the provider immediately when blood was noticed for direction from the doctor on what to do. DON confirmed there was no documentation of notification to the provider regarding dark red urine. R21 R21's MDS assessment dated 1/15/25, indicated intact cognition. R21 had a functional impairment of both lower extremities. R21 required substantial assistance with toileting and hygiene. R21 had an indwelling catheter requiring substantial assistance for care. R21's medical diagnosis included benign prostatic hyperplasia (overgrowth of cells causing organ enlargement) with lower urinary tract symptoms causing urinary retention. This diagnosis is further complicated by obstructive and reflux uropathy (blockage preventing urine from flowing normally). R21's care plan for Foley Catheter dated 9/13/23 included R21 will be free of signs and symptoms of urinary tract infections, will receive catheter cares per order, have catheter emptied every shift, monitor and record output every shift, and monitor/record/request/report to provider change in amount, color, consistency, or odor. R21's physician orders include catheter change every month on the 11th, routine catheter care twice daily, change urinary drainage bag once a week on Mondays, and flush catheter with 30 ml (milliliters) of normal saline every shift as needed.	2 875		

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2 875	Continued From page 22 During observation on 4/14/25 at 1:49 p.m., R21 had a leg bag for catheter drainage of urine. The drainage in the leg bag was red in color and filled approximately three quarters of the leg bag. R21 stated he was not in pain, did not recall if the drainage was new, and was unsure when staff had changed the catheter or the drainage bag. During observation on 4/14/25 at 6:09 p.m., R21 continued to have dark red urine in the catheter leg bag. R21's progress note dated on 4/15/2025 at 7:20 a.m., indicated R21 had approximately 600 ml's of blood in his urinary leg bag. The progress note lacked indication if staff notified a provider about the amount or color of the drainage in the urinary leg bag. R21's TAR indicated R21 had routine catheter care performed twice a day for the last seven days. R21's progress note dated on 4/15/2025 at 4:15 p.m., indicated R21 was sent to the emergency department and his son was notified. R21 returned to the facility after emergent evaluation; was diagnosed with a urinary tract infection and started on an oral antibiotic. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A could not state what routine catheter care entailed. RN-A stated she just looked to make sure the catheter was still flowing, what the output looked like, and if the catheter might need to be flushed. RN-A stated she charts the amount of urine output, not the characteristics. RN-A stated if the urine looked abnormal, such as redness, she would enter a	2 875		

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

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2 875	Continued From page 23 progress note and notify the provider via a situation/background/assessment/recommendation (SBAR) note. RN-A confirmed a progress note and SBAR notification was not charted for R21. During an interview on 4/16/25 at 10:33 a.m., the nurse practitioner (NP)-A indicated an unawareness of R21's output included blood. NP-A confirmed when the resident previously had blood in his urine, it was an indication of a urinary tract infection. NP-A confirmed if she had been notified, she would have been able to help prevent the visit to the emergency room by ordering a urine test to test for infection and would start oral antibiotics. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) identified the facility charting does not have a location to document urine characteristics such as color, clarity, and odor. The DON indicated if a provider was notified about a change the staff are expected to input a progress note. The DON confirmed staff communicate these components of urine output via word of mouth or a progress note. DON identified a progress note of R21's urine characteristics dated 4/15/2025 at 7:20 a.m., although DON would have expected a progress note of R21's urine characteristics and notification to the provider when the blood was identified on 4/14/25. The Immediate Jeopardy was removed on 4/21/25, at 1:07 p.m. when it was determined the facility provided re-education and competency testing to licensed nursing staff on the facility's policies/procedures pertaining to change of condition, notification of changes, physician's orders, congestive heart failure, nephrostomy, COPD and catheters to include standards of	2 875		

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2 875	Continued From page 24 documentation. In addition, the facility developed and implemented an auditing system for monitoring. R194 R194's admission Minimum Data Set (MDS) assessment was not completed in full at time of survey. R194's cognitive function was noted to be intact. R194 admitted on 3/28/25, following surgical repair of spinal stenosis (condition that narrows the space in the spine, putting pressure on the spinal cord or nerves). R194 diagnosis included atrial fibrillation (irregular heart rhythm), early ventricular depolarization (electrical signal in the heart come from lower chambers instead of upper chambers), atherosclerosis of the aorta (plaque buildup in the heart), bilateral carotid artery stenosis (partial or full blockage of the carotid artery located on each side of the neck), and hypertensive heart disease (develops due to prolonged high blood pressure, causing heart failure and abnormal heart muscle thickening). R194's care plan dated 3/28/25, identified a cardiac diagnosis and a pacemaker requiring monitoring, medications, and treatments. R194 care plan did not include person-centered interventions. R194's admission medication orders on 3/28/25 included amiodarone 200 mg each morning (used for irregular heart rate), metoprolol tartrate 75 mg twice per day (used for irregular heart rate and high blood pressure), apixaban 5 mg twice per	2 875		

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2 875	Continued From page 25 day (used as a blood thinner), nitroglycerin 0.4 mg sublingual tablet every 5 minutes for 4 doses as needed (used for acute chest pain), and torsemide 10 mg every morning (used to treat fluid retention). During an interview on 4/14/25 at 1:47 p.m., R194 stated he fell earlier this morning due to low blood pressure (a condition called hypotension). R194 stated he started to feel dizzy in physical therapy (PT) and the physical therapist was assisting him back to his room. R194 stated he felt dizzy and thinks he might have passed out in the hall on his way back to his room. R194 stated he had been given all his normally scheduled cardiac medications. R194's medication administration record (MAR) identified R194 was administered his scheduled medications. R194's blood pressure summary indicated he had not had his blood pressure (BP) checked before administering the cardiac medications. R194's fall report dated 4/14/25 at 10:45 a.m., included vital signs of a BP result of 83/40, heart rate (HR) of 83, and an oxygen saturation of 89%. At 11:09 am., upon returning to his room BP was 115/49. R194's post fall progress note dated 4/14/25 at 11:30 a.m., read the appropriate staff were notified, provider and family. R194's follow-up blood pressure was not documented until 4/14/25 at 5:06 p.m., with results being 123/52. R194 vital signs dated 4/15/25 at 10:56 a.m., included a BP of 86/64, a subsequent BP at 10:57 a.m., was noted to be 69/33.	2 875		

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2 875	Continued From page 26 During an interview on 4/15/25 at 11:11 a.m., R194 was in his room with his wife and stated he was at PT this morning when he became dizzy again and not able to complete PT. The results of his BP was low and R194 was returned to his room. R194 stated he had been given his normally scheduled BP medications this morning and indicated the staff did not take his blood pressure prior to administering the medications. R194 and his wife were uncertain whether the provider had been notified of R194's recent low BP's. During an interview on 4/15/25 at 11:20 a.m., registered nurse (RN)-A said staff would need an order to check a BP, blood sugar, or oxygen level before administering some medications. RN-A indicated she was aware R194 had an episode of low BP the previous day. RN-A confirmed she did not check the BP prior to giving the scheduled medications this morning. RN-A indicated some of the medications given could potentially have lower 194's BP. RN-A confirmed she did not check R194's BP due to the last results were with in normal range and because there was no order to check vital signs prior to administering medications. RN-A stated she would hold a BP medication if the systolic (first number) BP was less than 90. RN-A stated she would hold a BP medication if the resident was experiencing symptoms such as dizziness, weakness, or falling. RN-A stated she would call an ambulance if the BP was less than 80 and the resident had symptoms of dizziness, weakness, or falling. RN-A confirmed the resident had a BP less than 80 and he has had episodes of dizziness and falling. RN-A stated she had notified licensed practical nurse (LPN)-B (position as a nurse manager) about R194's low BP from this	2 875		

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2 875	Continued From page 27 morning. RN-A stated LPN-B would fill out a situation background assessment recommendation (SBAR) report and send to the provider. RN-A reviewed R194's vitals and verified last charted BP was 69/33. During interview on 4/15/25 at 11:35 a.m., physical therapist (PT)-A stated she worked with R194 on 4/14/25 and today (4/15/25). PT-A stated today they were monitoring R194's BP closely. At approximately 10:50 a.m., R194's BP was within normal limits while on the stationary bike, however, when he sat down in a regular chair, he stated he felt like his BP was low again. PT-A stated she called the nursing staff who assisted R194 back to his room. During observation on 4/15/25 at 11:48 a.m., R194 was seated in his room, leaning towards the left; his appearance pale and R194 stated when he gets up, he has a lot of pressure in his head. During observation and interview on 4/15/25 at 1:02 p.m., R194 confirmed he has not had his BP checked since he returned from therapy. He stated he is feeling ok, although felt his BP was still low. R194 confirmed he had not seen a provider. During observation and interview on 4/15/25 at 1:07 p.m., RN-A confirmed there was no follow up BP checks after R194's last results were 69/33 and had not been directed by a physician to retake. Surveyor encouraged RN-A to verify R194's BP, taken manually the results were 120/72. RN-A confirmed she had not heard back from the provider and had not attempted to reach out to the provider regarding the recent low blood pressures.	2 875		

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2 875	Continued From page 28 During an interview on 4/15/25 1:32 p.m., LPN-A and LPN-B stated an SBAR report was sent to the provider regarding R194's low blood pressures although had not received any new orders. LPN-A stated SBAR's are faxed to the providers for less emergent issues and phone calls are made for concerns with urgent situations to include a change in alertness, multiple falls, vital signs are abnormal or passing out. LPN-B confirmed R194 had experienced abnormal vital signs, two falls, and an episode of passing out and confirmed the provider was not phoned. During an interview on 4/15/25 1:55 p.m., director of nursing (DON) stated she was aware R194 experienced recent low blood pressures with two episodes of lightheadedness and dizziness which resulted in falls. DON confirmed the provider had been sent an SBAR report 4/15/25. DON stated she would consider anything less than 100/60 as low and anything less than 50/30 to be emergent, requiring a call to the provider or a call to 911. DON verified R194's documented BP of 69/33. DON confirmed no call was made to the provider. DON's expectation would be to continue monitoring R194 given his status and his cardiac history. DON stated she would expect a complete set of vital signs to include BP, heart rate, respiratory rate, and oxygen saturation prior to giving additional cardiac medications. DON also included their procedure for post-fall monitoring included vitals sign monitoring every 8 hours for 24 hours, notify provider, and document in a progress note. DON confirmed lack of post-fall documentation or provider notification for 4/14/25 or 4/15/25 falls. During interview and observation on 4/15/25 at 3:42 p.m., Medical Doctor (MD)-C visited R194 in	2 875		

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2 875	Continued From page 29 the physical therapy room accompanied by the DON. PT-A and DON provided a brief update about R194. During this update, R194 stated he had experienced another fall at approximately midnight. The DON stated she was unaware of the 2nd fall on 4/14/25. MD-C instructed staff to return R194 to his room and complete a full set of orthostatic blood pressures and notify his regular provider with the results and encouraged R194 to remain in his room until seen by his normal provider on 4/16/25. During an observation on 4/16/25 at 7:20 a.m., LPN-C completed R194's necessary orthostatic BP levels without documenting the correlating heart rate. LPN-C stated an unawareness orthostatic BPs required a heart rate. During an interview on 4/16/25 at 7:56 a.m., MD-B confirmed an unawareness of R194's condition and incidents from 4/14/25 and 4/15/25 and would expect staff to notify a provider by phone immediately when there is a significant change in BP readings. MD-B stated staff could call 911 for immediate attention with symptoms of dizziness, falls, or general unwellness like R194 experienced. During an interview on 4/16/25 at 10:13 a.m., nurse practitioner (NP)-A stated she was notified of R194's falls and very low BP's upon arriving to the facility. NP-A stated she would have expected to be notified when a resident's BP is less than 90, and not just a receipt of an SBAR report being faxed. NP-A confirmed 911 should have been called for a BP less than 80 with symptoms such as falling, dizziness, and lightheadedness. NP-A confirmed the expectation is to complete a full set of vital signs prior to administering more than one cardiac medication,	2 875		

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2 875	Continued From page 30 NP-A confirmed R194 received more than one cardiac medication. NP-A confirmed the expectation was to monitor vital signs, including a blood pressure, frequently after a fall that was suspected to be due to low blood pressure. NP-A confirmed the process for completing orthostatic BP's included laying, sitting, standing-waiting 3-5 minutes in between position changes with a correlating heart rate. During interview on 4/16/2025 at 12:48 p.m., DON stated it is the expectation to complete a full set of vital signs after a fall; to include BP, pulse, temperature, respirator rate and oxygen saturation. DON confirmed R194 had a BP completed although lacked the remainder of vital signs after his falls. DON confirmed the late entry in the medical record regarding the fall at midnight on 4/15/25. DON confirmed the fall should have been documented at the time of the fall. DON stated an orthostatic blood pressure is completed at laying, sitting, standing positioning, waiting 3-5 minutes between positions with a correlating heart rate. DON confirmed R194 did not receive accurate orthostatic BP's. DON confirmed R194 had fallen 3 times, had not received post-fall follow up in accordance with facility policy. DON confirmed the provider had not been accurately updated about R194's change in status. R6 R6's quarterly Minimum Data Set (MDS) assessment, dated 3/10/25 indicated R6 had severe cognitive impairment with no behaviors, is dependent on staff for all activities of daily living (ADLs) and has an indwelling catheter and ostomy. MDS also included R6 had diagnoses of multiple sclerosis (a progressive disease of the	2 875		

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2 875	Continued From page 31 nervous system), neurogenic bladder (disease where the bladder does not function properly), and history of recurrent urinary tract infections. A catheter/urostomy/nephrostomy care plan indicated R6 would remain free of signs and symptoms (s/sx) of urinary tract infections. Interventions included: catheter bag cover at all times in bed and wheelchair, change catheter as ordered by physician, empty catheter every shift and record output, keep catheter tubing free of kinks, keep drainage bag below bladder level, secure catheter to leg to avoid tension on urinary meatus (opening). Monitor/record/request/report to medical doctor (MD) change in amount, color, consistency, or odor, UTI s/sx, chills, fever, nausea/vomiting, and pain. R6's medication administration record included: -cefdinir (antibiotic) twice a day for infection x 7 days ordered 3/19/25 and discontinued 3/24/25. Medication was given 3/19/25-3/24/25. -Amoxicillin-potassium clavulanate (antibiotic) twice a day for bacterial infection x 7 days ordered 3/22/25 and given 3/22/25-3/29/25. -suprapubic catheter (a tube inserted into the bladder through the abdomen) 18f change the 28th of every month -suprapubic catheter change drainage bag weekly -routine catheter care every day and evening shift -suprapubic catheter check tubing for proper positioning and cath care every shift -suprapubic catheter monitor intake and output every shift A provider "telephone encounter" form dated 3/18/25 at 3:55 p.m., indicated staff called from facility stating her the end of her tube feeding broke and will be sending R6 to the emergency	2 875		

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2 875	Continued From page 32 department (ED) to get it replaced. Please send order to send to ED" A provider telephone order dated 3/18/25 at 4:08 p.m., indicated "ok to send to the ER". R6's hospital emergency room progress note dated 3/19/25 indicated R6 was sent to the emergency room due to her PEG tube (tube in stomach to for liquid feeding) was broken and needed replacing. R6 was also found to have a urinary tract infection and acute cystitis (inflammation of the bladder) and would return to the facility with orders for antibiotics. R6's hospital after visit summary (AVS) report dated 3/18/25, R6 was sent to the emergency room due to "complication mechanical gastrostomy [feeding tube]". It included results from a urinalysis indicating bacteria present. Cefdinir was ordered. R6's hospital orders dated 3/21/25, indicated prescription for amoxicillin-pot clavulanate 875-125 twice a day for 7 days starting 3/21/25 and ending 3/28/25. It also included orders to discontinue previously ordered cefdinir. R6's clinical assessment screen indicated two separate entries for "nursing skilled services data collection" from 3/18/25-3/29/25. Both entries occurred on 3/24/25 at 6:51 a.m. and 11:14 a.m. On both entries, "urinary tract infection monitoring" was left blank. R6's progress notes lacked documentation R6 returned from the emergency room, monitoring of urinary symptoms related to the UTI, or side effects of antibiotic as indicated by:	2 875		

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2 875	Continued From page 33 -3/18/25 8:30 p.m., hosp -3/21/25 10:02 a.m.,"cefdinir capsule 300 mg Give 1 capsule by mouth two times a day for infection for 7 days-Awaiting delivery" -3/21/25 10:07 a.m. had vitals documented due to R6 having an emesis the previous evening. -3/23/25 6:59 a.m., indicated cefdinir was held due to antibiotic change -3/23/25 4:50 p.m., indicated cefdinir was "unavailable" R18 Quarterly MDS assessment dated 2/11/25, indicated R18 was severely cognitively impaired with no behaviors and was incontinent of bladder and bowel. An incontinence/altered elimination care plan indicated R18 had ongoing incontinence and cannot communicate the need to void. Interventions included: assist perineal hygiene after toileting, encourage fluid intake, observe for signs/symptoms of UTI (dysuria, frequency, urgency, nocturia, suprapubic pain and discomfort, back pain, hematuria and report to MD/NP, offer toileting upon rising, before and after meals and bedtime and PRN. R18's medication administration record included: cefdinir 300 mg take 1 capsule by mouth two times a day for UTI for 5 days. Take before morning and evening meals dated 4/11/25 and in/out catheter to get UA sample dated 4/9/25. It lacked symptom monitoring or antibiotic side effect monitoring.	2 875		

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2 875	Continued From page 34 R18's provider progress notes indicated the following on date: -4/8/25 "family is noting increased confusion since 4/7/25 and is concerned of UTI. Family is requesting UA". -4/9/2025 indicated order for urine specimen to be sent to lab. -4/11/25 indicated positive urinalysis (test to check for infection) and order for cefdinir 300 mg take 1 capsule by mouth twice a day before morning and evening meal x 5 days. -4/13/25 indicated sensitivities confirming continued use of cefdinir. R18's clinical assessment screen lacked monitoring for urinary tract infection, vital signs lacked vitals taken during time frame antibiotics administered, progress notes lacked indication of urinary symptoms, why UA was obtained, symptom monitoring, or antibiotic side effect monitoring. During interview on 4/16/25 at 2:09 p.m., licensed practical nurse (LPN)-F stated if a resident is exhibiting signs or symptoms of a urinary tract infection, communication is faxed to the nurse line. If after hours or on weekends, a phone call is placed to an on-call provider. Documentation is made in progress notes. LPN-F reviewed R18's progress notes and confirmed there is no documentation of urinary symptoms. LPN-F also confirmed R18 started on antibiotics 4/11/25 and the record lacked documentation of vital monitoring, symptom monitor, or antibiotic monitoring. During interview on 4/17/25 at 12:04 p.m., registered nurse (RN)-B stated residents diagnosed with a urinary tract infection should be	2 875		

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2 875	Continued From page 35 monitored for symptoms on the treatment administration record (TAR). If it is not documented on the TAR, a progress note is made. During interview on 4/17/2025 at 1:06 p.m., the medical director (MD)-B stated daily nursing assessments for urinary tract infection should follow whatever the protocol is. During interview on 4/17/25 at 3:05 p.m., LPN-B stated R18 is normally not very verbal but had recently been singing a lot, prompting staff to obtain a urine sample. The urine sample tested positive for bacteria and resident was started on antibiotic. R18 has not had any aggressive behaviors and typically is not able to express symptoms. LPN-B stated R18 has not had any fevers. LPN-B stated, "I don't know what we ended up doing with her [R18] to be honest." Staff monitor residents diagnosed with urinary tract infection by obtaining temperature, monitoring for signs of infection, and side effects of antibiotics. Results are documented on the electronic medical record. Any abnormal findings are documented in a separate progress note. During interview on 4/18/25 at 11:40 a.m., the director of nursing (DON) confirmed facility progress notes lacked documentation R6 was sent to the emergency room, returned to the facility, and monitored related to the urinary tract infection and antibiotic use. The DON confirmed the hospital AVS is the only record R6 was sent to the emergency room. The director of nursing stated she is automatically notified of newly ordered antibiotics by the facility charting system and does not recall receiving notification of antibiotic ordered. Regarding R18, the DON stated R18's family member reported R18 had	2 875		

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2 875	Continued From page 36 been singing lately which is abnormal behavior. The family member questioned if R18 had an infection due to talking more. R18 did not exhibit any other symptoms. The DON stated she would expect some sort of documentation when a urine sample is obtained. If a resident is suspected of having a urinary tract infection, the expectation is to have monitoring put in place for vitals and symptoms. The provider should be updated, fluids increased, and cognition monitored. Monitoring should be entered as a progress note or a nursing order on the medication administration record. A resident on antibiotic should be monitor for signs and symptoms of the infection being treated, side effects of the antibiotics, and temperature. This monitoring may also be placed on the medication administration record SUGGESTED METHOD OF CORRECTION: The facility should create policies or review and/or revise existing policies and procedures related to notification of change in resident health status or a change of condition. The Director of Nursing (or designee) should educate or re-educate nursing staff to those policies and procedures and conduct measurable audits, to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 875		

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2 910	Continued From page 37	2 910		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper management of indwelling urinary devices for 1 of 1 residents (R6) reviewed for catheter care. R6's quarterly Minimum data Set (MDS) assessment dated 3/10/25 indicated R6 had severe cognitive impairment with no behaviors, is dependent on staff for all activities of daily living (ADLs) and has an indwelling catheter and ostomy. MDS also included R6 had diagnoses of multiple sclerosis (a progressive disease of the nervous system), neurogenic bladder (disease where the bladder does not function properly), and history of recurrent urinary tract infections. R6's care plan for	2 910	Acknowledged	5/29/25

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2 910	Continued From page 38 catheter/urostomy/nephrostomy indicated R6 would remain free from signs and symptoms of urinary tract infections. Interventions included: catheter bag cover when in bed and wheelchair, change catheter as ordered by physician, empty catheter every shift and record output, keep catheter tubing free of kinks, keep drainage bag below bladder level, secure catheter to leg to avoid tension on urinary meatus (opening). Monitor, record, report to MD change in amount, color, consistency, or odor, infection signs and symptoms, chills, fever, nausea/vomiting, and pain. R6's medication administration record included: -suprapubic catheter (a tube inserted into the bladder through the abdomen) 18f change the 28th of every month -suprapubic catheter change drainage bag weekly -routine catheter care every day and evening shift -suprapubic catheter check tubing for proper positioning and cath care every shift -suprapubic catheter monitor intake and output every shift During observation on 4/15/25 at 10:43 a.m., R6 was sitting in common dining area for an activity with catheter drainage bag hanging on the armrest of the wheelchair at a level equal to resident's pelvis. During interview on 4/16/25 at 10:42 a.m., nursing assistant (NA)-B stated, "sometimes I put the catheter bag under the chair and sometimes I hang it on the side". NA-B reported the catheter bag continues to drain properly if hanging on the side of the wheelchair. During observation on 4/16/25 at 1:41 p.m., R6	2 910		

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2 910	Continued From page 39 was sitting in wheelchair in the room with catheter bag hooked to arm rest of wheelchair at a level equal to resident's pelvis. During interview on 4/17/25 at 10:04 a.m., NA-D indicated catheter bags are clipped under the wheelchair so the bag does not drag. During interview on 4/17/25 at 1:06 p.m., the medical director (MD)-B stated drainage bags should be placed "where gravity works" to allow for proper drainage. During interview on 4/17/53 at 1:53 p.m., the director of nursing (DON) stated catheter drainage bags should be placed under the wheelchair to allow for proper drainage, otherwise staff should utilize a leg bag. Catheter bags should remain below the level of the bladder to prevent urine reflux and damage to the bladder. The DON stated drainage bags should not be placed on the arm of a wheelchair. A facility policy titled "Indwelling urinary catheter (Foley) care and management" dated November 18, 2024 indicated: "Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI [catheter-associated urinary tract infection]" SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policies and procedures regarding proper catheter care and tubing management. They could also perform random audits for all residents with catheters to ensure proper care and management of catheter tubing. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further	2 910		

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2 910	Continued From page 40 monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) for 2 of 2 (R138, R140) residents reviewed for infection prevention related to presence of peripherally inserted central catheter (PICC) line (enters a peripheral vein and extends to the supervisor vena cava of the heart). Findings include: R138 quarterly Minimum Data Set (MDS) assessment dated 4/3/25 was incomplete at the time of survey; cognitive function was intact. R138 was receiving IV antibiotic infusions. R138 was admitted on 3/28/25 with a diagnosis of right knee prosthesis infection and inflammation. R138 had a PICC line inserted into a peripheral vein in the upper right chest. R138's orders dated 3/31/25 did not include orders to change the PICC line dressing. Medication orders stated to administer ertapenem (IV antibiotic) 1 gram every 24 hours starting	21375	Acknowledged	5/29/25

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21375	Continued From page 41 3/28/25 at 11pm. R138's orders did not include orders for enhanced barrier precautions. During observation on 4/14/25 at 6:32 p.m., a PICC line was noted in R138's peripheral vein in the upper right chest. R138's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 4/15/25 at 13:56 p.m., registered nurse (RN)-A was observed entering R138's room to administer medication, RN-A did not put on PPE. R140 quarterly Minimum Data Set (MDS) assessment dated 4/8/25 was incomplete at the time of survey; cognitive function was intact. R140 was receiving IV antibiotic infusions. R140 was admitted on 3/31/25 with a diagnosis of left knee prosthesis infection. R140 had a PICC line inserted into a peripheral vein in the right upper arm. R140's orders dated 3/31/25 included changing PICC line dressing every 7 days and as needed if dressing was loose, soiled, or wet. Medication orders stated to administer ceftriaxone (IV antibiotic) 2 grams every 24 hours starting on 3/31/25 at 9pm. R140's orders did not include orders for enhanced barrier precautions. During observation on 4/14/25 at 1:16 p.m., a PICC line was noted in R140's peripheral vein in the right upper arm. R140's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 4/15/25 at 9:48 a.m., RN-A was observed entering R140's room to administer medications, RN-A did not put on PPE.	21375		

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21375	Continued From page 42 During interview on 4/16/25 10:24 a.m., nurse practitioner (NP)-A stated both R138 and R140 should have been placed in EBP precaution upon admission due to both having PICC lines placed prior to admission at facility. During interview on 4/15/25 at 11:20 a.m., RN-A stated it is common to use EBP for residents with urinary catheters, indwelling lines, ostomies, or other things coming out of the body. RN-A stated if a resident required EBP then they should have and EBP sign placed on the door. RN-A stated the health unit coordinator (HUC) or admission nurse would place the EBP signs on the doors. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated EBP precautions are used for residents who have open wounds, catheters, PICC lines, or a known infection. DON confirmed R138 and R140 did not have enhanced barrier precautions initiated at admission. Per undated facility policy titled IPC Manual Chapter 8 Transmission Based Precautions, EBP precautions are initiated for residents with PICC lines, urinary catheters, and feeding tubes. Further, clear signage should be hung on the door with an isolation cart containing PPE placed outside the room. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE use. They could also do environmental rounds and audits, and	21375		

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21375	Continued From page 43 re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. In addition, the DON, ICP, or designee could review facility policy and procedures regarding managment of Peripherally Inserted Central Catheters and do routine audits of treatment orders ensuring proper orders are in place and being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in	21830		5/29/25

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21830	Continued From page 44 an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a	21830		

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21830	Continued From page 45 family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow up on a resident requested medication change in a timely manner for 1 of 1 residents (R138) reviewed for choices. Findings include: R138's quarterly Minimum Data Set (MDS) assessment was not completed at time of survey. R138 had intact cognition and had no rejection of	21830	Acknowledged	

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21830	Continued From page 46 cares. R138 had a diagnosis of right knee prosthesis infection and inflammatory response requiring intravenous (IV) antibiotic therapy. R138 required ongoing limited assistance for dressing and limited assist for hygiene. R138's medication orders included: Ertapenem (medication for infection) 1 gram IV infusion over one hour every day for infection of right knee prosthetic with a start date of 3/28/25. The first dose available at the facility was administered at 11pm. During interview on 4/14/25 at 6:32 p.m., R138 stated she would like to have the Ertapenem infusion done earlier in the evening around 7 or 8 p.m. R138 stated the nurses must wake her up at 11 p.m. to start the infusion and then again in an hour when the infusion is complete. She has asked the nursing staff to change this or request to change this, but the change has not been made. During interview on 4/14/25 7:00 p.m., licensed practical nurse (LPN)-E stated R138 had previously asked him to administer the Ertapenem dose sooner; he had stated to her that the medication could not be done sooner. LPN-E confirmed a situation background assessment recommendation (SBAR) report had not been completed for this request. During interview on 4/16/25 at 9:07 a.m., registered nurse (RN)-A stated the resident had previously told her she wanted medication to be given during the day but told the resident the medication time could only be changed by a provider or a pharmacist. RN-A stated she had not completed a SBAR report to submit the request to the provider.	21830		

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21830	Continued From page 47 During interview on 4/16/25 at 10:29 a.m., nurse practitioner (NP)-A stated the antibiotic could be moved to any time R138 preferred. NP-A confirmed she was unaware R138 wanted to change the time of the antibiotic administration. NP-A confirmed she would expect this kind of request to come on the standard SBAR communication. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated medication change requests are completed on a SBAR document. DON confirmed anyone can fill out the SBAR on the resident's behalf. DON confirmed R138 did not have an SBAR note requesting medication administration times. R138 medication administration time for Ertapenem continues to be administered late and was given on 4/17/25 at 12:04 a.m. A policy regarding resident choices was requested and not provided. Based on interview and record review, the facility failed to notify resident representative following provider order changes in a timely manner for 1 of 1 residents (R18) who received an order for antibiotics for a urinary tract infection (UTI). Findings include: R18's quarterly Minimum Data Set (MDS) assessment dated 2/11/25, indicated R18 was severely cognitively impaired with no behaviors and was incontinent of bladder and bowel. R18's care plan for incontinence/altered elimination indicated R18 had ongoing	21830		

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21830	Continued From page 48 incontinence and could not communicate the need to void. Interventions included: assist perineal hygiene after toileting, encourage fluid intake, observe for signs/symptoms of UTI (difficulty with urination, frequency, urgency, lower abdominal pain and discomfort, back pain, blood in the urine and report to medical doctor/nurse practitioner (MD/NP), offer toileting upon rising, before and after meals and bedtime and as needed (PRN). R18's medication administration record included: cefdinir 300 mg take 1 capsule by mouth two times a day for UTI for 5 days. Take before morning and evening meals dated 4/11/25 and in/out catheter to get UA (urine analysis) sample dated 4/9/25. R18's provider progress notes indicated the following: -4/8/25 "family is noting increased confusion since 4/7/25 and is concerned of UTI. Family is requesting UA". -4/9/2025 indicated order for urine specimen to be sent to lab. -4/11/25 indicated positive urinalysis (test to check for infection) and order for cefdinir 300 mg take 1 capsule by mouth twice a day before morning and evening meal x 5 days. -4/13/25 indicated sensitivities confirming continued use of cefdinir. R18's progress notes lacked resident representative was notified after UA results and R18 was diagnosed with a urinary tract infection, or changes to medication orders. During interview on 4/17/25 at 4:39 p.m., R18's family member (FM)-A reported requesting staff to obtain a urinalysis on 4/4/25 due to R18 having increased vocalizations, however the urine	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 04/22/2025

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

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21830	Continued From page 49 sample was not obtained until 4/10/25. FM-A arrived at the facility on 4/14/25 and still had not heard any updates regarding R18's urine status. At the time FM-A was told R18 "was on something for 5 days". FM-A stated it causes "so much stress having to dig for information about [R18]." During interview on 4/18/25 at 11:40 a.m., the director of nursing (DON) stated resident representatives should be notified of any change in condition, medication changes, and "anything abnormal", or for clarification of anything. All nurses can update resident representatives of changes. The DON stated occasionally, the provider will update the resident or representative regarding recommendations however, it is expected staff would document notification of representative in a progress note. The DON reported, staff have been updated regarding notifying families and have seen improvement, however this instance "must have been missed". A facility policy titled "Notification of changes" dated 12/2016, indicated immediate notification of the resident and/or representative is to be done in situations including " a need to alter treatment/plan of care significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form or treatment)." It continues, "document, in the resident's medical record, the time called, the person spoken with, what was reported, and their response if any." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the resident/resident representative. The facility could update policies and procedures, educate staff on	21830		

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21830	Continued From page 50 these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. In addition, Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING **01 - BUILDING 1** B. WING _____	**04/15/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/15/2025. At the time of this survey, ROCHESTER REHAB AND LIVING CENTER was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 05/22/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ROCHESTER REHAB AND LIVING CENTER is a 1 story building with partial basement and parking garage. The building was constructed in 2015 and was determined to be Type V (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm	K 000		

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K 000	Continued From page 2 system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. There is a 2-hour fire separation between the Skilled Nursing Facility and the Assisted Living. The facility has a capacity of 56 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review, and staff interview the facility failed to inspect and maintain	K 353	Plan of Correction K353 Sprinkler System – Maintenance	5/29/25

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K 353	Continued From page 3 the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section(s) 8.5.5, 8.5.5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/15/2025 between 9:00 AM and 12:30 PM, it was revealed by observation in resident room 1128 that item(s) were found vertically stacked or stored closer than 18 inches to sprinkler head(s) in the closet. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	and Testing Affected Residents • Moved items from sprinkler clearance for 1128, educated resident on proper storage near sprinkler systems. Potential Affected Residents • All resident rooms have been reviewed to ensure adequate sprinkler clearance is in place. Measures/Systemic Changes • All staff to receive education on safe storage in resident rooms. • Education on safe storage in resident rooms to be added to the admission packet for all incoming residents. Monitoring • Director of Plant Operations to audit sprinkler clearance in all resident rooms weekly for 6 weeks. • Audit results will be shared at QAPI meetings for further recommendations. • Director of Plant Operations is responsible for compliance. Date of Alleged Compliance: 5/29/2025	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors	K 374		5/29/25

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K 374	Continued From page 4 are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test, maintain and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/15/2025 between 9:00 AM and 12:30 PM, it was revealed by observation that the smoke barrier door assembly, adjacent to RM 1101, did not close and seal the opening upon test and also had a damaged astragal - both of which would allow the passage of smoke. 2. On 04/15/2025 between 9:00 AM and 12:30 PM, it was revealed by observation that the smoke barrier door assembly, adjacent to RM 1124, did not close and seal the opening upon test which would allow the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	Plan of Correction K374 Subdivision of Building Spaces – Smoke Barrier Doors Measures/Systemic Changes • Smoke barrier doors adjusted for compliance on 4/16/2025. • Smoke barrier doors will be added to preventative maintenance schedule for routine auditing monthly. Monitoring • Director of Plant Operations to audit smoke barrier doors monthly for three months. • Audit results to be shared at QAPI for further recommendations. • Director of Plant Operations is responsible for compliance. Date of Alleged Compliance: 5/29/2025	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101	K 541		5/29/25

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K 541	Continued From page 5 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the laundry chute door per NFPA 101 (2012 edition), section 19.5.4.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/15/2025 between 9:00 AM and 12:30 PM, it was revealed by observation and testing that the Main Floor - Trash cute door handle plunger assembly did not operate properly upon	K 541	Plan of Correction K541 Rubbish Chutes, Incinerators, and Laundry Chutes Measures/Systemic Changes • Deficiencies noted were repaired on 4/19/2025 for compliance. • Maintenance and Housekeeping staff to receive education on the proper operation and function of rubbish chutes, incinerators, and laundry chutes. • Rubbish chutes, incinerators, and laundry chutes will be added to TELs task	

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K 541	Continued From page 6 test and the door was unable to properly latch and seal the vertical shaft. 2. On 04/15/2025 between 9:00 AM and 12:30 PM, it was revealed by observation that the Lower Level - Laundry chute closure assembly had a disconnected closure spring. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 541	list for quarterly evaluation for compliance. Monitoring • Director of Plant Operations to audit rubbish chutes, incinerators, and laundry chutes weekly for 12 weeks. • Audit results will be shared at QAPI meetings for further recommendations. • Director of Plant Operations is responsible for compliance. Date of Alleged Compliance: 5/29/2025	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		5/29/25

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K 923	Continued From page 7 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/15/2025 between 9:00 AM and 12:30 PM, it was revealed by observation that the Med Gas (O2) Storage Room had mixed storage of cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Plan of Correction K923 Gas Equipment – Cylinder and Container Storage Measures/Systemic Changes • A line was painted on the floor in oxygen storage room on 4/20/2025 to properly distinguish containers for compliance. • All licensed nurses and nursing assistants to receive education on proper oxygen storage. Monitoring • Assistant Administrator or designee to audit oxygen storage weekly for 12 weeks. • Audit results to be shared at QAPI for further recommendations. • Assistant Administrator is responsible for compliance. Date of Alleged Compliance: 5/29/2025	

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K 926	Continued From page 8	K 926		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed to provide documentation of education and staff training per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/15/2025 between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation that documentation presented for review was generic in content and did not provide confirmation that staff are receiving initial and continuing education on risks associated with the handling of Med Gas (O2) and cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926	Plan of Correction K926 Gas Equipment – Qualifications and Training Measures/Systemic Changes • All licensed nurses and nursing assistants to receive oxygen training and competency to ensure compliance. • All incoming staff to receive oxygen training and competency during the orientation process to ensure compliance. Monitoring • Director of Plant Operations or designee to audit oxygen training and competency weekly for 12 weeks. • Audit results to be shared at QAPI for further recommendations. • Director of Plant Operations is responsible for compliance. Date of Alleged Compliance: 5/29/2025	5/29/25