Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 10, 2023

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

RE: CCN: 245626
Cycle Start Date: March 1, 2023

Dear Administrator:

On April 19, 2023, we notified you a remedy was imposed. On June 12, 2023 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 May 31, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 1, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 14, 2023, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 1, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 31, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 10, 2023

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

Re: Reinspection Results
Event ID: M7SS12, MY8812, and UVA012

Dear Administrator:

On April 19, 2023, May 17, 2023, and June 12, 2023 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 surveys completed on March 1, 2023, April 4, 2023, and May 4, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2023

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

RE: CCN: 245626
Cycle Start Date: March 1, 2023

Dear Administrator:

On April 19, 2023, we informed you of imposed enforcement remedies.

On May 4, 2023, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 1, 2023, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 1, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 1, 2023.

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.

As we notified you in our letter of April 19, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 1,

2023.

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.

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

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

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

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 an"E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

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 - Health Regulation Division 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 September 1, 2023 (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

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:

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: UVA011

Dear Administrator:

The above facility was surveyed on May 1, 2023 through May 4, 2023 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 05/04/2023

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 5/1/23, to 5/4/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT 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		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least	E 004		5/31/23

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

Electronically Signed | 05/30/2023

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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E 004	Continued From page 1 every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure their emergency preparedness program (EPP) was reviewed and updated at least annually. This had the potential to affect all 42 residents residing in the facility, as well as all staff and visitors. Findings include: Record review on 5/2/23 showed the last documented review of the Emergency Preparedness Plan was 4/18/22.	E 004	E004=C Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the	

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E 004	Continued From page 2 During interview on 5/4/23 at 10:22 a.m., the administrator stated the Emergency Preparedness Plan had not been comprehensively revived since 4/18/22.	E 004	facility's allegation of compliance. Based on interview and documentation review the facility failed to ensure their EPP was reviewed and updated annually. Affected Resident(s) The facility completed the annual review and approved the EPP during the QAPI meeting on May 16, 2023. Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: QAPI will meet annually to review and approve the EPP to maintain compliance. Monitoring: Administrator or designee are responsible for compliance. 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. Completion Date: May 31, 2023	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises	E 039		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 3 to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 4 exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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E 039	Continued From page 5 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that	E 039		

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	245626	A. BUILDING _____ B. WING _____	C 05/04/2023

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E 039	Continued From page 6 requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 7 based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next	E 039		

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E 039	Continued From page 8 required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 9 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 10 community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct	E 039		

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E 039	Continued From page 11 exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a full-scale community exercise, or a facility-based exercise to test their emergency preparedness program annually, or to document activation of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This had the potential to affect all 42 residents who currently resided in the facility, along with visitors and staff who work in the facility. Findings include: Review of the facilities emergency preparedness plan (EPP) binder did not include a facility exercise performed between May 2022 and May 2023. The drills provided by the facility included a Active Shooter Table top dated February 2022, and a Missing person drill dated 10/27/22. The missing person drill documentation did not include a staff attendance sheet, or any post evaluation documentation of the exercise.	E 039	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on interview and documentation review the facility failed to include a facility exercise that included a staff attendance sheet and a post evaluation documentation of the exercise. Affected Resident(s) The facility completed a community-based exercise on 5/5/23 which included a staff attendance sheet and a post evaluation. The facility completed a natural disaster exercise on 5/25/23 which included a staff attendance sheet and a post evaluation.	

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E 039	Continued From page 12 On 5/3/23 at 11:45 a.m., the administrator verified the facility did not conduct a tabletop drill between the dates of May 2022 and May 2023. However, stated the facility did a community based missing person drill on 10/27/22 where two police officers participated in the drill. Documentation of a attendance roster and required after-action analysis of the Missing person drill dated 10/27/22 was requested. The facility did not provide documentation.	E 039	Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: The facility will maintain compliance by completing annual exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. Monitoring: Administrator or designee are responsible for compliance. 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. Completion Date: May 31, 2023	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		5/31/23

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E 041	Continued From page 13 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 14 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 15 Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/02/2023 between 9:00 AM and 1:00 PM, it was revealed during documentation review that the most recent 36 month - 4-hour load bank test documentation was dated 09/05/2018. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on interview and documentation review the facility failed to complete a 4-hour load bank test for the emergency generator. Affected Resident(s) The facility completed a 4-hour load bank test for the emergency generator on May 24, 2023 from 8:00am to 12:00pm. Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: The facility will maintain compliance by completing a 4-hour load bank test for the emergency generator per the regulations. Monitoring: The emergency generator testing was out into the TELS system. This system will notify the facility when the next testing date occurs. Director of Environmental Services or designee are responsible for compliance. 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. Completion Date:	

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E 041	Continued From page 16	E 041	May 31, 2023	
F 000	INITIAL COMMENTS On 5/1/23-5/4/23, 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. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed during the survey and found to be NOT in compliance however NO deficiencies were cited due to actions implemented by the facility prior to survey: MN00092817 H56261842C MN00092677 H56261843C MN00090915 H56268616C AND The following complaints were found to be IN compliance: MN00092933 H56262023C MN00092737 H56261845C MN00092362 H56261844C MN00089065 H56261901C MN00088539 H56261864C MN00088166 H56261865C MN00087492 H56261868C MN00085107 H56261867C MN00081126 H5626054C MN00082098 H5626055C MN00093041 H56261871C	F 000		

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F 000	Continued From page 17 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		5/31/23

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	245626	A. BUILDING _____ B. WING _____	C 05/04/2023

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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F 550	Continued From page 18 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide dignified dining for 1 of 14 (R247) residents reviewed during dining. In addition, the facility failed to provide timely assistance to the bathroom to prevent incontinent episodes for 1 of 1 (R295) resident reviewed for dignity. Findings include: R247's medical diagnoses list dated 4/24/23, indicated R247 had diagnoses which included dementia, depression, gastro-esophageal reflux disease, anxiety, hypercholesterolemia (high cholesterol), and hypertension (high blood pressure). During an observation on 5/4/23, starting at 8:25 a.m., R248's breakfast meal was delivered to her.	F 550	F550 SS=D Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on observation, interview, and document review the facility failed to provide dignified dining for 1 of 14 (R247) residents during dining. In addition, the facility failed to provide timely assistance to the bathroom to prevent incontinent	

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F 550	Continued From page 19 -at 8:38 a.m., the warming cart for meal trays was transported from the kitchen and left at the nurse's station. -at 8:43 a.m., R247 and R248 sat together with nursing assistant (NA)- A sitting between them. R247 had a cup of coffee and no breakfast meal. R248 was being assisted with eating her meal by NA-A. -at 8:44 a.m., NA-A indicated that R247's meal was in the warming cart at the nurse's station and someone would bring it to her soon. R247 then stated, "I'm hungry". NA-A told R247 her food would be coming soon. -at 8:57 a.m., NA-A asked another NA to go and check the meal cart for R247's meal. -at 8:58 a.m., R247's meal was delivered to her. During an interview on 5/04/23, at 9:00 a.m., R247 stated her breakfast was very good and that it was warm enough. During an interview on 5/4/23, at 10:02 a.m., the director of nursing (DON) was unsure of the procedure for serving residents in the dining room and if they would be served and assisted at the same time when sitting together. R295 R295's admission Minimum Data Set (MDS), dated 4/23/23, identified R295 had intact	F 550	episodes for 1 of 1 (R295) resident reviewed for dignity. Affected Resident(s): R247 was served her breakfast and Resident stated “it was according to her satisfaction and was very good and warm.” R295 was followed up with immediately and reminded to use her call light for any needs, and also to alert nursing management if she is had any concerns with a delay in response time. At the time, all resident call lights were audited to ensure call lights were answered timely. Management staff did dining room rotations during meals to ensure all residents eating together were getting their meals at the same time. Potential Affected Resident (s): All residents have the potential to be affected. Measures/Systematic Changes: Policy was reviewed and remains current. Education provided to the staff to include the dining experience. Residents that need assistance will be served their meals at the same time. The food for residents that need assistance with meals will be placed in the food warming cart to ensure the food remains warm until staff are able to assist them. Education will be provided regarding toileting plans, and answering call lights timely to ensure resident dignity. Education will be provided to staff on rounds, to ensure residents are comfortable and have been toileted and have what they need.	

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F 550	Continued From page 20 cognition, diagnoses of osteoarthritis of the knees, diabetes mellitus, and aftercare following joint replacement surgery. Further, the MDS indicated R295 needed assistance with transfers, toilet use, personal hygiene and was at risk for skin breakdown. A care plan, dated 4/17/23, indicated R295 needed an assist of two for bathroom assistance, and an assist of one for ambulation. R295 was to be aided with perineal hygiene and incontinence products. A Bowel and Bladder Data Collection Summary report, dated 4/27/23, indicated R295 was always continent of bowel and bladder. During an interview, on 5/01/23 at 1:42 p.m., R295 stated she has had four incontinent episodes because of waiting too long for assistance to the bathroom. R295 explained she wasn't supposed to walk alone so she had to wait for staff to assist her. And further, R295 described that this was frustrating and upsetting to her as she was not normally incontinent. During an interview, on 5/02/23 at 11:38 a.m., R295 stated on one occasion when she couldn't make it to the bathroom, because it took too long, she was incontinent of urine while standing to transfer to the toilet. R295's gauntlet-style brace to the left ankle became wet with urine. R295 requested assistance from the nursing assistant (NA), whom she was unable to identify, to dry the brace but they indicated to her it would be alright. R295 further explained she had a wet sock and brace until the end of the day when she was assisted with evening care. R295 stated she was upset about this because she didn't want her	F 550	Monitoring: Audits on call light times will be completed weekly for 4 weeks and monthly times 2 months. Staff will meet with residents to ensure their bathroom needs are being met timely. These audits will be done weekly for 4 weeks and monthly times 2 months. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee are responsible for compliance. Completion Date: 5/31/2023	

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F 550	Continued From page 21 brace to smell like urine. During an interview with the director of nursing (DON), on 5/04/2023 at 10:15 a.m., the DON stated she would expect about a 15 to 20-minute wait time for call lights. Explained it could be longer if there were an emergent situation in the unit. The DON further stated it was important to ensure the resident had their needs met so they feel comfortable and taken care of. The DON would expect a continent resident would not have accidents waiting for care. Facility policy The Dining Experience, not dated, identified individuals at the same table would be served and assisted at the same time. Facility policy titled Resident's Bill of Rights and Dignity Policy, dated 10/24/22, indicated residents would be cared for in a manner that promotes maintenance or enhancement of his/her quality of life.	F 550		
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 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	F 656		5/31/23

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F 656	Continued From page 22 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. §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 ensure a comprehensive care plan was developed to include mood and behavior monitoring, and monitoring signs, and symptoms of adverse side effects (undesired harmful effect resulting from a medication) for	F 656	F656 SS=D Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions	

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F 656	Continued From page 23 high-risk medications (i.e., antidepressant and antipsychotic medications) for 1 of 5 residents (R246) reviewed for unnecessary medications. Findings include: R246's Admission/Medicare-5-day Minimum Data Set (MDS), was "in progress". R246's medical diagnoses list dated 4/20/23, indicated R246 had diagnoses which included major depressive disorder and generalized anxiety disorder. R246's care plan, dated 4/20/23, lacked evidence of antidepressant and antipsychotic medication use and monitoring. R246's physician orders included Abilify 2 mg; give 0.5 tablet by mouth one time a day related to major depressive disorder and generalized anxiety disorder and Duloxetine HCL 60 mg; give 1 capsule by mouth one time a day for depression. R246's medication administration record (MAR) lacked any specific monitoring to be completed regarding the use of Abilify and Duloxetine. During an interview on 5/4/23, at 10:02 a.m., the director of nursing (DON) stated if a resident is on antidepressant and/or antipsychotic medications they should be monitored for signs and symptoms of medication side effects, and mood, and behavior monitoring. The DON described the process as the health unit coordinator (HUC) enters orders for side effects, mood and behavior monitoring in the resident's electronic health record (EHR). Social services complete a mood	F 656	in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on interview and documentation review the facility ailed to ensure a comprehensive care plan was developed to include mood and behavior monitoring, and monitoring signs and symptoms of adverse side effects for high risk medications for 1 of 5 residents (R246) reviewed for unnecessary medications. Affected Resident(s): R246's care plan was updated to include psychotropic medications and monitoring. MAR/TAR was updated immediately to add behavior and side effect monitoring. Potential Affected Resident(s): All residents with psychotropic medications had the potential to be affected. Measures/Systematic Changes: Psychoactive medication use and gradual dose reduction policy was reviewed and remains current. Education to staff includes that we will continue to use our current process and follow the RAI manual for care planning and MDS completion. Education will be completed for the HUCS and all nurses entering orders to look for high alert psychotropic medications and ensure side effect monitoring and behavior monitoring are entered when a resident is receiving these medications.	

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F 656	Continued From page 24 and behavior care plan. The DON stated she expected this process to be followed for all residents that received antidepressant and antipsychotic medications. DON reviewed R246's EHR and confirmed R246 lacked a mood and behavior care plan and lacked evidence of monitoring for adverse side effects. Facility policy titled Psychoactive Medication Use and Gradual Dose Reduction, on 3/2019, identified each psychoactive medication would be given to treat clearly defined targeted conditions and to promote or maintain highest practicable physical, functional, and psychosocial well-being. It also identified residents prescribed psychoactive medications would receive adequate monitoring.	F 656	Monitoring: Audits on all new admissions and new orders on psychotropic meds will be done to ensure they have appropriate monitoring in place. Audits will be done weekly x 4 weeks and monthly times 2 months. DON or designee are responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Completion Date: 5/31/2023	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		5/31/23

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F 757	Continued From page 25 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication applied to resident had a provider order prior to administration for 1 of 6 (R295) residents observed during medication review. Findings include: R295's admission Minimum Data Set (MDS) assessment, dated 4/23/23, identified R295 had intact cognition, diagnoses of osteoarthritis of the knees, diabetes mellitus, and aftercare following joint replacement surgery. Further, the MDS indicated R295 needed assistance with transfers, toilet use, personal hygiene and was at risk for skin breakdown. R295's care plan, dated 4/17/23, indicated R295 needed an assist of two for bathroom assistance, and an assist of one for ambulation. R295 was to be aided with perineal hygiene and incontinence product. Documents titled, Weekly Skin Check, revealed the following: -On 4/22/23, R295 had no skin issues. -On 5/2/23, R295 had moisture associated skin damage (MASD) under the abdominal folds and groin areas and indicated areas were treated with an antifungal powder.	F 757	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on observation, interview, and record review, the facility failed to ensure medication applied to resident had a provider order prior to administration for 1 of 6 residents (R295) residents observed during medication review. Affected Resident(s): R295 was corrected immediately by removing the cream from the room. The Nurse manager also obtained an order for the cream to be applied. Potential Affected Resident(s): All residents could have been affected, as medications & creams can be initiated per Standing House orders. Measures/Systematic Changes: Standing House Orders for Skilled Nursing Facility Policy was reviewed and remains current. Nursing staff will be educated regarding	

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F 757	Continued From page 26 R295's provider orders did not indicate an order for antifungal powder. A progress note, dated 4/30/23, indicated R295 had redness and itching on the skin under her abdominal folds. An antifungal powder was in R295's room and was applied to the red areas. During an interview, on 5/01/23 at 1:51 p.m., R295 stated she had a rash and itching under the abdominal folds and that about two days ago a nurse put some type of powder on it and relieved the itching. During an interview, on 5/02/23 at 11:38 a.m., R295 stated no one had put any powder on her rash that day. R295 further stated she had requested staff (however, R295 was unable to identify the nurse) to get some type of treatment for her rash. During an interview, on 5/03/23 at 2:11 p.m., licensed practical nurse (LPN)-A reviewed the standing orders and confirmed R295 did not have an order for antifungal powder and further, the standing orders for the facility did not contain an order for antifungal powder. During an interview, on 5/03/23 at 2:20 p.m., LPN-B reviewed the standing orders and confirmed R295 did not have an order for antifungal powder and further, the standing orders for the facility did not contain an order antifungal powder. During an interview, on 5/2/23 at 2:25 p.m., clinical manager (CM)-A confirmed antifungal powder was not a standing order and an order was needed to apply antifungal powder to a	F 757	the appropriate use and initiation of the standing house orders. Education will also include only administering medications for which we have an order. Education will be completed to ensure staff are monitoring rooms during rounds to look for any medications in the room and to remove them if there is no self-administration order. DON to connect with Medical Director to review current standing house orders and adjust as needed. Monitoring: Room audits will be completed weekly for 4 weeks and then monthly for two months. DON or designee are responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Completion Date: 5/31/2023	

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F 757	Continued From page 27 resident and the facility would pursue an order. A facility document titled, Standing Orders Policy and Procedure and dated 2/2/14, indicated standing orders provided nursing care for specific conditions in accordance with approved standing orders. Nursing staff would document a progress note indicating the assessment, plan of care and standing orders that were implemented. Further, the electronic medication administration record (eMAR) would be used to document standing orders and medications administered by nursing or other trained staff. A facility document titled, Standing Orders for Skilled Nursing Facilities and dated April 2022, did not indicate a standing order for antifungal powder to be applied to residents.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		5/31/23

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F 812	Continued From page 28 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential spread of foodborne illness, ensure proper glove use and hand washing techniques were used during food preparation. Furthermore, the facility failed to ensure dishes were appropriately air dried, and failed to ensure food stored in the refrigerators, freezers and dry storage were labeled and dated. These failures had the potential to affect all residents who were served food and beverages from the kitchen. Findings include: During an observation on 5/01/23, at 11:44 a.m., chef manager (CM) was at the serving station prepping the dessert for lunch without a hairnet. During the initial tour of the kitchen on 5/01/23, at 11:47 a.m., the general manager (GM) noted the following: 1. the main dry storage shelves had unsealed bags of rice and noodles, not labeled, or dated. 2. the main kitchen refrigerator had unsealed bags of squash, and mixed vegetables, not labeled or dated. The bottom of the fridge had brown residue with crumbs and food particles scattered throughout. 3. the main freezer had unsealed bags of brussel sprouts, waffles, and mini pizzas, not labeled or dated.	F 812	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on observation, interview and documentation review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential of spread of foodborne illness, ensure proper glove use and hand washing techniques were used during food preparation. Facility failed to ensure dishes were appropriately air dried, and failed to ensure food stored in the refrigerators, freezer and dry storage were labeled and dated. Affected Resident(s) The facility will store, prepare, distribute and serve food in accordance with professional standards for food service safety. Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: Culinary staff were immediately educated and will continue to be regarding hand	

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	245626	A. BUILDING _____ B. WING _____	C 05/04/2023

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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F 812	Continued From page 29 4. a black cart held clean dishes for meal service, had food crumbs noted in all the corners of the bottom shelf and several nickel sized dried, flaky brown residue marks on both shelves and on all four wheels. 5. the rehab 1 refrigerator had a brown sticky residue on all the shelves along with clumps of crumbs and food particles. The rehab 1 freezer has several Italian ice's stuck together with a sticky pink material. The floor of the freezer had several areas of brown residue and food particles. 6. the rehab 2 refrigerator had brown and yellow dried residue on all the shelves. The rehab 2 freezer had several Italian ice's stuck together with a sticky pink material built up on the shelf. A second shelf had a thick white substance dried to the bottom of it. 7. the prairie refrigerator had a pitcher of yellow liquid not labeled or dated. GM stated it was a pitcher of lemonade. All shelves had a yellow and brown sticky residue with food particles. The prairie freezer had a large ice pack stuck to an Italian ice. During the tour the GM stated all food items should have a date of when it arrived, and another date of when it was opened. GM stated it was important to have all items dated because the shelf life is 5-7 days and if not dated, they would not know when to discard the item. GM also stated once an item is opened it should be placed in a zip lock bag or plastic container. GM stated she would expect all kitchen equipment including refrigerators and freezers to be cleaned	F 812	hygiene, cleaning/sanitation, labeling/storing food and wearing hair restraints. Preventive maintenance schedules will be posted in the TELS system for vents, ceiling. Floors and ice machine. Cleaning schedules will be posted and require staff signatures when tasks have been completed. Monitoring: Sanitation, infection control and food labeling audits will be completed daily for 1 week, weekly for 1 month and monthly for 3 months. Administrator or designee are responsible for compliance. 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. Completion Date: May 31, 2023	

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F 812	Continued From page 30 on a regular basis. During an observation of the lunch meal service on 5/02/2023, the following observations were noted: -At 11:10 a.m., the wall above the three-compartment sink had visible gray matter, approximately 1 1/2 feet x 12 depth, and extended into where there are plastic containers stacked on two shelves above the sink. The ceiling vent in the clean dishwashing area had visible gray matter covering the entire vent and extended approximately 2 feet out from the vent. -At 11:31 a.m., the outside of the ice machine is covered with a white substance. -At 11:43 a.m., DA-A retrieved salad bowls from dish area and removed his gloves. DA-A did not perform hand hygiene, put on a new pair of gloves, and dished up sliced apples into the salad bowls. -At 11:56 a.m., CM put two slices of bread on the grill and then removed her gloves. CM did not perform hand hygiene and put on a new pair of gloves. -At 12:01 p.m., noted several thin white/yellow strands about 1/2 inch in length hanging from ceiling, directly above serving station. -At 12:01 p.m., CM put chili in food processor for mechanical soft diet, hand gloves were on. CM placed the chili in steam table and removed her gloves. CM did not perform hand hygiene, and dished up the grilled cheese, and then CM put a new pair of gloves on. -At 12:12 p.m., housekeeper-A rubbed her face with her gloves on. Housekeeper-A did not remove gloves or perform hand hygiene and continued to set up beverages and desserts for meal trays.	F 812		

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F 812	Continued From page 31 During an interview on 5/3/23, at 10:35 a.m., the CM stated hand hygiene would take place when you enter the kitchen and when you change jobs or went from one task to another task. CM stated hairnets would always be worn when in the kitchen and in the beverage/serving area. CM stated they do not have a cleaning schedule but try to do what they can for now because they are short staffed. CM stated all food should be labeled and dated when opened so staff know when it needs to be discarded. During an interview on 5/3/23, at 10:48 a.m., the GM stated hand hygiene would take place when you enter the kitchen, after using the bathroom, any time you touch your face, hair, or your eye, when going between tasks and in between changing gloves. GM stated hairnets are required when in the kitchen and anytime they are handling food. GM stated housekeeper-A was the only employee from another department who helped with meal trays and stated she has been trained on hand hygiene. During an interview on 5/3/23, at 11:00 a.m., the GM stated the white substance on the outside of the ice machine was lime build up and they had issues with the water softener. GM stated the gray matter noted on the walls, vents and ceiling were dust bunnies. GM stated the thin white and yellow strands hanging from the ceiling was dried spaghetti sauce that had been there for a few months. GM stated it was of concern that the particles could fall onto the food being served directly below. GM stated they did not clean the ceiling and vents or anything they cannot reach. GM stated the maintenance department cleans those areas out of reach. GM stated she requested the maintenance department to clean	F 812		

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F 812	Continued From page 32 these areas several times over the last three months, but it never got done. GM stated they do not have a cleaning schedule, instead she leaves the staff notes on what to clean. GM stated the cooler directly below the microwave should be closed when cleaned to prevent the sanitizer or particles in the microwave from falling into the food located in the cooler. GM stated, that was me that did that yesterday, I should have made sure the cooler was closed first. During interview on 5/04/23, at 9:04 a.m., maintenance assistant (MA) stated it was the kitchen's responsibility to complete all their cleaning, including the upper walls, ceilings, and vents. MA stated anyone could fill out a work order if they needed help from the maintenance department. MA did not have any work orders from the kitchen to assist with cleaning the upper walls, ceilings or the vents and had not received any work orders for those areas over the last few months. During an observation on 5/04/23, at 10:53 a.m., DA-D entered the dish washing station, and removed his gloves. DA-D did not perform hand hygiene, placed his dirty gloves on top of a clean tray and put on a new pair of gloves. During an observation on 5/04/23, at 10:54 a.m., DA-D took plate covers and trays that were wet from the dishwashing stating and wiped them down with yellow towel before placing them on the drying rack. During an interview on 5/04/23, at 10:58 a.m., DA-D stated when the dishes come out of the dishwasher, they stay there to air dry, but he keeps towels on hand to wipe them down in case	F 812		

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F 812	Continued From page 33 they don't dry all the way. DA-D stated air drying is best but sometimes they need to use the dishes before they have had time to dry. During an interview on 5/04/23, at 11:01 a.m., GM stated clean dishes should be air dried. GM stated it was okay for staff to use paper towels or the yellow towels to wipe the dishes dry if needed. During interview on 5/04/23, at 11:06 a.m., the administrator stated in her experience it was not standard practice to not allow the dishes to fully air dry and instead wipe them down with a towel, but she was unsure of the process for this facility and would need to look at the policy. A facility policy Dish machine not dated, identified to air-dry all items. A facility policy Personal Hygiene, not dated, identified that staff would wash hands frequently, and wear a hairnet to restrain all hair. A facility policy Cleaning and sanitizing, not dated, identified that all food service departments would have an effective cleaning program that included a cleaning schedule. A facility policy Handwashing, not dated, identified handwashing was required immediately before starting work, before putting on single-use gloves and after removing single-use gloves, cleaning tables, or busing dirty dishes, after touching hair, face and body, touching clothing or aprons, after handling chemicals that might affect food safety, leaving or returning to the kitchen/prep area and after touching anything else that may contaminate hands (e.g., dirty equipment, work surfaces, phones or clothes).	F 812		

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F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to repair a bathroom door and ceiling tiles were free of stains and debris for a safe, sanitary, functional comfortable environment for residents, staff and visitors. Findings include: On 5/1/23 at 1:28 p.m., R4 and R15's bathroom door (barn sliding door on a track) was observed to have the back wheel completely off of the sliding track. The bathroom door was partially resting on the floor. On 5/1/23 at 7:35 p.m., the bathroom door was off track and in the closed position. The positioning of the door created a space between the wall and door where it was possible to see into the bathroom from the hallway. Nursing assistant (NA)-C stated the door will get fixed for a while, but then it breaks again. On 5/2/23 at 9:39 a.m., the door remained off track. On 5/2/23 at 11:15 am., R4 was in the bathroom, and could be seen sitting on the toilet through an approximate six-inch gap. On 5/2/23 at 2:42 p.m., NA-B confirmed the door was off track and stated the door does get stuck	F 921	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. Based on Observation the facility failed to repair a bathroom door and ceiling tiles in the medication room. Affected Resident(s) R4 and R15 bathroom door was repaired on 5/4/23. The medication room ceiling tiles were removed on 5/4/23. New ceiling tiles will be installed. Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: Staff will enter work orders through the TELS system to ensure that repairs will be completed timely. Monitoring: Facility will interview residents randomly weekly to ensure that their environment is safe/functional/sanitary and comfortable	5/31/23

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F 921	Continued From page 35 and then it comes off the track. R15's family member was in the bathroom with R15 and stated the janitor has to fix the door about once a week. NA-B grabbed the door and attempted to guide wheel back into the track, R-15's family member gave the door an extra lift and NA-B secured the wheel back in the track. On 5/3/23 at 8:37 a.m., the maintenance manager (MA) stated R4 and R15's bathroom door was an ongoing problem because sometimes staff pushed the door to far back causing it to go off the track. MA confirmed the door had been fixed several times in the past, but he had not been notified the door was off track on 5/1 or 5/2/23. MA confirmed the door does not close all the way when off track. The door has a large gap because the door rests on the floor, this could be a dignity issue, but there is not a safety concern related to the door being off track. The door will need to be permanently fixed so it does not continue to slip out of the sliding track. On 5/4/23 at 8:18 a.m., the director of nursing (DON) stated she was not aware the bathroom door in R4 and R15's suite had been intermittently broken for periods of time and stated she would expect the door be permanently fixed. On 5/2/23 the fire marshal notified the survey team of ceiling tiles in the medication (med) room that were stained with a black substance. On 5/2/23 at 2:37 p.m., licensed practical nurse (LPN)-C opened the mediation room door and confirmed the ceiling tiles around a vent above the Omnicell (medication storage and dispensing unit) were damaged. LPN-C stated there was a	F 921	for 4 weeks and monthly for 3 months. Administrator or designee are responsible for compliance. 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. Completion Date: May 31, 2023	

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F 921	Continued From page 36 condensation problem of some sort that had caused the same black mold on the ceiling before. Indicated the ceiling had currently been that way for at least a couple months. The administrator stepped into the room and stated service master was coming tomorrow to service the ceiling. The area of damage was observed to be around a vent. The ceiling tile closest to the door wall had a large area of moisture stain brown in color and a large surface area covered with a black dot pattern appearance. The second tile also had a smaller surface area of brown moisture stains and the black substance. On 5/3/23 at 8:29 a.m., the facility MA stated a couple months ago the facility had a vendor in to address the same area of the ceiling for the same type of staining. At the time the facility did not test for mold, and indicated it was likely dirt from the vent. Stated when the tiles get condensation on them, they are changed, and the surrounding area gets cleaned. LPN-D opened the med room. MA entered and confirmed the ceiling had 2 tiles with what appeared to be stains from moisture along with areas of raised black spots on two of the ceiling tiles by the vent. MA explained moisture happens inside of the air duct and then gets blown out of the diffuser duct. In the winter the moisture is increased because the air conditioning has to run in the medication room, which creates a higher level of moisture in the vents. Stated the stains on the ceiling may be mostly dirt, but agreed it was possible it was mold, but could not confirm it was mold without a test. MA stated the maintenance department had not received notice that there was an issue with the med room ceiling tiles. On 5/4/23 at 8:18 a.m., LPN-C opened the med	F 921		

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F 921	Continued From page 37 room and confirmed the soiled ceiling tiles were still in place. MMC invoice dated 10/12/22 for the medication room ceiling described work performed as: ceiling diffuser has black mold around it. Coil checked in air handler in med room, found the coil was dirty and nearly impossible to clean without dropping it. Plan to see if it's salvageable and if it is to clean it and put it back in, otherwise will need to be replaced. Air diffuser is listed under parts and materials on the service billing invoice.	F 921		

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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 5/1/23 to 5/4/23, 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. 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 Minnesota Department of Health. In addition, a complaint survey was conducted at	2 000		

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2 000	Continued From page 2	2 000		

your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure

The following complaints were reviewed during the survey.

The following complaints were found to be SUBSTANTIATED however NO deficiencies were cited due to actions implemented by the facility prior to survey:

MN00092817 H56261842C
MN00092677 H56261843C
MN00090915 H56268616C

AND

The following complaints were found to be UNSUBSTANTIATED:

MN00092933 H56262023C
MN00092737 H56261845C
MN00092362 H56261844C
MN00089065 H56261901C
MN00088539 H56261864C
MN00088166 H56261865C
MN00087492 H56261868C
MN00085107 H56261867C
MN00081126 H5626054C
MN00082098 H5626055C
MN00093041 H56261871C

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.

The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first

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 05/04/2023

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	Continued From page 3 page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. 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		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive care plan was developed to include mood and behavior monitoring, and monitoring signs, and symptoms of adverse side effects (undesired harmful effect resulting from a medication) for high-risk medications (i.e., antidepressant and antipsychotic medications) for 1 of 5 residents (R246) reviewed for unnecessary medications. Findings include: R246's Admission/Medicare-5-day Minimum Data Set (MDS), was "in progress".	2 565	Corrected	5/31/23

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2 565	Continued From page 4 R246's medical diagnoses list dated 4/20/23, indicated R246 had diagnoses which included major depressive disorder and generalized anxiety disorder. R246's care plan, dated 4/20/23, lacked evidence of antidepressant and antipsychotic medication use and monitoring. R246's physician orders included Abilify 2 mg; give 0.5 tablet by mouth one time a day related to major depressive disorder and generalized anxiety disorder and Duloxetine HCL 60 mg; give 1 capsule by mouth one time a day for depression. R246's medication administration record (MAR) lacked any specific monitoring to be completed regarding the use of Abilify and Duloxetine. During an interview on 5/4/23, at 10:02 a.m., the director of nursing (DON) stated if a resident is on antidepressant and/or antipsychotic medications they should be monitored for signs and symptoms of medication side effects, and mood, and behavior monitoring. The DON described the process as the health unit coordinator (HUC) enters orders for side effects, mood and behavior monitoring in the resident's electronic health record (EHR). Social services complete a mood and behavior care plan. The DON stated she expected this process to be followed for all residents that received antidepressant and antipsychotic medications. DON reviewed R246's EHR and confirmed R246 lacked a mood and behavior care plan and lacked evidence of monitoring for adverse side effects. Facility policy titled Psychoactive Medication Use	2 565		

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2 565	Continued From page 5 and Gradual Dose Reduction, on 3/2019, identified each psychoactive medication would be given to treat clearly defined targeted conditions and to promote or maintain highest practicable physical, functional, and psychosocial well-being. It also identified residents prescribed psychoactive medications would receive adequate monitoring. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure a comprehensive care plan for high-risk medications (i.e., antidepressant and antipsychotic medications) is developed to include mood and behavior monitoring, and monitoring signs, and symptoms of adverse side effects. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and	21000		5/31/23

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21000	Continued From page 6 trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential spread of foodborne illness, ensure proper glove use and hand washing techniques were used during food preparation. Furthermore, the facility failed to ensure dishes were appropriately air dried, and failed to ensure food stored in the refrigerators, freezers and dry storage were labeled and dated. These failures had the potential to affect all residents who were served food and beverages from the kitchen. Findings include: During an observation on 5/01/23, at 11:44 a.m., chef manager (CM) was at the serving station prepping the dessert for lunch without a hairnet. During the initial tour of the kitchen on 5/01/23, at 11:47 a.m., the general manager (GM) noted the following: 1. the main dry storage shelves had unsealed bags of rice and noodles, not labeled, or dated. 2. the main kitchen refrigerator had unsealed bags of squash, and mixed vegetables, not labeled or dated. The bottom of the fridge had brown residue with crumbs and food particles scattered throughout. 3. the main freezer had unsealed bags of brussel sprouts, waffles, and mini pizzas, not labeled or dated.	21000	Corrected	

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21000	Continued From page 7 4. a black cart held clean dishes for meal service, had food crumbs noted in all the corners of the bottom shelf and several nickel sized dried, flaky brown residue marks on both shelves and on all four wheels. 5. the rehab 1 refrigerator had a brown sticky residue on all the shelves along with clumps of crumbs and food particles. The rehab 1 freezer has several Italian ice's stuck together with a sticky pink material. The floor of the freezer had several areas of brown residue and food particles. 6. the rehab 2 refrigerator had brown and yellow dried residue on all the shelves. The rehab 2 freezer had several Italian ice's stuck together with a sticky pink material built up on the shelf. A second shelf had a thick white substance dried to the bottom of it. 7. the prairie refrigerator had a pitcher of yellow liquid not labeled or dated. GM stated it was a pitcher of lemonade. All shelves had a yellow and brown sticky residue with food particles. The prairie freezer had a large ice pack stuck to an Italian ice. During the tour the GM stated all food items should have a date of when it arrived, and another date of when it was opened. GM stated it was important to have all items dated because the shelf life is 5-7 days and if not dated, they would not know when to discard the item. GM also stated once an item is opened it should be placed in a zip lock bag or plastic container. GM stated she would expect all kitchen equipment including refrigerators and freezers to be cleaned on a regular basis.	21000		

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21000	Continued From page 8 During an observation of the lunch meal service on 5/02/2023, the following observations were noted: -At 11:10 a.m., the wall above the three-compartment sink had visible gray matter, approximately 1 1/2 feet x 12 depth, and extended into where there are plastic containers stacked on two shelves above the sink. The ceiling vent in the clean dishwashing area had visible gray matter covering the entire vent and extended approximately 2 feet out from the vent. -At 11:31 a.m., the outside of the ice machine is covered with a white substance. -At 11:43 a.m., DA-A retrieved salad bowls from dish area and removed his gloves. DA-A did not perform hand hygiene, put on a new pair of gloves, and dished up sliced apples into the salad bowls. -At 11:56 a.m., CM put two slices of bread on the grill and then removed her gloves. CM did not perform hand hygiene and put on a new pair of gloves. -At 12:01 p.m., noted several thin white/yellow strands about 1/2 inch in length hanging from ceiling, directly above serving station. -At 12:01 p.m., CM put chili in food processor for mechanical soft diet, hand gloves were on. CM placed the chili in steam table and removed her gloves. CM did not perform hand hygiene, and dished up the grilled cheese, and then CM put a new pair of gloves on. -At 12:12 p.m., housekeeper-A rubbed her face with her gloves on. Housekeeper-A did not remove gloves or perform hand hygiene and continued to set up beverages and desserts for meal trays. During an interview on 5/3/23, at 10:35 a.m., the CM stated hand hygiene would take place when	21000		

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21000	Continued From page 9 you enter the kitchen and when you change jobs or went from one task to another task. CM stated hairnets would always be worn when in the kitchen and in the beverage/serving area. CM stated they do not have a cleaning schedule but try to do what they can for now because they are short staffed. CM stated all food should be labeled and dated when opened so staff know when it needs to be discarded. During an interview on 5/3/23, at 10:48 a.m., the GM stated hand hygiene would take place when you enter the kitchen, after using the bathroom, any time you touch your face, hair, or your eye, when going between tasks and in between changing gloves. GM stated hairnets are required when in the kitchen and anytime they are handling food. GM stated housekeeper-A was the only employee from another department who helped with meal trays and stated she has been trained on hand hygiene. During an interview on 5/3/23, at 11:00 a.m., the GM stated the white substance on the outside of the ice machine was lime build up and they had issues with the water softener. GM stated the gray matter noted on the walls, vents and ceiling were dust bunnies. GM stated the thin white and yellow strands hanging from the ceiling was dried spaghetti sauce that had been there for a few months. GM stated it was of concern that the particles could fall onto the food being served directly below. GM stated they did not clean the ceiling and vents or anything they cannot reach. GM stated the maintenance department cleans those areas out of reach. GM stated she requested the maintenance department to clean these areas several times over the last three months, but it never got done. GM stated they do not have a cleaning schedule, instead she leaves	21000		

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21000	Continued From page 10 the staff notes on what to clean. GM stated the cooler directly below the microwave should be closed when cleaned to prevent the sanitizer or particles in the microwave from falling into the food located in the cooler. GM stated, that was me that did that yesterday, I should have made sure the cooler was closed first. During interview on 5/04/23, at 9:04 a.m., maintenance assistant (MA) stated it was the kitchen's responsibility to complete all their cleaning, including the upper walls, ceilings, and vents. MA stated anyone could fill out a work order if they needed help from the maintenance department. MA did not have any work orders from the kitchen to assist with cleaning the upper walls, ceilings or the vents and had not received any work orders for those areas over the last few months. During an observation on 5/04/23, at 10:53 a.m., DA-D entered the dish washing station, and removed his gloves. DA-D did not perform hand hygiene, placed his dirty gloves on top of a clean tray and put on a new pair of gloves. During an observation on 5/04/23, at 10:54 a.m., DA-D took plate covers and trays that were wet from the dishwashing stating and wiped them down with yellow towel before placing them on the drying rack. During an interview on 5/04/23, at 10:58 a.m., DA-D stated when the dishes come out of the dishwasher, they stay there to air dry, but he keeps towels on hand to wipe them down in case they don't dry all the way. DA-D stated air drying is best but sometimes they need to use the dishes before they have had time to dry.	21000		

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21000	Continued From page 11 During an interview on 5/04/23, at 11:01 a.m., GM stated clean dishes should be air dried. GM stated it was okay for staff to use paper towels or the yellow towels to wipe the dishes dry if needed. During interview on 5/04/23, at 11:06 a.m., the administrator stated in her experience it was not standard practice to not allow the dishes to fully air dry and instead wipe them down with a towel, but she was unsure of the process for this facility and would need to look at the policy. A facility policy Dish machine not dated, identified to air-dry all items. A facility policy Personal Hygiene, not dated, identified that staff would wash hands frequently, and wear a hairnet to restrain all hair. A facility policy Cleaning and sanitizing, not dated, identified that all food service departments would have an effective cleaning program that included a cleaning schedule. A facility policy Handwashing, not dated, identified handwashing was required immediately before starting work, before putting on single-use gloves and after removing single-use gloves, cleaning tables, or busing dirty dishes, after touching hair, face and body, touching clothing or aprons, after handling chemicals that might affect food safety, leaving or returning to the kitchen/prep area and after touching anything else that may contaminate hands (e.g., dirty equipment, work surfaces, phones or clothes). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	21000		

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21000	Continued From page 12 procedures to ensure proper glove use and hand washing techniques are used during food preparation in the kitchen. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential spread of foodborne illness, ensure proper glove use and hand washing techniques were used during food preparation. Furthermore, the facility failed to ensure dishes were appropriately air dried, and failed to ensure food stored in the refrigerators, freezers and dry storage were labeled and dated. These failures had the potential to affect all residents who were served food and beverages from the kitchen. Findings include:	21015	Corrected	5/31/23

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21015	Continued From page 13 During an observation on 5/01/23, at 11:44 a.m., chef manager (CM) was at the serving station prepping the dessert for lunch without a hairnet. During the initial tour of the kitchen on 5/01/23, at 11:47 a.m., the general manager (GM) noted the following: 1. the main dry storage shelves had unsealed bags of rice and noodles, not labeled, or dated. 2. the main kitchen refrigerator had unsealed bags of squash, and mixed vegetables, not labeled or dated. The bottom of the fridge had brown residue with crumbs and food particles scattered throughout. 3. the main freezer had unsealed bags of brussel sprouts, waffles, and mini pizzas, not labeled or dated. 4. a black cart held clean dishes for meal service, had food crumbs noted in all the corners of the bottom shelf and several nickel sized dried, flaky brown residue marks on both shelves and on all four wheels. 5. the rehab 1 refrigerator had a brown sticky residue on all the shelves along with clumps of crumbs and food particles. The rehab 1 freezer has several Italian ice's stuck together with a sticky pink material. The floor of the freezer had several areas of brown residue and food particles. 6. the rehab 2 refrigerator had brown and yellow dried residue on all the shelves. The rehab 2 freezer had several Italian ice's stuck together with a sticky pink material built up on the shelf. A second shelf had a thick white substance dried to	21015		

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21015	Continued From page 14 the bottom of it. 7. the prairie refrigerator had a pitcher of yellow liquid not labeled or dated. GM stated it was a pitcher of lemonade. All shelves had a yellow and brown sticky residue with food particles. The prairie freezer had a large ice pack stuck to an Italian ice. During the tour the GM stated all food items should have a date of when it arrived, and another date of when it was opened. GM stated it was important to have all items dated because the shelf life is 5-7 days and if not dated, they would not know when to discard the item. GM also stated once an item is opened it should be placed in a zip lock bag or plastic container. GM stated she would expect all kitchen equipment including refrigerators and freezers to be cleaned on a regular basis. During an observation of the lunch meal service on 5/02/2023, the following observations were noted: -At 11:10 a.m., the wall above the three-compartment sink had visible gray matter, approximately 1 1/2 feet x 12 depth, and extended into where there are plastic containers stacked on two shelves above the sink. The ceiling vent in the clean dishwashing area had visible gray matter covering the entire vent and extended approximately 2 feet out from the vent. -At 11:31 a.m., the outside of the ice machine is covered with a white substance. -At 11:43 a.m., DA-A retrieved salad bowls from dish area and removed his gloves. DA-A did not perform hand hygiene, put on a new pair of gloves, and dished up sliced apples into the salad bowls. -At 11:56 a.m., CM put two slices of bread on the	21015		

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21015	Continued From page 15 grill and then removed her gloves. CM did not perform hand hygiene and put on a new pair of gloves. -At 12:01 p.m., noted several thin white/yellow strands about 1/2 inch in length hanging from ceiling, directly above serving station. -At 12:01 p.m., CM put chili in food processor for mechanical soft diet, hand gloves were on. CM placed the chili in steam table and removed her gloves. CM did not perform hand hygiene, and dished up the grilled cheese, and then CM put a new pair of gloves on. -At 12:12 p.m., housekeeper-A rubbed her face with her gloves on. Housekeeper-A did not remove gloves or perform hand hygiene and continued to set up beverages and desserts for meal trays. During an interview on 5/3/23, at 10:35 a.m., the CM stated hand hygiene would take place when you enter the kitchen and when you change jobs or went from one task to another task. CM stated hairnets would always be worn when in the kitchen and in the beverage/serving area. CM stated they do not have a cleaning schedule but try to do what they can for now because they are short staffed. CM stated all food should be labeled and dated when opened so staff know when it needs to be discarded. During an interview on 5/3/23, at 10:48 a.m., the GM stated hand hygiene would take place when you enter the kitchen, after using the bathroom, any time you touch your face, hair, or your eye, when going between tasks and in between changing gloves. GM stated hairnets are required when in the kitchen and anytime they are handling food. GM stated housekeeper-A was the only employee from another department who helped with meal trays and stated she has been	21015		

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21015	Continued From page 16 trained on hand hygiene. During an interview on 5/3/23, at 11:00 a.m., the GM stated the white substance on the outside of the ice machine was lime build up and they had issues with the water softener. GM stated the gray matter noted on the walls, vents and ceiling were dust bunnies. GM stated the thin white and yellow strands hanging from the ceiling was dried spaghetti sauce that had been there for a few months. GM stated it was of concern that the particles could fall onto the food being served directly below. GM stated they did not clean the ceiling and vents or anything they cannot reach. GM stated the maintenance department cleans those areas out of reach. GM stated she requested the maintenance department to clean these areas several times over the last three months, but it never got done. GM stated they do not have a cleaning schedule, instead she leaves the staff notes on what to clean. GM stated the cooler directly below the microwave should be closed when cleaned to prevent the sanitizer or particles in the microwave from falling into the food located in the cooler. GM stated, that was me that did that yesterday, I should have made sure the cooler was closed first. During interview on 5/04/23, at 9:04 a.m., maintenance assistant (MA) stated it was the kitchen's responsibility to complete all their cleaning, including the upper walls, ceilings, and vents. MA stated anyone could fill out a work order if they needed help from the maintenance department. MA did not have any work orders from the kitchen to assist with cleaning the upper walls, ceilings or the vents and had not received any work orders for those areas over the last few months.	21015		

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	29822	A. BUILDING: _____ B. WING _____	C 05/04/2023

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

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21015	Continued From page 17 During an observation on 5/04/23, at 10:53 a.m., DA-D entered the dish washing station, and removed his gloves. DA-D did not perform hand hygiene, placed his dirty gloves on top of a clean tray and put on a new pair of gloves. During an observation on 5/04/23, at 10:54 a.m., DA-D took plate covers and trays that were wet from the dishwashing stating and wiped them down with yellow towel before placing them on the drying rack. During an interview on 5/04/23, at 10:58 a.m., DA-D stated when the dishes come out of the dishwasher, they stay there to air dry, but he keeps towels on hand to wipe them down in case they don't dry all the way. DA-D stated air drying is best but sometimes they need to use the dishes before they have had time to dry. During an interview on 5/04/23, at 11:01 a.m., GM stated clean dishes should be air dried. GM stated it was okay for staff to use paper towels or the yellow towels to wipe the dishes dry if needed. During interview on 5/04/23, at 11:06 a.m., the administrator stated in her experience it was not standard practice to not allow the dishes to fully air dry and instead wipe them down with a towel, but she was unsure of the process for this facility and would need to look at the policy. A facility policy Dish machine not dated, identified to air-dry all items. A facility policy Personal Hygiene, not dated, identified that staff would wash hands frequently, and wear a hairnet to restrain all hair. A facility policy Cleaning and sanitizing, not dated,	21015		

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21015	Continued From page 18 identified that all food service departments would have an effective cleaning program that included a cleaning schedule. A facility policy Handwashing, not dated, identified handwashing was required immediately before starting work, before putting on single-use gloves and after removing single-use gloves, cleaning tables, or busing dirty dishes, after touching hair, face and body, touching clothing or aprons, after handling chemicals that might affect food safety, leaving or returning to the kitchen/prep area and after touching anything else that may contaminate hands (e.g., dirty equipment, work surfaces, phones or clothes). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the kitchen is maintained in a sanitary manner to prevent the potential for spread of foodborne illness. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and	21095		5/31/23

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21095	Continued From page 19 other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential spread of foodborne illness, ensure proper glove use and hand washing techniques were used during food preparation. Furthermore, the facility failed to ensure dishes were appropriately air dried, and failed to ensure food stored in the refrigerators, freezers and dry storage were labeled and dated. These failures had the potential to affect all residents who were served food and beverages from the kitchen. Findings include: During an observation on 5/01/23, at 11:44 a.m., chef manager (CM) was at the serving station prepping the dessert for lunch without a hairnet. During the initial tour of the kitchen on 5/01/23, at 11:47 a.m., the general manager (GM) noted the following: 1. the main dry storage shelves had unsealed bags of rice and noodles, not labeled, or dated.	21095	Corrected	

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21095	Continued From page 20 2. the main kitchen refrigerator had unsealed bags of squash, and mixed vegetables, not labeled or dated. The bottom of the fridge had brown residue with crumbs and food particles scattered throughout. 3. the main freezer had unsealed bags of brussel sprouts, waffles, and mini pizzas, not labeled or dated. 4. a black cart held clean dishes for meal service, had food crumbs noted in all the corners of the bottom shelf and several nickel sized dried, flaky brown residue marks on both shelves and on all four wheels. 5. the rehab 1 refrigerator had a brown sticky residue on all the shelves along with clumps of crumbs and food particles. The rehab 1 freezer has several Italian ice's stuck together with a sticky pink material. The floor of the freezer had several areas of brown residue and food particles. 6. the rehab 2 refrigerator had brown and yellow dried residue on all the shelves. The rehab 2 freezer had several Italian ice's stuck together with a sticky pink material built up on the shelf. A second shelf had a thick white substance dried to the bottom of it. 7. the prairie refrigerator had a pitcher of yellow liquid not labeled or dated. GM stated it was a pitcher of lemonade. All shelves had a yellow and brown sticky residue with food particles. The prairie freezer had a large ice pack stuck to an Italian ice. During the tour the GM stated all food items	21095		

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21095	Continued From page 21 should have a date of when it arrived, and another date of when it was opened. GM stated it was important to have all items dated because the shelf life is 5-7 days and if not dated, they would not know when to discard the item. GM also stated once an item is opened it should be placed in a zip lock bag or plastic container. GM stated she would expect all kitchen equipment including refrigerators and freezers to be cleaned on a regular basis. During an observation of the lunch meal service on 5/02/2023, the following observations were noted: -At 11:10 a.m., the wall above the three-compartment sink had visible gray matter, approximately 1 1/2 feet x 12 depth, and extended into where there are plastic containers stacked on two shelves above the sink. The ceiling vent in the clean dishwashing area had visible gray matter covering the entire vent and extended approximately 2 feet out from the vent. -At 11:31 a.m., the outside of the ice machine is covered with a white substance. -At 11:43 a.m., DA-A retrieved salad bowls from dish area and removed his gloves. DA-A did not perform hand hygiene, put on a new pair of gloves, and dished up sliced apples into the salad bowls. -At 11:56 a.m., CM put two slices of bread on the grill and then removed her gloves. CM did not perform hand hygiene and put on a new pair of gloves. -At 12:01 p.m., noted several thin white/yellow strands about 1/2 inch in length hanging from ceiling, directly above serving station. -At 12:01 p.m., CM put chili in food processor for mechanical soft diet, hand gloves were on. CM placed the chili in steam table and removed her gloves. CM did not perform hand hygiene, and	21095		

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21095	Continued From page 22 dished up the grilled cheese, and then CM put a new pair of gloves on. -At 12:12 p.m., housekeeper-A rubbed her face with her gloves on. Housekeeper-A did not remove gloves or perform hand hygiene and continued to set up beverages and desserts for meal trays. During an interview on 5/3/23, at 10:35 a.m., the CM stated hand hygiene would take place when you enter the kitchen and when you change jobs or went from one task to another task. CM stated hairnets would always be worn when in the kitchen and in the beverage/serving area. CM stated they do not have a cleaning schedule but try to do what they can for now because they are short staffed. CM stated all food should be labeled and dated when opened so staff know when it needs to be discarded. During an interview on 5/3/23, at 10:48 a.m., the GM stated hand hygiene would take place when you enter the kitchen, after using the bathroom, any time you touch your face, hair, or your eye, when going between tasks and in between changing gloves. GM stated hairnets are required when in the kitchen and anytime they are handling food. GM stated housekeeper-A was the only employee from another department who helped with meal trays and stated she has been trained on hand hygiene. During an interview on 5/3/23, at 11:00 a.m., the GM stated the white substance on the outside of the ice machine was lime build up and they had issues with the water softener. GM stated the gray matter noted on the walls, vents and ceiling were dust bunnies. GM stated the thin white and yellow strands hanging from the ceiling was dried spaghetti sauce that had been there for a few	21095		

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21095	Continued From page 23 months. GM stated it was of concern that the particles could fall onto the food being served directly below. GM stated they did not clean the ceiling and vents or anything they cannot reach. GM stated the maintenance department cleans those areas out of reach. GM stated she requested the maintenance department to clean these areas several times over the last three months, but it never got done. GM stated they do not have a cleaning schedule, instead she leaves the staff notes on what to clean. GM stated the cooler directly below the microwave should be closed when cleaned to prevent the sanitizer or particles in the microwave from falling into the food located in the cooler. GM stated, that was me that did that yesterday, I should have made sure the cooler was closed first. During interview on 5/04/23, at 9:04 a.m., maintenance assistant (MA) stated it was the kitchen's responsibility to complete all their cleaning, including the upper walls, ceilings, and vents. MA stated anyone could fill out a work order if they needed help from the maintenance department. MA did not have any work orders from the kitchen to assist with cleaning the upper walls, ceilings or the vents and had not received any work orders for those areas over the last few months. During an observation on 5/04/23, at 10:53 a.m., DA-D entered the dish washing station, and removed his gloves. DA-D did not perform hand hygiene, placed his dirty gloves on top of a clean tray and put on a new pair of gloves. During an observation on 5/04/23, at 10:54 a.m., DA-D took plate covers and trays that were wet from the dishwashing stating and wiped them down with yellow towel before placing them on	21095		

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21095	Continued From page 24 the drying rack. During an interview on 5/04/23, at 10:58 a.m., DA-D stated when the dishes come out of the dishwasher, they stay there to air dry, but he keeps towels on hand to wipe them down in case they don't dry all the way. DA-D stated air drying is best but sometimes they need to use the dishes before they have had time to dry. During an interview on 5/04/23, at 11:01 a.m., GM stated clean dishes should be air dried. GM stated it was okay for staff to use paper towels or the yellow towels to wipe the dishes dry if needed. During interview on 5/04/23, at 11:06 a.m., the administrator stated in her experience it was not standard practice to not allow the dishes to fully air dry and instead wipe them down with a towel, but she was unsure of the process for this facility and would need to look at the policy. A facility policy Dish machine not dated, identified to air-dry all items. A facility policy Personal Hygiene, not dated, identified that staff would wash hands frequently, and wear a hairnet to restrain all hair. A facility policy Cleaning and sanitizing, not dated, identified that all food service departments would have an effective cleaning program that included a cleaning schedule. A facility policy Handwashing, not dated, identified handwashing was required immediately before starting work, before putting on single-use gloves and after removing single-use gloves, cleaning tables, or busing dirty dishes, after touching hair, face and body, touching clothing or aprons, after	21095		

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21095	Continued From page 25 handling chemicals that might affect food safety, leaving or returning to the kitchen/prep area and after touching anything else that may contaminate hands (e.g., dirty equipment, work surfaces, phones or clothes). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure dishes are appropriately air dried, and food stored in the refrigerators, freezers and dry storage are labeled and dated. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential spread of foodborne illness, ensure proper glove use and hand washing techniques were used during food preparation. Furthermore,	21100	Corrected	5/31/23

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21100	Continued From page 26 the facility failed to ensure dishes were appropriately air dried, and failed to ensure food stored in the refrigerators, freezers and dry storage were labeled and dated. These failures had the potential to affect all residents who were served food and beverages from the kitchen. Findings include: During an observation on 5/01/23, at 11:44 a.m., chef manager (CM) was at the serving station prepping the dessert for lunch without a hairnet. During the initial tour of the kitchen on 5/01/23, at 11:47 a.m., the general manager (GM) noted the following: 1. the main dry storage shelves had unsealed bags of rice and noodles, not labeled, or dated. 2. the main kitchen refrigerator had unsealed bags of squash, and mixed vegetables, not labeled or dated. The bottom of the fridge had brown residue with crumbs and food particles scattered throughout. 3. the main freezer had unsealed bags of brussel sprouts, waffles, and mini pizzas, not labeled or dated. 4. a black cart held clean dishes for meal service, had food crumbs noted in all the corners of the bottom shelf and several nickel sized dried, flaky brown residue marks on both shelves and on all four wheels. 5. the rehab 1 refrigerator had a brown sticky residue on all the shelves along with clumps of crumbs and food particles. The rehab 1 freezer has several Italian ice's stuck together with a	21100		

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21100	Continued From page 27 sticky pink material. The floor of the freezer had several areas of brown residue and food particles. 6. the rehab 2 refrigerator had brown and yellow dried residue on all the shelves. The rehab 2 freezer had several Italian ice's stuck together with a sticky pink material built up on the shelf. A second shelf had a thick white substance dried to the bottom of it. 7. the prairie refrigerator had a pitcher of yellow liquid not labeled or dated. GM stated it was a pitcher of lemonade. All shelves had a yellow and brown sticky residue with food particles. The prairie freezer had a large ice pack stuck to an Italian ice. During the tour the GM stated all food items should have a date of when it arrived, and another date of when it was opened. GM stated it was important to have all items dated because the shelf life is 5-7 days and if not dated, they would not know when to discard the item. GM also stated once an item is opened it should be placed in a zip lock bag or plastic container. GM stated she would expect all kitchen equipment including refrigerators and freezers to be cleaned on a regular basis. During an observation of the lunch meal service on 5/02/2023, the following observations were noted: -At 11:10 a.m., the wall above the three-compartment sink had visible gray matter, approximately 1 1/2 feet x 12 depth, and extended into where there are plastic containers stacked on two shelves above the sink. The ceiling vent in the clean dishwashing area had visible gray matter covering the entire vent and	21100		

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21100	Continued From page 28 extended approximately 2 feet out from the vent. -At 11:31 a.m., the outside of the ice machine is covered with a white substance. -At 11:43 a.m., DA-A retrieved salad bowls from dish area and removed his gloves. DA-A did not perform hand hygiene, put on a new pair of gloves, and dished up sliced apples into the salad bowls. -At 11:56 a.m., CM put two slices of bread on the grill and then removed her gloves. CM did not perform hand hygiene and put on a new pair of gloves. -At 12:01 p.m., noted several thin white/yellow strands about 1/2 inch in length hanging from ceiling, directly above serving station. -At 12:01 p.m., CM put chili in food processor for mechanical soft diet, hand gloves were on. CM placed the chili in steam table and removed her gloves. CM did not perform hand hygiene, and dished up the grilled cheese, and then CM put a new pair of gloves on. -At 12:12 p.m., housekeeper-A rubbed her face with her gloves on. Housekeeper-A did not remove gloves or perform hand hygiene and continued to set up beverages and desserts for meal trays. During an interview on 5/3/23, at 10:35 a.m., the CM stated hand hygiene would take place when you enter the kitchen and when you change jobs or went from one task to another task. CM stated hairnets would always be worn when in the kitchen and in the beverage/serving area. CM stated they do not have a cleaning schedule but try to do what they can for now because they are short staffed. CM stated all food should be labeled and dated when opened so staff know when it needs to be discarded. During an interview on 5/3/23, at 10:48 a.m., the	21100		

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21100	Continued From page 29 GM stated hand hygiene would take place when you enter the kitchen, after using the bathroom, any time you touch your face, hair, or your eye, when going between tasks and in between changing gloves. GM stated hairnets are required when in the kitchen and anytime they are handling food. GM stated housekeeper-A was the only employee from another department who helped with meal trays and stated she has been trained on hand hygiene. During an interview on 5/3/23, at 11:00 a.m., the GM stated the white substance on the outside of the ice machine was lime build up and they had issues with the water softener. GM stated the gray matter noted on the walls, vents and ceiling were dust bunnies. GM stated the thin white and yellow strands hanging from the ceiling was dried spaghetti sauce that had been there for a few months. GM stated it was of concern that the particles could fall onto the food being served directly below. GM stated they did not clean the ceiling and vents or anything they cannot reach. GM stated the maintenance department cleans those areas out of reach. GM stated she requested the maintenance department to clean these areas several times over the last three months, but it never got done. GM stated they do not have a cleaning schedule, instead she leaves the staff notes on what to clean. GM stated the cooler directly below the microwave should be closed when cleaned to prevent the sanitizer or particles in the microwave from falling into the food located in the cooler. GM stated, that was me that did that yesterday, I should have made sure the cooler was closed first. During interview on 5/04/23, at 9:04 a.m., maintenance assistant (MA) stated it was the kitchen's responsibility to complete all their	21100		

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	29822	A. BUILDING: _____ B. WING _____	C 05/04/2023

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21100	Continued From page 30 cleaning, including the upper walls, ceilings, and vents. MA stated anyone could fill out a work order if they needed help from the maintenance department. MA did not have any work orders from the kitchen to assist with cleaning the upper walls, ceilings or the vents and had not received any work orders for those areas over the last few months. During an observation on 5/04/23, at 10:53 a.m., DA-D entered the dish washing station, and removed his gloves. DA-D did not perform hand hygiene, placed his dirty gloves on top of a clean tray and put on a new pair of gloves. During an observation on 5/04/23, at 10:54 a.m., DA-D took plate covers and trays that were wet from the dishwashing stating and wiped them down with yellow towel before placing them on the drying rack. During an interview on 5/04/23, at 10:58 a.m., DA-D stated when the dishes come out of the dishwasher, they stay there to air dry, but he keeps towels on hand to wipe them down in case they don't dry all the way. DA-D stated air drying is best but sometimes they need to use the dishes before they have had time to dry. During an interview on 5/04/23, at 11:01 a.m., GM stated clean dishes should be air dried. GM stated it was okay for staff to use paper towels or the yellow towels to wipe the dishes dry if needed. During interview on 5/04/23, at 11:06 a.m., the administrator stated in her experience it was not standard practice to not allow the dishes to fully air dry and instead wipe them down with a towel, but she was unsure of the process for this facility and would need to look at the policy.	21100		

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21100	Continued From page 31 A facility policy Dish machine not dated, identified to air-dry all items. A facility policy Personal Hygiene, not dated, identified that staff would wash hands frequently, and wear a hairnet to restrain all hair. A facility policy Cleaning and sanitizing, not dated, identified that all food service departments would have an effective cleaning program that included a cleaning schedule. A facility policy Handwashing, not dated, identified handwashing was required immediately before starting work, before putting on single-use gloves and after removing single-use gloves, cleaning tables, or busing dirty dishes, after touching hair, face and body, touching clothing or aprons, after handling chemicals that might affect food safety, leaving or returning to the kitchen/prep area and after touching anything else that may contaminate hands (e.g., dirty equipment, work surfaces, phones or clothes). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure dishes are appropriately air dried, and food is stored in the refrigerators, freezers and dry storage are labeled and dated. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was conducted in accordance with facility policy and the Centers for Disease Control (CDC) guidelines for 5 of 5 residents (R17, R23, R146, R203, R295) reviewed for TB screening on admission and 2 of 5 employees (HK-B and LPN-F) reviewed for TB screening on hire. Findings include: R17's electronic health record (EHR) reflected an	21426	Corrected	5/31/23

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21426	Continued From page 33 admission date of 2/6/23 and lacked documentation of TB symptom screening. R23's EHR reflected an admission date of 7/14/21 and lacked documentation of TB symptom screening. R146's EHR reflected an admission date of 4/28/23 and lacked documentation of TB symptom screening. R203's EHR reflected an admission date of 4/6/23 and lacked documentation of TB symptom screening. R295's EHR reflected an admission date of 4/17/23 and lacked documentation of TB symptom screening. Licensed Practical Nurse (LPN)-F was hired on 4/8/22 and did not receive TB symptom screening or two-step TST or single TB blood test on hire. LPN-F has been employed on a part-time bases since hire. Housekeeping employee (HK)-B was hired on 1/11/23 and did not receive TB symptom screening or two-step TST or single TB blood test on hire. HK-B has been employed on a full-time bases since hire. On 5/4/23 documentation for symptom screening for R17, R23, R146, R203, and R295 was requested from the Director of Nursing (DON) but was not received. On 5/4/23 documentation for symptom screening and TB testing for HK-B and LPN-F was requested from the DON but not received.	21426		

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21426	Continued From page 34 Facility document, Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH, last updated 2/21/23 indicated baseline TB screening of all health care personnel and was performed at the time of hire. Further, the form indicated baseline screening of residents was performed at the time of admission. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review tuberculosis policies and procedures to ensure screening and TST for employees and residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interviews and document review, the facility failed to repair a bathroom door and ceiling tiles were free of stains and debris for a safe, sanitary, functional comfortable environment for residents, staff and visitors. Findings include:	21665	Corrected	5/31/23

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21665	Continued From page 35 On 5/1/23 at 1:28 p.m., R4 and R15's bathroom door (barn sliding door on a track) was observed to have the back wheel completely off of the sliding track. The bathroom door was partially resting on the floor. On 5/1/23 at 7:35 p.m., the bathroom door was off track and in the closed position. The positioning of the door created a space between the wall and door where it was possible to see into the bathroom from the hallway. Nursing assistant (NA)-C stated the door will get fixed for a while, but then it breaks again. On 5/2/23 at 9:39 a.m., the door remained off track. On 5/2/23 at 11:15 am., R4 was in the bathroom, and could be seen sitting on the toilet through an approximate six-inch gap. On 5/2/23 at 2:42 p.m., NA-B confirmed the door was off track and stated the door does get stuck and then it comes off the track. R15's family member was in the bathroom with R15 and stated the janitor has to fix the door about once a week. NA-B grabbed the door and attempted to guide wheel back into the track, R-15's family member gave the door an extra lift and NA-B secured the wheel back in the track. On 5/3/23 at 8:37 a.m., the maintenance manager (MA) stated R4 and R15's bathroom door was an ongoing problem because sometimes staff pushed the door to far back causing it to go off the track. MA confirmed the door had been fixed several times in the past, but he had not been notified the door was off track on 5/1 or 5/2/23. MA confirmed the door does not	21665		

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21665	Continued From page 36 close all the way when off track. The door has a large gap because the door rests on the floor, this could be a dignity issue, but there is not a safety concern related to the door being off track. The door will need to be permanently fixed so it does not continue to slip out of the sliding track. On 5/4/23 at 8:18 a.m., the director of nursing (DON) stated she was not aware the bathroom door in R4 and R15's suite had been intermittently broken for periods of time and stated she would expect the door be permanently fixed. On 5/2/23 the fire marshal notified the survey team of ceiling tiles in the medication (med) room that were stained with a black substance. On 5/2/23 at 2:37 p.m., licensed practical nurse (LPN)-C opened the mediation room door and confirmed the ceiling tiles around a vent above the Omnicell (medication storage and dispensing unit) were damaged. LPN-C stated there was a condensation problem of some sort that had caused the same black mold on the ceiling before. Indicated the ceiling had currently been that way for at least a couple months. The administrator stepped into the room and stated service master was coming tomorrow to service the ceiling. The area of damage was observed to be around a vent. The ceiling tile closest to the door wall had a large area of moisture stain brown in color and a large surface area covered with a black dot pattern appearance. The second tile also had a smaller surface area of brown moisture stains and the black substance. On 5/3/23 at 8:29 a.m., the facility MA stated a couple months ago the facility had a vendor in to address the same area of the ceiling for the same	21665		

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21665	Continued From page 37 type of staining. At the time the facility did not test for mold, and indicated it was likely dirt from the vent. Stated when the tiles get condensation on them, they are changed, and the surrounding area gets cleaned. LPN-D opened the med room. MA entered and confirmed the ceiling had 2 tiles with what appeared to be stains from moisture along with areas of raised black spots on two of the ceiling tiles by the vent. MA explained moisture happens inside of the air duct and then gets blown out of the diffuser duct. In the winter the moisture is increased because the air conditioning has to run in the medication room, which creates a higher level of moisture in the vents. Stated the stains on the ceiling may be mostly dirt, but agreed it was possible it was mold, but could not confirm it was mold without a test. MA stated the maintenance department had not received notice that there was an issue with the med room ceiling tiles. On 5/4/23 at 8:18 a.m., LPN-C opened the med room and confirmed the soiled ceiling tiles were still in place. MMC invoice dated 10/12/22 for the medication room ceiling described work performed as: ceiling diffuser has black mold around it. Coil checked in air handler in med room, found the coil was dirty and nearly impossible to clean without dropping it. Plan to see if it's salvageable and if it is to clean it and put it back in, otherwise will need to be replaced. Air diffuser is listed under parts and materials on the service billing invoice. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure a safe, sanitary, functional	21665		

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21665	Continued From page 38 comfortable environment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time	21880		5/31/23

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21880	Continued From page 39 limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide dignified dining for 1 of 14 (R247) residents reviewed during dining. In addition, the facility failed to provide timely assistance to the bathroom to prevent incontinent episodes for 1 of 1 (R295) resident reviewed for dignity. Findings include: R247's medical diagnoses list dated 4/24/23, indicated R247 had diagnoses which included dementia, depression, gastro-esophageal reflux disease, anxiety, hypercholesterolemia (high cholesterol), and hypertension (high blood pressure). During an observation on 5/4/23, starting at 8:25 a.m., R248's breakfast meal was delivered to her.	21880	Corrected	

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21880	Continued From page 40 -at 8:38 a.m., the warming cart for meal trays was transported from the kitchen and left at the nurse's station. -at 8:43 a.m., R247 and R248 sat together with nursing assistant (NA)- A sitting between them. R247 had a cup of coffee and no breakfast meal. R248 was being assisted with eating her meal by NA-A. -at 8:44 a.m., NA-A indicated that R247's meal was in the warming cart at the nurse's station and someone would bring it to her soon. R247 then stated, "I'm hungry". NA-A told R247 her food would be coming soon. -at 8:57 a.m., NA-A asked another NA to go and check the meal cart for R247's meal. -at 8:58 a.m., R247's meal was delivered to her. During an interview on 5/04/23, at 9:00 a.m., R247 stated her breakfast was very good and that it was warm enough. During an interview on 5/4/23, at 10:02 a.m., the director of nursing (DON) was unsure of the procedure for serving residents in the dining room and if they would be served and assisted at the same time when sitting together. R295 R295's admission Minimum Data Set (MDS), dated 4/23/23, identified R295 had intact cognition, diagnoses of osteoarthritis of the knees, diabetes mellitus, and aftercare following joint replacement surgery. Further, the MDS indicated R295 needed assistance with transfers, toilet use, personal hygiene and was at risk for	21880		

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21880	Continued From page 41 skin breakdown. A care plan, dated 4/17/23, indicated R295 needed an assist of two for bathroom assistance, and an assist of one for ambulation. R295 was to be aided with perineal hygiene and incontinence products. A Bowel and Bladder Data Collection Summary report, dated 4/27/23, indicated R295 was always continent of bowel and bladder. During an interview, on 5/01/23 at 1:42 p.m., R295 stated she has had four incontinent episodes because of waiting too long for assistance to the bathroom. R295 explained she wasn't supposed to walk alone so she had to wait for staff to assist her. And further, R295 described that this was frustrating and upsetting to her as she was not normally incontinent. During an interview, on 5/02/23 at 11:38 a.m., R295 stated on one occasion when she couldn't make it to the bathroom, because it took too long, she was incontinent of urine while standing to transfer to the toilet. R295's gauntlet-style brace to the left ankle became wet with urine. R295 requested assistance from the nursing assistant (NA), whom she was unable to identify, to dry the brace but they indicated to her it would be alright. R295 further explained she had a wet sock and brace until the end of the day when she was assisted with evening care. R295 stated she was upset about this because she didn't want her brace to smell like urine. During an interview with the director of nursing (DON), on 5/04/2023 at 10:15 a.m., the DON stated she would expect about a 15 to 20-minute wait time for call lights. Explained it could be	21880		

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21880	Continued From page 42 longer if there were an emergent situation in the unit. The DON further stated it was important to ensure the resident had their needs met so they feel comfortable and taken care of. The DON would expect a continent resident would not have accidents waiting for care. Facility policy The Dining Experience, not dated, identified individuals at the same table would be served and assisted at the same time. Facility policy titled Resident's Bill of Rights and Dignity Policy, dated 10/24/22, indicated residents would be cared for in a manner that promotes maintenance or enhancement of his/her quality of life. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure provide a dignified experience. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

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	245626	A. BUILDING **01 - BUILDING 1** B. WING _____	**05/02/2023**

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
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 05/02/2023. At the time of this survey, ROCHESTER REHABILITATION 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 | 05/30/2023

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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	245626	A. BUILDING **01 - BUILDING 1** B. WING _____	**05/02/2023**

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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
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 REHABILITATION 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 system with smoke detection in corridors and	K 000		

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 _____	**05/02/2023**

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
K 000	Continued From page 2 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 55 beds and had a census of 48 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 observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life	K 353	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction	5/31/23

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	245626	A. BUILDING **01 - BUILDING 1** B. WING _____	**05/02/2023**

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

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K 353	Continued From page 3 Safety Code, sections 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections, 5.2.1.1.1, 5.2.1.1.2(5). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/02/2023 between 9:00 AM and 1:00 PM, it was revealed by observation that the sprinkler heads located in the Kitchen and Dishwashing Areas exhibited signs of debris loading. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on observation and staff interview the facility failed to maintain the sprinkler system. Affected Resident(s) The sprinkler heads located in the kitchen and dishwashing area were professionally cleaned on 5/19/23. Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: QAPI will meet annually to review and approve the EPP to maintain compliance. Monitoring: The cleaning schedule was put into the TELS system. The sprinkler heads will be cleaned every 3 months and the cleaning will be recorded in the TELS system. Director of Environmental Services or designee are responsible for compliance. 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. Completion Date: May 31, 2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		5/31/23

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	245626	A. BUILDING **01 - BUILDING 1** B. WING _____	**05/02/2023**

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

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K 918	Continued From page 4 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA	K 918	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction	

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K 918	Continued From page 5 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/02/2023 between 9:00 AM and 1:00 PM, it was revealed during documentation review that the most recent 36 month - 4-hour load bank test documentation was dated 09/05/2018. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on review of documents the facility failed to test the on-site emergency generator system with a 4-hour load bank test. Affected Resident(s) The facility conducted a 4-hour load bank test of the emergency generator system on 5/26/23 from 8:00-12:00pm Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: The facility will maintain compliance by completing a 4-hour load bank test for the emergency generator per the regulations. Monitoring: The emergency generator testing was put into the TELS system. This system will notify the facility when the next testing date occurs. Director of Environmental Services or designee are responsible for compliance. 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. Completion Date: May 31, 2023	
K 920 SS=E	Electrical Equipment - Power Cords and Extens	K 920		5/31/23

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K 920	Continued From page 6 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of flexible cords and cables as-well-as listed and labeled equipment in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a patterned impact on the residents within the facility.	K 920	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the	

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

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K 920	Continued From page 7 Findings include: 1. On 05/02/2023 between 9:00 AM and 1:00 PM, it was revealed by observation, that in the following locations appliances were connected to relocatable power taps: Lower Level - House Resident Storage Area; 1st Floor - D.O.N. Office; 1st Floor - Activities Office; and 1st Floor - Nurses Station Rehab #2. 2. On 05/02/2023 between 9:00 AM and 1:00 PM, it was revealed by observation, that in the 1st Floor - D.O.N. Office, relocatable power taps were found daisy-chained together. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	facility's allegation of compliance. Based on observation and staff review the facility failed to manage usage of flexible cords and cables. Affected Resident(s) The facility immediately removed all power strips found within the facility on 5/3/23. Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: Staff education on the proper use of power strips was completed and will be on going. Monitoring: Facility audits will regarding power strips will be conducted weekly for 4 weeks and monthly for 3 months. Director of Environmental Services or designee are responsible for compliance. 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. Completion Date: May 31, 2023	
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	K 926		5/31/23

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

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K 926	Continued From page 8 maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/02/2023 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that no evidence was presented for review to confirm that a medical gas training program is currently in use by the facility. An interview with Maintenance Director and Director of Nursing verified this deficient finding at the time of discovery.	K 926	Plan of Correction Components: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Based on documentation the facility failed to confirm that a medical gas training program is currently in use. Affected Resident(s) The facility does have a medical gas training program. Potential Affected Resident(s): All residents have the potential to be affected by this practice. Measures/Systematic Changes: Licensed staff were educated on the general handling of oxygen tanks. Licensed staff were educated on how to fill liquid oxygen into a portable tank. Education was completed and will be on going. Monitoring: Facility will conduct audits on all hired licensed staff to ensure proper training has been completed. DON or designee are responsible for compliance. Results of monitoring shall be reported at	

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K 926	Continued From page 9	K 926	the facility QAPI meeting with ongoing frequency and duration to be determined through analysis and review of results. Completion Date: May 31, 2023	