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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UYP5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29822

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 05/23/2018 (L19)

Date:
Michaelyn Bruer, Enforcement Specialist 05/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245626

May 23, 2018

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

Dear Ms. Otto:

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

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

Effective May 1, 2018 the above facility is certified for or recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 23, 2018

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

RE: Project Number S5626003

Dear Ms. Otto:

On May 1, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 11, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2018, effective May 1, 2018 and therefore remedies outlined in our letter to you dated May 1, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UYP5

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(L3) **ROCHESTER REHABILITATION AND LIVING CENTER**
(L4) **1900 BALLINGTON BOULEVARD NW**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE - NE II 05/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 05/11/2018 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/07/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2018

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

RE: Project Number S5626003

Dear Ms. Otto:

On March 22, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 1, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 22, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	03/22/2018

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on March 19, 20, 21 & 22, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 19, 20, 21 and 22, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		5/1/18

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

Electronically Signed | 05/10/2018

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 _____	03/22/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 1 of 1 resident (R14) reviewed for preference of waking times was granted. Findings include: R14's admission form included an admission on 2/16/17 also with diagnosis of Hypothyroidism, Congestive heart failure, altered mental status unspecified. R14's care plan indicated that usual rising time is 6-7 a.m. Breakfast served from 7:30 a.m. to 9:00 a.m. Physician orders summary report, showed an	F 561	Submission of this credible allegation of compliance by Rochester Rehabilitation and Living Center is not a legal admission that a deficiency exists or that the statement of deficiencies were cited correctly. It is not to be construed as an admission against interest of the facility, its administrator, employees, agents or other individuals who draft or may be documented in this credible allegation of compliance. The preparation and submission of this document does not constitute an admission of agreement with the alleged deficiencies or conclusions made by the survey agency. This credible allegation of compliance is submitted due to state and federal law requirements as a	

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 _____	03/22/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 order for Synthroid tablet 112 mcg, give 1 tablet by mouth in the morning for hypothyroidism. During an interview with R14, on 3/19/18, 5:25 p.m. stated, "They wake me up a lot of times at 5:20 a.m., they give me meds at that time. I thought we had talked about getting it at a different time." Progress noted that care conference was held on 2/21/18, R14, family member (FM)-A, and social worker. Indicated no concern of medication schedule, or waking times. During conservation with R14 on 3/22/18, at 8:45 a.m., R14 observed to be seated at breakfast table. R14 was asked what time they received their morning pill. R14 stated about 6:30, when asked how long it was that they been coming in at this time. "Oh, since I complained that I didn't like them coming in at 5:20; oh, the last four days." During phone interview on 3/21/18, at 12:38 p.m. Family member (FM)-A stated that she had attended care conference on 2/21/18 per phone. FM-A stated that nursing was not at the last care conference. Stated discussed R14's concern with being woke up at 5: 20 a.m., and sometimes earlier. The staff were going to look into the time of the medications. Also, stated I realize he needs the medication before he eats but I do not think that it needs to be that early, as he does not eat until 7:30 or later. FM-A also stated that staff at care conference was to let nursing know the concerns. In addition, have not heard anything at this time different since. Review of medications indicated that R14 receives Synthroid was scheduled for 6 a.m.	F 561	condition to participate in the Medicare and Medicaid programs. After Rochester Rehabilitation and Living Center became aware of R14□s early morning medication interfering with his sleeping and waking times, the medication administration time was changed to a later time. Follow up interview with resident was conducted; resident reported that the new time was working well for him with no requests for additional changes to his time of medications. Rochester Rehabilitation and Living Center also conducted interviews on all residents with early morning medications to determine if administration times were acceptable or interfering with their sleeping and waking times. The findings concluded that all residents interviewed stated that their current administration schedules are working well for them. Rochester Rehabilitation and Living Center will continue with care rounds for short term residents and care conferences for long term care residents and will address any concerns with medication administration times. During these conferences if residents request changes on administration times of medications, these requests will be addressed by nursing and the provider. Changes in administration times will be implemented as indicated if reasonable to do so per the resident□s request. Rochester Rehabilitation and Living Center provided training for all staff education on residents□ rights, and will continue to provide training on resident	

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F 561	Continued From page 3 Review of documented times for Synthroid showed that R14 received this medication on 3/11/2018, at 5:01 a. m.; 3/17/18 at 5:17 a. m.; and on 3/18/18 at 5:10 a. m. Requested documentation times from 2/21/18, to present, only received administration documentation for the past two weeks (3/8/18 to 3/22/18). During interview on 3/22/18, at 11:13 a.m. with licensed practical nurse (LPN)-A stated, Synthroid is scheduled at 6 a.m., due to it needing to be given on an empty stomach and then having to wait an hour before eating. Breakfast starts serving at 7:30 a.m., and runs until 9 a.m. On asking LPN-A if someone did not want to be woke up for his or her medications at 6:00 a.m. how would you fix this concern? LPN-A said, "I would coordinate with the kitchen so that we can make should resident wishes are accommodated and would not receive breakfast until after the correct time frame." During interview on 3/22/18, at 11:45 a.m., with director of nursing (DON) stated, that even though nursing was not at a care conference when a concern was brought up regarding medication times for R14. DON said, "Should be followed up on, and time changed if reasonable to do so per resident wishes." The resident Bill of Rights states: The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: The right to choose sleeping and waking times.	F 561	rights upon hire and annually to all staff. Rochester Rehabilitation and Living Center will conduct weekly audits for 3 months in relation to new orders that have early medication administration times. Rochester Rehabilitation and Living Center will interview those residents regarding satisfaction with administration time. Self-determination will be reviewed quarterly in QAPI. DON and/or designee will be responsible for compliance.	
F 565	Resident/Family Group and Response	F 565		5/1/18

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F 565 SS=E	Continued From page 4 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 565	Rochester Rehabilitation and Living	

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F 565	Continued From page 5 facility failed to take prompt action to resolve grievances identified during resident council meeting for 9 of 9 residents (R48, R30, R49, R20, R37, R8, R5, R14, R35) with concerns of no response or rationale to grievances made by residents or family members. Findings include: On 3/21/18 at 10:05 a.m. a resident council meeting was held and the following residents attended the meeting R48, R30, R49, R20, R37, R8, R5, R14, R35. During the meeting, the following concerns were voiced: R48 said, "When I fill them [in reference to a grievances form] out, they [staff] do not get back to me. I cannot fill out forms myself, husband sometimes completes. We should have an in-service on how to fill out a grievance, so we know how and know who to go to." R48 said she is frustrated when her needs are not being met, she try's not too, but "I get frustrated," she said. R37 said after R48 finished speaking that she would like to know as well (in regards to completing a grievance form and who to contact). R48 said, "It would be nice to have a meeting like this [referring to current meeting] so we know who to complain to and how." R48 also said that some of the resident cannot communicate well "you have to look out for your neighbor." During an interview on 3/22/18, at 11:55 a.m. R48's family member (FM)-D was in resident's room. FM-D stated, "They [staff] do not take care of things, I have found [R48] wet in bed,	F 565	Center provided in-service at Resident Council meeting to residents on the grievance process on April 30, 2018. R48 was individually in-serviced on the grievance process, and was provided a supply of grievance forms. Rochester Rehabilitation and Living Center provided training for all staff education on residents rights, and will continue to provide training on resident rights upon hire and annually to all staff. All management staff were provided training on the grievance policy and procedure on April 4, 2018. Rochester Rehabilitation and Living Center will continue to conduct Care rounds for short term and care conferences for long term care residents to discuss any concerns that residents and families may have. Any concerns brought up will be addressed by the responsible department. Rochester Rehabilitation and Living Center s licensed social worker is the grievance official. The Grievance Official will route grievance forms to the appropriate department for follow up; in addition, track the grievances on the grievance log. Rochester Rehabilitation and Living Center s Executive Director will review the grievances for completion and follow up provided to resident and/or family before signing off on the form. The interdisciplinary team will do weekly reviews on any grievances for completion and follow up with residents and/or families on an ongoing basis. Grievances will be reviewed quarterly in QAPI	

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F 565	Continued From page 6 continues to happen even after we write grievances." FM-D said it happened again today and informed licensed practical nurse (LPN)-C who was working today. At the end of the interview FM-D asked surveyor if he could show writer the copies of the grievances to the surveyor and he provided the following complaints from 3/2017 to 1/2018: 3/9/17, the call light not in reach 3/23/17, call light not answered/staffing 5/16/17, room temperature 6/17/17, staffing 8/25/17, pain medications not given 9/8/17, pain 12/4/17, call light not in reach was stuck in side of bed 12/4/17, wet 12/19/17, staffing/wet 1/3/18, oxygen concentrator soiled. FM-A was questioned concerning these grievances provided and FM-A said the only grievance he was aware of resolved by facility was the soiled concentrator (dated 1/3/18 grievance) because the concentrator was clean. On 3/22/18, at 2:05 p.m. during an interview with the administrator regarding grievances. The administrator was asked for the facility's grievance forms for the last twelve months. Administrator said department managers do their own grievances and then turned into her. The administrator provided only two grievances for past twelve months and neither of the two were for 2018. The administrator said the grievances are tracked monthly. On reviewing the grievances concerning R48's cares which were submitted to the facility by FM-A. Administrator said, "I am not sure I have seen these." After looking for the	F 565	Social Worker/Executive Director and/or designee will be responsible for compliance.	

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F 565	Continued From page 7	F 565		

grievances from FM-A the administrator said there were none found.

On 3/22/18, at 2:43 p.m. LPN-C said she thought the grievance forms go to the nurse managers and assumed at stand up the next day. At 3:01 p.m. asked LPN-C if there were any recent concern voiced from R48, LPN-C stated, "Yes, today [R48] wants medication changed." LPN-C said R48 gets mad at us when we do not make her get up. We tell her we cannot make her get up. LPN-C said R48 is frustrated. Surveyor asked LPN-C if she felt R48 was frustrated because her concerns are not being addressed. LPN-C stated, "Probably."

On 3/22/18, at 3:28 p.m. LPN-C said R48 literally fills out so many grievance forms that they supply her with 15-20 forms at a times. LPN-C said has seen them laying in room and not sure where they go when completed and sometimes in room laying around un-finished.

Review of facility policy titled "Grievance/Concern" revised 11/16 reads:
-Grievances will be routed and tracked by the grievance officer. The grievance officer in the long-term care is the social service director.
- Grievances will be responded to within 72-hours for non-emergency concerns. The facility will notify the complainant to provide updates on resolution for complaint. Additionally, complainants have the right to a written decision regarding the grievances.
-the complainant will be informed of the final outcome and resolution.
-A file for grievances will be maintained by the grievance official.

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F 578	Continued From page 8	F 578		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578		5/1/18

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F 578	Continued From page 9 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 4 of 9 residents (R36, R38, R56, R10) had clear Health Care Directives that reflected the resident's wishes. Findings include: R36's Admission Record, printed 3/21/18, indicated R36 was admitted to the facility on 1/8/18, with diagnoses included: atrial fibrillation, hypertension, and major depressive disorder. Code status revealed do not resuscitate/do not intubate (DNR/DNI). R36's Provider Orders for Life Sustaining Treatment (POLST) form dated 1/8/18, indicated cardiopulmonary resuscitation (CPR). POLST order is signed by R36 and registered nurse (RN)-A. Document does not have a physician signature. The following parts of the form were left blank: Part B is goals of treatment: comfort care, limit interventions and treat reversible conditions, provide life sustaining treatment. Part C is interventions and treatment: antibiotics and nutrition/hydration. Part D is summary of goals indicating who the treatment was discussed with and the basis for these orders. This second POLST was completed by R36's Power of Attorney and was available with the resident signed POLST: Provider Orders for Life Sustaining Treatment (POLST) form dated 1/8/18, indicated DNR/DNI.	F 578	Rochester Rehabilitation and Living Center ensures that residents have clear and concise directives for Code Status on record. Upon notification of findings during the survey process, Rochester Rehabilitation and Living Center obtained a current POLST form (Minnesota Provider Orders for Life-Sustaining Treatment (POLST) Revised: August 2017). Nurse Managers completed updated POLST forms with the current residents in the facility. A complete audit was performed on all residents records to ensure a POLST form was signed by a physician and the code status was entered in point click care. Care plans were reviewed for accuracy with corrections made as indicated. Rochester Rehabilitation and Living Center s Policy for Code Status were reviewed with management and the Medical Director. The Medical Director will bring forward to her medical team the importance of ensuring the providers sign the POLST forms in section D. MDS nurse will audit POLST forms, code status, and care plans for code status consistency with the MDS schedule on all residents. Code status will be addressed in QAPI	

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F 578	Continued From page 10 POLST order is signed by R38 and registered nurse (RN)-A. Document does not have a physician signature. Part B of the form was left blank and did not identify goals of treatment: comfort care, limit interventions and treat reversible conditions, provide life sustaining treatment. Part C for nutrition/hydration indicated to offer food and liquids by mouth. To give antibiotics was left blank. Part D indicated summary of goals was discussed with health care agent and the basis for these orders is patient's known preference, best interest and health care directive/living will. Power of attorney (POA) signed and dated this on 2/24/18. The form is missing a physician signature. R36's Advance Directive For Healthcare dated 6/2/14, indicated, "This advanced directive becomes effective upon my incapacity and remains effective so long as I am incapacitated." Further indicated to, "withhold artificial nourishment," and "donate all organs/tissues." R36's electronic medical record was reviewed on 3/20/18 at 9:54 a.m., and indicated his code status was DNR/DNI. R36's care plan dated, 1/8/18 indicated a focus of, "Resident has Advance Directives." Interventions, "Resident has decided to remain a Full Code." R36's medication administration record (MAR) indicated advanced directive was DNR/DNI. R36's Order Summary Report dated, 2/24/18 revealed R36 to be DNR/DNI. R36's Primary Care Internal Med Nursing Home	F 578	MDS Nurse/social worker and/or designee will be responsible for compliance.	

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F 578	Continued From page 11	F 578		

document dated 2/28/18, indicated R36's code status, "Patient is listed a DNR/DNI here at the facility, POLST on file form 2016 confirms. His Mayo chart says full code, I was unable to contact his POA today to clarify but I presume DNR/DNI based on present records at facility."

During an interview on 3/20/18, at 2:40 p.m., RN-A stated he was told when filling out a POLST form on admission to only fill out part A, if they are CPR or DNR/DNI, then a physician should be reviewing them within the first 72 hours to go over it with the resident and sign it. "Honestly we do not know 100% if the doctors are reviewing them, the doctor is supposed to go through for parts B and C and sign." Further stated DNR does not mean do not treat, it means do not resuscitate.

During an interview on 3/21/18, at 7:48 a.m., director of nursing (DON) stated upon admission the providers only want the POLST orders for the long term care residents not the short term ones. The short term residents POLST orders are reviewed by the doctors when they become long term and the POLST would need to be signed by a doctor for it to be in effect. DON further stated R36 was a full code when he was first admitted on 1/8/18, but that his POA changed it on 2/24/18 to DNR/DNI. DON verified R36 POLST order was not signed by a physician and he has not been deemed incapacitated and that R36 therefore is able to make his own wishes. DON stated, "I expect the POLST orders to be signed for every resident."

R38's Admission Record, printed 3/21/18, indicated R38 was admitted to the facility on

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F 578	Continued From page 12	F 578		

2/20/18, with diagnoses of orthopedic aftercare and seizures. Code status revealed cardiopulmonary resuscitation (CPR).

R38's Provider Orders for Life Sustaining Treatment (POLST) form dated 2/20/18, indicated cardiopulmonary resuscitation (CPR). POLST order is signed by R38 and admission coordinator (AC)-A. Document does not have a physician signature. The following parts of the form were left blank: Part B is goals of treatment: comfort care, limit interventions and treat reversible conditions, provide life sustaining treatment. Part C is interventions and treatment: antibiotics and nutrition/hydration. Part D is summary of goals indicating who the treatment was discussed with and the basis for these orders.

R38's electronic medical record was reviewed on 3/20/18, at 9:28 a.m., and indicated his code status was full code CPR.

R38's care plan dated, 2/20/18, indicated a focus of, "Resident has Advance Directives." Interventions, "Resident has decided to remain a Full Code."

R38's medication administration record (MAR) indicated advanced directive was full code CPR.

R38's Order Summary Report dated, 2/24/18 revealed R38 to be full code CPR.

During an interview on 3/21/18, at 7:48 a.m., director of nursing (DON) stated upon admission the providers only want the POLST orders for the long term care residents not the short term ones. The short term residents POLST orders are reviewed by the doctors when they become long

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term. DON stated the POLST form would need to be signed by a doctor for it to be in effect and verified R38 was a full code when he was first admitted on 2/20/18, and his POLST order is not signed by a physician. DON stated, "I expect the POLST orders to be signed for every resident." R56's Admission Record, printed 3/21/18, indicated R36 was admitted to the facility on 3/7/18, with diagnoses included: End stage renal disease, hypertension, spinal stenosis to lumbar region, and major depressive disorder. Code status revealed full code/cardiopulmonary resuscitation (CPR).

R56's care plan identifies focus: R56 has advance directives, with goal of R56's advance directives will be honored. However, no intervention are identified on the care plan.

R56's Provider Orders for Life Sustaining Treatment (POLST) form dated 3/7/18, indicated cardiopulmonary resuscitation (CPR). POLST order is signed by R56 in section E and licensed practical nurse (LPN)-A in section D. Document does not have a physician signature. The following parts of the form were left blank: Part B is goals of treatment: comfort care, limit interventions and treat reversible conditions, provide life-sustaining treatment. Part C is interventions and treatment: antibiotics and nutrition/hydration. Part D is summary of goals indicating who the treatment was discussed with and the basis for these orders. However, section D is signed by health care professional preparing form.

R10's Admission Record, printed 3/22/18, indicated R36 was admitted to the facility on 1/25/18, with diagnoses included: chronic

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	245626	A. BUILDING _____ B. WING _____	03/22/2018

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F 578	Continued From page 14	F 578		

obstructive pulmonary disease, UTI, Atrial fibrillation, hypertension, and major depressive disorder. Code status revealed do not resuscitate/do not intubate (DNR/DNI).

R10's Provider Orders for Life Sustaining Treatment (POLST) form dated 1/25/18, indicated. Code status revealed do not resuscitate/do not intubate (DNR/DNI). POLST order is signed by R10 and registered nurse (RN)-A. Document does not have a physician signature. The following parts of the form were left blank: Part B is goals of treatment: comfort care, limit interventions and treat reversible conditions, provide life-sustaining treatment. Part C is interventions and treatment: antibiotics and nutrition/hydration. Part D is summary of goals indicating who the treatment was discussed with and the basis for these orders. However, section D is signed by health care professional preparing form.

On 3/21/18, at 2:07 p.m. RN-A, stated, that R10's POLST is not signed by the physician, though we are currently working on fixing them, we were told by one of the nurse practitioners that short-term care resident POLST do not need to be signed by physician.

Undated facility POLST order indicated, "Any section of the POLST order not completed implies most aggressive treatment of that section. A new POLST should be completed when the patient's treatment preferences change. The POLST must be signed by a physician."

Facility policy, Determination of Code Status, dated 5/2012, indicated code status provides a means in which the resident plan of care can be

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F 578	Continued From page 15 communicated to comply with the resident's wishes. POLST form is to support the quality of life in last phases of life, and translates an advanced directive into provider orders. Facility policy, Advanced Directive/Health Care Directive dated, June 2012, revised August, 2013, indicated advanced directives are instructions given for future medical care should you become unable to communicate. Health Care Power of Attorney allows you to name someone to carry out your health care wishes. Health Care decision making policy refers to possessing the ability (as defined by state law) to make decisions regarding health care and related treatment choices."	F 578		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		5/1/18

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F 657	Continued From page 16 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the plan of care related to fall prevention for 1 of 1 resident (R18) reviewed. Findings include: R18's admission record included an admission date of 5/17/16. The admission record also included the diagnoses of Alzheimer's disease, dementia with behaviors, heart failure, kidney disease, a history of falling and depression. R18's fall risk assessment dated 1/29/18, indicated R18 a high risk for falls According to the interdisciplinary team's (IDT) post fall report, R18 fell out of bed on 7/17/17, at 11:00 p.m. The IDT's root cause analysis revealed resident rolled too far to the right side of the bed (which is the side she normally gets up on). To further prevent this resident should be positioned slightly closer to the left side of the bed which is the side her walker is not positioned on and she doesn't normally arise on this side. During a review of the nursing assistant (NA) bedside kardex report, a care plan, dated 3/21/18, no intervention related to bed positioning was located.	F 657	After Rochester Rehabilitation and Living Center became aware of the intervention implemented on the resident affected (R18) was not being pulled to the nursing assistant kardex report, the care plan was then reviewed by the DON. The falls care plan for R18 was updated so that the intervention was triggered and pulled to the kardex regarding bed positioning. A review of care plans for residents with falls was reviewed by the DON with corrections made as indicated to have interventions be pulled to the nursing assistant kardex report. The DON was provided instruction on how to trigger nursing interventions to be pulled to the kardex report for nursing assistants. Interdisciplinary team (IDT) meets weekly to review any falls from the previous week to review interventions implemented. An audit to ensure that new interventions will be conducted weekly during the IDT meetings. Falls will be reviewed quarterly in QAPI. Director of Nursing or designee will be responsible for compliance.	

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F 657	Continued From page 17 During an interview with the director of nursing (DON) on 3/21/18 at 1:15 p.m., the DON verified that the interventions were not on the NA bedside kardex report. The DON stated the software program was new to her and she thought the information would pull to the NA kardex report. A facility policy "Fall Prevention Protocol," dated 2006 indicated that the care plan would be revised as appropriate after each fall.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide bathing preferences for 1 of 3 residents (R38) reviewed for choices. Findings include: R38's, Admission Record, dated 3/21/18, identified an admit date of 2/20/18, and diagnoses of orthopedic aftercare and seizures. R38's admission, Minimum Data Set (MDS) assessment dated 2/27/18, revealed R38 needed	F 684	Rochester Rehabilitation and Living Center ensures bathing preferences are obtained and scheduled accordingly. Rochester Rehabilitation and Living Center□s Admission Coordinator tracks all new admissions for bathing preferences entered into the medical record. The Admissions Coordinator uses the preferences to create the bathing schedules according to resident preferences. The nursing assistants document bathing completion on bath sheets, as well as in the medical record.	5/1/18

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F 684	Continued From page 18 1 person extensive assist with bathing, impairment on one side of lower extremity, and bathing did not occur. R38's fourteen day, MDS dated 3/6/18, revealed R38 needed 1 person extensive assist with bathing, impairment on one side of lower extremity, and bathing did not occur. R38's care area assessment (CAA) dated 2/27/18, revealed R38 was hospitalized resulting in right lower extremity quadriceps tendon rupture with surgical repair on 2/15/18, and wears a cast on his right lower extremity. R38's untitled document, printed 3/21/18, revealed R38 needed 1 assist with shower chair and "I take a bath 3 times per week." R38's care plan dated 2/20/18, identified the focus: "Wears cast right lower extremity (RLE) with surgical incision under cast." Intervention: "showering: assist of 1 with shower chair, I take a bath 3 times a week." R38's occupational therapy (OT) document, dated 2/27/18, identified R38 received a shower assessment and identified, increased time required to cover lower extremity in plastic. Facility document, Daily Bath Sheets, dated from 2/25/18, to 3/18/18, identified R38 received a shower on 3/16/18. During observation and interview on 3/19/18, at 7:02 p.m., R38 is sitting in his wheelchair in his room wearing a white t-shirt with a blanket on his lap, with his right leg extended in a wheel chair leg extender, wearing a green cast from upper	F 684	Rochester Rehabilitation and Living Center has created a new position for a full time bath aide scheduled seven (7) days per week to focus on completing bathing tasks. Rochester Rehabilitation and Living Center provided training for all staff education on residents rights, and will continue to provide training on resident rights upon hire and annually to all staff. Rochester Rehabilitation and Living Center will conduct weekly audits by reviewing documentation of bathing per bath schedules. Any discrepancies will be addressed with the responsible staff. QAPI will review and analyze compliance and trends with bathing to determine need for changes. Admissions Coordinator/DON and/or designee will be responsible for compliance.	

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F 684	Continued From page 19 thigh area to the ankle. R38 stated he takes a shower every day at home. "I would definitely like a shower at least 2-3 times a week!" R38 verified he does not get a shower according to his preference here and needed help with a shower because of the cast on his leg. During interview on 3/21/18, at 8:38 a.m., admission's coordinator (AC)-A stated the care plan is updated for resident preference for what days they would like their shower upon admission. Verified R38 is scheduled to have a shower on Sunday, Tuesday, and Friday during the morning, and that per documentation he has not been getting his scheduled showers. Further verified his only documentation of a shower was on Friday, 3/16/18, since his admission on 2/20/18. During interview on 3/21/18, at 11:25 a.m., director of nursing (DON) verified R38 only showers since his admission on 2/20/18, was the following: a shower assessment from OT on 2/27/18, and one documented shower on 3/16/18. DON stated, "My expectation regarding resident preference with bathing is we should really try to uphold the resident wishes." A bathing preference policy was requested and not received.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		5/1/18

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F 698	Continued From page 20 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent monitoring of dialysis access sites for 1 of 1 resident (R56) reviewed for dialysis. Findings include: R56 was admitted on 3/7/18, diagnoses included end stage renal disease and dependence on renal dialysis per the admission record. R56's baseline care plan dated with admission date of 3/7/18, indicated a problem area for activities of daily living (ADLs): R56's has end-stage renal disease (ESRD) and receives hemodialysis 3 times weekly. The care plan lacked identification of and interventions for monitoring of R56's intravenous catheter and peritoneal catheter currently not in use. In addition, lacked emergency procedures for both sites if bleeding were to occur. R56's Kardex (care card for nursing assistant to know how to care for resident) does not indicate that resident has two catheters, for dialysis, or any interventions regarding dialysis. R56's Physician Orders signed 3/14/18, did not address monitoring of R56's intravenous in right chest or peritoneal (abdomen) catheter sites. R56's March 2018 medication administration record and treatment administration record did not include staff monitoring of the intravenous catheter or peritoneal access sites. R56's record review revealed there was only	F 698	After Rochester Rehabilitation and Living Center became aware of lack of identification of an interventions for monitoring of R56□s intravenous catheter and his peritoneal dialysis catheter that was currently not in use, the care plan was then reviewed by the DON. The care plan for resident R56 was updated to include an area of focus to address end stage renal disease with requiring dialysis. Goals and nursing interventions implemented to include but not limited to: observing for signs and symptoms of infection, shunt and peritoneal site locations, emergency protocol, diet, bleeding, life threatening emergencies, and directives for emergencies. Standing orders were also initiated to monitor both sites for complications and directives for potential complications. Nurse Managers and HUCs were provided re-education and instruction on initiation of dialysis focused care plan and standing orders for dialysis residents on admission when the lack of monitoring and care plans was pointed out to facility. Interdisciplinary team (IDT) team reviews residents on a daily basis (Monday through Friday). An audit is performed to ensure care plan and nursing interventions are in place to ensure consistent monitoring of dialysis access sites and potential complications with new admissions receiving dialysis.	

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F 698	Continued From page 21 minimal documentation regarding in progress notes or assessments of monitoring R56's catheter sites every shift. Nursing Day 1 admission readmission dated 3/7/18, on page 10 of 19, Urinary / Hepatic system 9. indicates ESRD. 9n. ESRD care plan, no goals or intervention are checked. In addition, on page 13 of 19 under body audit/integumentary system indicates skin warm, dry, IV (intravenous)hemoport chest, and peritoneal port. Nursing Day 2 post admission/readmission dated 3/8/18, shift/skilled services and education completed, dialysis pre and post cares and assessment. Nursing daily charting dated 3/8/18, 3/18/18, and 3/20/18 , shows documentation of nursing assessment including, vitals signs, and dialysis monitoring. Bath Skin Check dated 3/11/17, indicates right iliac crest (front) port for peritoneal dialysis and right shoulder (front) tunneled IJ access, must be covered for showers, no immersion. On 3/21/18, at 8:24 a.m., R56 stated, currently going to DaVita, for dialysis and has intravenous assess site in right chest. In addition still has peritoneal catheter site in abdomen, currently not utilized. R56 said, "They check my site every day." On 3/21/18, at 8:46 a.m. nursing assistant (NA)-C stated R56 gone to dialysis when I come in the morning as R56 leaves around 5:30 a.m., in the morning to go to dialysis. On 3/21/18, at 9:59 a.m. LPN-A stated that R56 has two sites, hemodialysis and peritoneal, and that she had not assess them but the nurses should be assessing them. They are assessed on Tuesday, Thursday, and Saturday at DaVita,	F 698	Education provided to all licensed staff regarding monitoring dialysis shunt sites and observing for potential complications. HUCs were provided training for initiating standing orders to ensure consistent monitoring of dialysis access sites and potential complications to residents e-MAR/e-TAR. Dialysis residents will be addressed quarterly in QAPI. Director of Nursing or designee will be responsible for compliance.	

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F 698	Continued From page 22	F 698		

and they send us a report back.

On 3/21/18, at 10:05 a.m., director of nursing (DON) stated that there should be an order to monitor both sites for bleeding, bruit and trill, sign of infection. Order should be on the medication administration record (MAR) / treatment administration record (TAR) or in the nursing notes that they are monitoring. The DON verified through record review no documenting for monitoring of the dialysis site. Also verified that care plan does not address that resident has a catheter access site in right chest and there is no interventions regarding dialysis or monitoring of either dialysis access. DON stated, "My expectation would be that the nurse would be monitoring the sites for bruit and trill, monitoring for bleeding and sign of infection. We have standing orders that we can use for this." DON stated, she expected staff to chart on R56's dialysis sites and to chart post dialysis assessments.

Dialysis (Program guidelines) policy and procedure, volunteers of America 2006, included: under section D. Comprehensive Care Plan. The facility must develop a comprehensive care plan:
1) the care plan should address the following: *identify potential risks and complications of dialysis, * measurable goals for potential risks and complications monitor for complications, * frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure etc ..., * monitoring of shunt or access site for signs of infection, * alteration of fluid volume, * potential for bleeding, * care of the access site,* potential for infection, * alteration in nutrition, * alteration in skin integrity, * medication with appropriate

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F 698	Continued From page 23 scheduling as they relate to dialysis, *compatible goals and interventions between the skill nursing facility (SNF) and dialysis providers. Section E Nursing Management. 4) Possible dialysis complications: A) The most common complication is hypotension. Monitor Blood pressure (BP), B) Other possible complications include: Nausea, vomiting, fever, chest pain, congestive heart failure, pulmonary edema, electrolyte imbalances, drug toxicity, air embolism, seizures, yawning, anaphylaxis, disequilibrium, dialyzer reaction.	F 698		

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	245626	A. BUILDING **01 - BUILDING 1** B. WING _____	**03/20/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on March 20, 2018. At the time of this survey, (Rochesster Rehab & Living) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Facility is a 1 story building with a partial basement. The facility was constructed in 2015 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 56 certified beds. The requirement at 42 CFR, Subpart 483.70 (b), is MET.	K 000		

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

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