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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VCL4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER EAST HEALTH SERVICES**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**

6. DATE OF SURVEY **05/21/2018** (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)
12/31

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

12.Total Facility Beds **116** (L18)
13.Total Certified Beds **116** (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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 06/05/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245184
August 28, 2018

Mr. Stephen Jobe, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Dear Mr. Jobe:

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 9, 2018 the above facility is certified for:

116 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 116 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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

Electronically delivered

June 18, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Numbers S5450028, H5250034, H5450029, H5450036

Dear Ms. Pierzina:

On May 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 19, 2018. The standard 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 23, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 28, 2018. (42 CFR 488.422)

Also, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 19, 2018. (42 CFR 488.417 (b))

In addition, we notified you in our letter of May 23, 2018, 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 July 19, 2018.

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on May 9, 2018. The most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 24, 2018, a partial extended survey was completed to verify that your facility had achieved and maintained compliance with federal certification deficiencies.

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

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We verified, on May 24, 2018, that the conditions resulting in our notification of immediate jeopardy

have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction from the abbreviated standard survey completed on May 9, 2018 should be directed to:

Matthew Heffron, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: matthew.heffronheffron@state.mn.us
Phone: (651) 201-4221

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 28, 2018, will remain in effect. (42 CFR 488.422)

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 19, 2018, will remain in effect. (42 CFR 488.417 (b))

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject a denial of payment. Therefore, Three Links Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 19, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendation and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Three Links Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 29, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human
Services Departmental Appeals Board,
MS 6132

Civil Remedies Division
Attention: Karen R. Robinson,
Director 330 Independence
Avenue, SW Cohen Building, Room
G-644 Washington, DC 20201

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public

Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

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 July 19, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

June 18, 2018

Mr. Stephen Jobe, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Numbers S5184030, H5184097

Dear Mr. Jobe:

On May 25, 2018, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That notice, imposed a daily fine in the amount of $950.00.

A reinspection was held on May 21, 2018 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is $950.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $1216.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $266.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VCL4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER EAST HEALTH SERVICES**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**

6. DATE OF SURVEY **05/01/2018** (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)
12/31

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

12.Total Facility Beds **116** (L18)
13.Total Certified Beds **116** (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
	116			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 06/05/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/24/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2018
(L33)

DETERMINATION APPROVAL

Electronically delivered

May 17, 2018

Mr. Stephen Jobe, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Numbers S5184030, H5184096, H5184097

Dear Mr. Jobe:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On April 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaint for the Abbreviated survey completed on February 5, 2018 and the standard survey completed on March 2, 2018 by the Minnesota Department of Health. The most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of the survey findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

Also, this Department recommended the enforcement remedies listed below to the CMS Region V Office. CMS Region V Office concurred, so the following remedies have been authorized to be imposed:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 5, 2018, would remain in effect. (42 CFR 488.417 (b))

- Civil money penalty for the deficiencies cited at F688, F689, be imposed. (42 CFR 488.430 through 488.444)

On May 1, 2018 the Minnesota Department of Health, and May 2, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed Post Certification Revisits. Also, on April 6, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of

correction, that your facility had corrected these deficiencies as of April 30, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to the standard surveys completed on March 2, 2018. The deficiencies not corrected are as follows:

F0554 -- S/S: D -- 483.10(c)(7) -- Resident Self-Admin Meds-Clinically Approp
F0656 -- S/S: D -- 483.21(b)(1) -- Develop/Implement Comprehensive Care Plan
F0684 -- S/S: D -- 483.25 -- Quality Of Care
F0688 -- S/S: D -- 483.25(c)(1)-(3) -- Increase/Prevent Decrease In ROM/Mobility

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of April 9, 2018:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 5, 2018, would remain in effect. (42 CFR 488.417 (b))

- Civil money penalty for the deficiencies cited at F688, F689, be imposed. (42 CFR 488.430 through 488.444)

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy(ies):

- Civil money penalty for the deficiencies cited at F554, F656, F684, F688. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Rochester East Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective May 5, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a

waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction from the abbreviated standard survey completed on February 5, 2018 should be directed to:

Matthew Heffron, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: matthew.heffron@state.mn.us
Phone: (651) 201-4221
Fax: (651) 281-9796

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction from the standard survey completed on March 2, 2018 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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 5, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	R-C 05/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 No deficiencies were noted at the time of the survey.	E 000		
{F 000}	INITIAL COMMENTS Rochester East Health Services is a Special Focus Facility (SFF) and received an onsite post certification revisit (PCR) completed on April 30, and May 1, 2018, and found to have NOT corrected all the citations issued on the survey exited March 2, 2018. An investigation of complaint H5184097 was substantiated at F689 during the survey exited March 2, 2018 and was found corrected during this PCR. 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.	{F 000}		
{F 554} SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow assessed recommendations for Medication Self Administration for 1 of 3 resident (R27) reviewed for self-administration of medications. Finding include:	{F 554}	PLAN OF CORRECTION F554: Resident Self-administered Medication-Clinically Appropriate SS: D	5/9/18

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

Electronically Signed | 06/05/2018

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{F 554}	Continued From page 1 R27's Medication Self Administration assessment dated 3/22/18 reads, "Resident may self-administer medications WITH SUPERVISION." In addition, the facilities interdisciplinary team does not feel R27 is safe to self-administer. R27's current care plan reads, Self-medication administration: Resident may self-administer medications WITH SUPERVISION with intervention/tasks: "Staff will supervise administration." R27's Order Summary Report signed by physician dated 4/13/18, reads, "Resident may self-administer WITH SUPERVISION." Progress note dated 3/22/18, at 3:30 p.m. reads, "A self-administration of medication assessment today. At this time, resident may self-administer medications under the supervision of licensed staff members. Discussed findings with the resident who is alert and oriented x 3 and her own decision maker. She is agreeable to the findings. Nursing staff also notified. Care plan and orders updated. Interview with R27 on 4/30/18, at 8:50 a.m. who said things are better. Then said, "They leave the medication for me to take and do not stay in room." Interview with administrator on 4/30/18, at 10:15 a.m. said the facility only had five residents who can self-administer medication and it is only for nebulizers, no oral medications are self-administered.	{F 554}	1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R27 was re-assessed on 5/7/2018 for safe Self Administration of Medications; Not leaving medications at bed side; Reason for taking medications; Acknowledgement of Adverse Side effects; and Identification of medications. " R27□s Medical Provider was notified of the findings that were obtained from the Safe Self Administration Assessment on 5/7/18; and a Physician□s order to self-administer medications was obtained. " R27□s Responsible Party was notified of the findings that were obtained from the Safe Self Administration Assessment on 5/7/18 and that a Physician□s order to self-administer medication was obtained. " R27 was reeducated on safety of self-administration of medication; not leaving medications at bed side; and knowledge base of adverse side effects and identification of medications " R27□s Care Plan was reviewed and updated on 5/7/2018 related to R1□s findings of safe Self Administration per the Self Administration Assessment. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents at Rochester East Health	

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{F 554}	Continued From page 2 During an observation of R27 on 4/30/18, at 11:49 a.m. there was a medication cup with oral pills sitting on her tray table. No staff were present at this time. R27 was able to name the medications, which included, one tablet iron, two Tylenol, two lactase, one tramadol and 1 potassium. On 5/1/18, at 8:33 a.m., during an interview with registered nurse (RN)-A concerning R27's medications left on tray table yesterday (4/30/18 at 11:49 a.m.) RN-A remembered she had left the medications again for R27 to take on her own. Interview on 5/1/18, at 12:41 p.m. with Director of Nursing (DON) regarding R27's medications being left for her to take independently with no supervision. The DON said if it says to be supervised during the taking of medications the nurse should stay with the resident until the medications are taken and not left for the resident to take later. Policy titled-"Self-administered medications" dated 12/16 reads Medications should not be kept at bedside unless they are able to be in a locked container that cannot be easily removed from the residents room. Keeping medications at bedside will be decided by the Administrator and DON. Under no circumstances will narcotics be kept at bedside.	{F 554}	Services who chose to self-administer medication have the same potential to be affected by the same deficient practice. " An audit was conducted on 5/8/2018 to assess Residents at Rochester Health Services East who chose to self-administer medications for safe Self Administration. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nurses and TMAs were in-serviced on 5/7/18 or 5/8/18, related to the Minnesota Health Department findings of F-554, from the Revisit Survey that ended on 5/1/18. This in-service included how to manage Residents who have been determined safe to Self-Administer medications per the Self-Administration Assessment; have a current Physician order to Self-Administer Medication; with a focus on following MAR & TAR documentation properly. Training was followed with a post test. " Residents who reside and choose to Self-Administer at Rochester East Health Services will be assessed for Self-Administer Medications Quarterly, Annual, with Significant Change of Condition, after Readmission, and PRN for continued safety per the Self-Administration Assessment. " Residents who choose to Self-Administer Medication at Rochester East Health Services will perform a return demonstration; and be able to verbalize	

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{F 554}	Continued From page 3	{F 554}	education provide. " IDT will review residents that have been screened for Self-Administration of Medication to determine safety risk. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Resident□s of Rochester Health Services East□s are monitoring Residents who have been assessed to Self-Administer Medications. " The Director of Nursing and/or designee will complete a quality assurance tool for Self-Administration audit on residents who self-administer medication on all current residents 3 times a week for one week; then 2 times a week for one week, and then weekly for total of 12 weeks of audits. Director of Nursing or his/her designee performed random audits to monitor Safe Self Medication Administration. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along	

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{F 554}	Continued From page 4	{F 554}	with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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.	{F 656}		5/9/18

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{F 656}	Continued From page 5 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assist with oral care for 1 of 3 residents (R26) according to assessed need. Finding include: R26's admission sheet included a diagnosis of Dysphagia (a difficulty in swallowing) and cerebral infarction (stroke). R26's current care plan includes R26 wears dentures and requires one staff assistance for oral care. As well as swallowing and self-feeding difficulty as related to limited physical strength on left side. R26 has mechanical soft diet with nectar-thickened liquid. R26's Treatment administration records (TAR) includes R26 needs assistance twice daily brushing her teeth, after breakfast and before bed. Focus on areas above the gum line. Every morning and at bedtime for dental care start date	{F 656}	F656: Develop/Implement Comprehensive Care Plans SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " On 5/8/18, R26 was re-assessed and her overall clinical status is unchanged. R26□s oral status remains at baseline. " R26□s Medical Provider was updated on the overall clinical and oral status remaining at baseline on 5/8/18. " R26□s Responsible Party was updated on the overall clinical and oral status remaining at baseline on 5/8/18. " R26□s Care Plan was reviewed and updated on 5/7/2018 on oral care status. 2. How will you identify other residents	

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{F 656}	Continued From page 6 12/20/16. During observation of R26 on 5/1/18, at 845 a.m. R26 was seated at the dining table and had finished eating her breakfast. At 9:44 a.m. R26 continued to be in dining room. An interview with nursing assistant (NA)-B on 5/1/18, at 10:06 a.m. who stated most resident get their oral care before breakfast only a few resident have their teeth brushed after breakfast and R26 was not included in the list given by NA-B. An interview with NA-A on 5/1/18, at 10:10 a.m. stated no residents get their teeth brushed after breakfast. On asking about R26 NA-A stated she gave oral care to R26 before breakfast. An interview on 5/1/18, at 10:16 a.m. Licensed practical nurse (LPN)-A said no residents are monitored for oral care by the nurses, however, nurses may monitor when residents have dentures. On asking LPN-A regarding oral cares for R26, LPN-A checked the doctors orders and found R26 had an order for brushing teeth after breakfast and before bed time. LPN-A said she did not verify with NA-A and NA-B if they had brushed R26's teeth following breakfast. But would do it at this time. Interview with Director of Nurses on 5/1/18, at 10:30 a.m. said if residents are being monitored for oral care would expect nurses to make sure the cares were completed as ordered.	{F 656}	having the potential to be affected by the same deficient practice? " Residents who are admitted to Rochester East Health Services have the same potential to be affected by the same deficient practice. " An audit of resident's oral care was conducted on 5/6/18 and 5/7/18. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Facility staff were In-serviced on 5/7/18 or 5/8/18, related to the Minnesota Health Department findings of F-656 from the Revisit Survey that ended on 5/1/18, related to oral cares and proper documentation of Oral care post completion of oral care. " Nursing Staff will document AM/PM cares per physician order, when care is completed and validated. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s are receiving oral care during AM and PM cares " The Director of Nursing and/or designee will complete a quality	

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{F 656}	Continued From page 7	{F 656}	assurance tool, related resident oral care during AM and PM care or as otherwise specified by medical provider; 3 times a week for one week; then 2 times a week for one week, and then weekly for total of 12 weeks of audits. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	
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.	F 684		5/9/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement specific parameters for administration of an two as needed (PRN) migraine medications for 1 of 1 resident (R92) who had chronic migraine headaches. Findings Include: R92's Admission Record identified R67 was admitted to the facility on 9/12/05, with diagnoses of Hemiplegia (paralysis on one side of the body) following a cerebral infarction (stroke) affecting the dominant left side, and headache. R92's care plan, dated 3/14/16, included, potential for alteration in comfort related to chronic headaches. Interventions included: Administer medications as ordered. Monitor and document for effectiveness. Evaluate the effectiveness of pain regime as needed. Review for compliance, effectiveness, dosing schedules, resident satisfaction, impact on functional ability and impact on cognition. R92's physician orders signed 4/23/18, included: 1. Ketoprofen 50 mg: give 1 capsule by mouth as needed for migraine headaches. Administer for headache pain greater than level 7 and take with food. A maximum of 6 capsules per week. 2. Rizatriptan Benzoate 10 mg: give 1 tablet by mouth as needed for migraine headache, "MUST ADMINISTER KETOPROFEN, AS ORDERED, FIRST!!" Unrelieved by Ketoprofen after 2 hours. May repeat in 2 hours. Maximum 2 tablets in 24 hours, 4 tablets in 1 week. R92's medication administration record (MAR) for	F 684	F684: Quality of Care SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R92 was re-assessed and her over clinical status remains at baseline with no influence noted related to the use of prn on 5/7/2018. " R92□s current order for Ketoprofen has been reviewed and adjust and is now written without < and > abbreviations. " R92□s Medical Provider was notified of her continued baseline status. " R92□s is responsible for herself and is aware of her own clinical status. " R92□s Care Plan was reviewed and updated on 5/7/2018. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who reside at Rochester East Health Services who use prn medications have the same potential to be affected by the same deficient practice. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Facility staff were In-serviced on	

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	245184	A. BUILDING _____ B. WING _____	R-C 05/01/2018

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F 684	Continued From page 9 April, 2018 was reviewed and revealed the following: April 27, and 28, 2018, Ketoprofen was given with level 5 pain. Rizatriptan was given on April 2, 22, and 24, without getting the Ketoprofen prior. During an interview 5/1/18, at 12:08 p.m., licensed practical nurse (LPN)-A stated if R92 had a headache she could have Ketoprofen, but was unclear if the order said more than or less than pain level of 7 (of a 1 to 10 pain scale with 10 being worst pain ever), because the order used a symbol ">" of greater than versus being written out. After clarification that the medical order read greater (>) than a level 7 pain, LPN-A verified R92 received Ketoprofen on April 27 and 28, with a pain level of 5 and shouldn't have. Further verified R92 received Rizatriptan on April 2, 22, and 28, without first giving Ketoprofen which was ordered to be given first and if not affective to give Rizatriptan. During an interview on 5/1/18, at 12:26 pm, director of nursing (DON) verified R92 did not receive her as needed headache medication within the specified parameters as ordered by the physician. DON stated, "My expectation for the nurses administering prn medications with parameters is they (residents) should be given prn medications as written by the doctor." A policy on PRN medication administration was requested and not provided.	F 684	5/7/18 or 5/8/18, related to the Minnesota Health Department findings for F-684 from the Revisit Survey that ended on 5/1/18; proper use of PRN medications; and to administer Medications as per Physician□s Orders. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s Medications are available as per Physician□s Order. " The Director of Nursing and/or designee will complete a quality assurance tool on three residents who receive PRN medications: 3 times a week for one week; then 2 times a week for one week, and then weekly for a total of 12 weeks of audits. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for	

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F 684	Continued From page 10	F 684	three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	
{F 688} SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement a palm guard per physician orders for 1 of 1 resident (R23) reviewed who had contractures. Findings include: R23's Admission Record document identified an	{F 688}	F-TAG 688: Increase/Prevent Decrease in ROM/Mobility SSD: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient	5/9/18

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{F 688}	Continued From page 11 admission date of 2/20/12, and diagnoses of left hand contractures (10/3/16). R23's physician progress note dated 3/8/18, revealed: "R23 has severe contractures of her left hand especially. She has a palm guard for the left hand." A quarterly Minimum Data Set (MDS) assessment dated 3/12/18, identified R23 to be severely cognitively impaired, with limited range of motion (ROM) in bilateral upper and lower extremities, contractures of the left hand and ankle, and contractures of the right ankle. R23's treatment administration record (TAR) dated April, 2018, identified: Apply left palm guard with a.m. care and remove with p.m. care. R23's current care plan, revealed the following: "I have a physical functioning deficit related to self-care impairment left upper arm contractures." Intervention: apply palm guard with a.m. care and remove with p.m. care. During observation on 4/30/18, at 12:22 p.m., R23 is sitting in her Broda (a tilt and position wheelchair) chair up to the table in the dining room and has left palm guard in place. During observation on 5/1/18, at 9:04 a.m., R23 is sitting in her broda chair up to the table while being assisted with eating by trained medication aide (TMA)-A. R23 does not have left palm guard in place. During an interview on 5/1/18, at 9:15 a.m., nursing assistant (NA)-C verified that R23 does not have left palm guard in place. NA-C stated, "I	{F 688}	practice? " R23 was assessed on 5/8/18 for her overall clinical status and adaptive equipment needs. " R23□s Medical Provider was updated related to her overall clinical status remains at baseline with continued use of her adaptive device on 5/8/18. " R23□s Responsible Party was updated related to her overall clinical status remains at baseline with continued use of her adaptive device on 5/8/18. " R23 □s Care Plan was reviewed and updated on 5/6/818. 2. How will you identify other residents having the potential to be affected by the same practice? " Residents who reside at Rochester East Heath Services that have use splints/braces have the same potential to be affected by the same deficient practice. " An audit of Residents with splints/braces was conducted on 5/8/18. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Facility staff were In-serviced on 5/7/18 or 5/8/18, related to the Minnesota Health Department findings of F-688 from the Revisit Survey that ended on 5/1/18. This in-service included the need to follow Physician□s Order for residents wearing	

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{F 688}	Continued From page 12 am the one who got her up today and I forgot, she has been up for a while now, I should have put it on her." During interview on 5/1/18, at 9:20 a.m., licensed practical nurse (LPN)-B verified R23 does not have left palm guard in place and verified it should be. LPN-B stated, "My expectation would be for a resident with an order from therapy to wear a palm guard that it should be put on when ordered." During interview on 5/1/18, at 9:28 a.m., director of nursing (DON) verified R23's left palm guard should have been put on with a.m. cares per the care plan. During interview on 5/1/18, at 10:00 a.m., certified occupational therapy aide (COTA)-D verified R23 should have a palm guard applied in the morning and off at night, "this is to help prevent further contractures." COTA-D further stated, "Those palm guards are essential to prevent further contractures of her left hand and to reduce pain when washing hands promoting resident comfort." Facility policy for splints and devices requested and was not received.	{F 688}	splints or braces. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure that Residents of Rochester Health Services East□s Passive Range of motion program. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit #688-C) to monitor compliance of Passive Range of Motion. With the 3 residents who need passive range of motion; 3 times a week for one week; then 2 times a week for one week, and then weekly for a total of 12 weeks of audits. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations.	

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{F 688}	Continued From page 13	{F 688}	" The facility administrator and/or designee will monitor that the tools are completed.	

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on May 25, 2018.

May 25, 2018

Mr. Stephen Jobe, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Project # S5184030, H5184097

Dear Mr. Jobe:

On May 1, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 2, 2018 with orders received by you electronically on March 19, 2018.

State licensing orders issued pursuant to the last survey completed on March 2, 2018 and found corrected at the time of this May 1, 2018 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on March 2, 2018, found not corrected at the time of this May 1, 2018 revisit and subject to penalty assessment are as follows:

F0830	MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General	$350.00
F0895	MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion	$350.00
F1565	MN Rule 4658.1325 Subp. 4 -- Administration Of Medications Self Admin	$250.00

The details of the violations noted at the time of this revisit completed on May 1, 2018 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $950.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or

delivered to:

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

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

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

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

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

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

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

Sincerely,

Kamala Fiske-Downing
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
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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{2 000}	Initial Comments	{2 000}		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
An onsite follow-up visit was completed on April 30, May 1, 2018. During this visit it was determined that the following citations were NOT Corrected.

In addition, complaint investigation H5184097 had been substantiated at MN Rule 4658.0520 Supb.

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{2 000}	Continued From page 1 1 during the licensing survey exited on March 2, 2018. During this on-site licensing visit the complaint was found corrected. The uncorrected citations will remain in effect and will be reviewed at the next onsite visit.	{2 000}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and record review, the facility failed to assist with oral care for 1 of 3 residents (R26) according to assessed need. Also based on interview and document review, the facility failed to implement specific parameters for administration of an two as needed (PRN) migraine medications for 1 of 1 resident (R92) who had chronic migraine headaches.	{2 830}	F656: Develop/Implement Comprehensive Care Plans SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " On 5/8/18, R26 was re-assessed and her overall clinical status is unchanged.	5/9/18

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{2 830}	Continued From page 2 Finding include: R26's admission sheet included a diagnosis of Dysphagia (a difficulty in swallowing) and cerebral infarction (stroke). R26's current care plan includes R26 wears dentures and requires one staff assistance for oral care. As well as swallowing and self-feeding difficulty as related to limited physical strength on left side. R26 has mechanical soft diet with nectar-thickened liquid. R26's Treatment administration records (TAR) includes R26 needs assistance twice daily brushing her teeth, after breakfast and before bed. Focus on areas above the gum line. Every morning and at bedtime for dental care start date 12/20/16. During observation of R26 on 5/1/18, at 845 a.m. R26 was seated at the dining table and had finished eating her breakfast. At 9:44 a.m. R26 continued to be in dining room. An interview with nursing assistant (NA)-B on 5/1/18, at 10:06 a.m. who stated most resident get their oral care before breakfast only a few resident have their teeth brushed after breakfast and R26 was not included in the list given by NA-B. An interview with NA-A on 5/1/18, at 10:10 a.m. stated no residents get their teeth brushed after breakfast. On asking about R26 NA-A stated she gave oral care to R26 before breakfast. An interview on 5/1/18, at 10:16 a.m. Licensed practical nurse (LPN)-A said no residents are monitored for oral care by the nurses, however,	{2 830}	R26□s oral status remains at baseline. " R26□s Medical Provider was updated on the overall clinical and oral status remaining at baseline on 5/8/18. " R26□s Responsible Party was updated on the overall clinical and oral status remaining at baseline on 5/8/18. " R26□s Care Plan was reviewed and updated on 5/7/2018 on oral care status. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who are admitted to Rochester East Health Services have the same potential to be affected by the same deficient practice. " An audit of resident's oral care was conducted on 5/6/18 and 5/7/18. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Facility staff were In-serviced on 5/7/18 or 5/8/18, related to the Minnesota Health Department findings of F-656 from the Revisit Survey that ended on 5/1/18, related to oral cares and proper documentation of Oral care post completion of oral care. " Nursing Staff will document AM/PM cares per physician order, when care is completed and validated. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance	

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{2 830}	Continued From page 3 nurses may monitor when residents have dentures. On asking LPN-A regarding oral cares for R26, LPN-A checked the doctors orders and found R26 had an order for brushing teeth after breakfast and before bed time. LPN-A said she did not verify with NA-A and NA-B if they had brushed R26's teeth following breakfast. But would do it at this time. Interview with Director of Nurses on 5/1/18, at 10:30 a.m. said if residents are being monitored for oral care would expect nurses to make sure the cares were completed as ordered. R92's Admission Record identified R67 was admitted to the facility on 9/12/05, with diagnoses of Hemiplegia (paralysis on one side of the body) following a cerebral infarction (stroke) affecting the dominant left side, and headache. R92's care plan, dated 3/14/16, included, potential for alteration in comfort related to chronic headaches. Interventions included: Administer medications as ordered. Monitor and document for effectiveness. Evaluate the effectiveness of pain regime as needed. Review for compliance, effectiveness, dosing schedules, resident satisfaction, impact on functional ability and impact on cognition. R92's physician orders signed 4/23/18, included: 1. Ketoprofen 50 mg: give 1 capsule by mouth as needed for migraine headaches. Administer for headache pain greater than level 7 and take with food. A maximum of 6 capsules per week. 2. Rizatriptan Benzoate 10 mg: give 1 tablet by mouth as needed for migraine headache, "MUST ADMINISTER KETOPROFEN, AS ORDERED, FIRST!!" Unrelieved by Ketoprofen after 2 hours. May repeat in 2 hours. Maximum 2 tablets in 24	{2 830}	program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s are receiving oral care during AM and PM cares " The Director of Nursing and/or designee will complete a quality assurance tool, related resident oral care during AM and PM care or as otherwise specified by medical provider; 3 times a week for one week; then 2 times a week for one week, and then weekly for total of 12 weeks of audits. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	R-C 05/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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{2 830}	Continued From page 4 hours, 4 tablets in 1 week. R92's medication administration record (MAR) for April, 2018 was reviewed and revealed the following: April 27, and 28, 2018, Ketoprofen was given with level 5 pain. Rizatriptan was given on April 2, 22, and 24, without getting the Ketoprofen prior. During an interview 5/1/18, at 12:08 p.m., licensed practical nurse (LPN)-A stated if R92 had a headache she could have Ketoprofen, but was unclear if the order said more than or less than pain level of 7 (of a 1 to 10 pain scale with 10 being worst pain ever), because the order used a symbol ">" of greater than versus being written out. After clarification that the medical order read greater (>) than a level 7 pain, LPN-A verified R92 received Ketoprofen on April 27 and 28, with a pain level of 5 and shouldn't have. Further verified R92 received Rizatriptan on April 2, 22, and 28, without first giving Ketoprofen which was ordered to be given first and if not affective to give Rizatriptan. During an interview on 5/1/18, at 12:26 pm, director of nursing (DON) verified R92 did not receive her as needed headache medication within the specified parameters as ordered by the physician. DON stated, "My expectation for the nurses administering prn medications with parameters is they (residents) should be given prn medications as written by the doctor." A policy on PRN medication administration was requested and not provided. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 830}	Continued From page 5 penalty assessment/s.	{2 830}		
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and record review, the facility failed to implement a palm guard per physician orders for 1 of 1 resident (R23) reviewed who had contractures. Findings include: R23's Admission Record document identified an admission date of 2/20/12, and diagnoses of left hand contractures (10/3/16). R23's physician progress note dated 3/8/18, revealed: "R23 has severe contractures of her left hand especially. She has a palm guard for the left hand."	{2 895}	F-TAG 688: Increase/Prevent Decrease in ROM/Mobility SSD: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R23 was assessed on 5/8/18 for her overall clinical status and adaptive equipment needs. " R23□s Medical Provider was updated related to her overall clinical status remains at baseline with continued use of her adaptive device on 5/8/18.	5/9/18

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{2 895}	Continued From page 6 A quarterly Minimum Data Set (MDS) assessment dated 3/12/18, identified R23 to be severely cognitively impaired, with limited range of motion (ROM) in bilateral upper and lower extremities, contractures of the left hand and ankle, and contractures of the right ankle. R23's treatment administration record (TAR) dated April, 2018, identified: Apply left palm guard with a.m. care and remove with p.m. care. R23's current care plan, revealed the following: "I have a physical functioning deficit related to self-care impairment left upper arm contractures." Intervention: apply palm guard with a.m. care and remove with p.m. care. During observation on 4/30/18, at 12:22 p.m., R23 is sitting in her Broda (a tilt and position wheelchair) chair up to the table in the dining room and has left palm guard in place. During observation on 5/1/18, at 9:04 a.m., R23 is sitting in her broda chair up to the table while being assisted with eating by trained medication aide (TMA)-A. R23 does not have left palm guard in place. During an interview on 5/1/18, at 9:15 a.m., nursing assistant (NA)-C verified that R23 does not have left palm guard in place. NA-C stated, "I am the one who got her up today and I forgot, she has been up for a while now, I should have put it on her." During interview on 5/1/18, at 9:20 a.m., licensed practical nurse (LPN)-B verified R23 does not have left palm guard in place and verified it should be. LPN-B stated, "My expectation would	{2 895}	" R23□s Responsible Party was updated related to her overall clinical status remains at baseline with continued use of her adaptive device on 5/8/18. " R23 □s Care Plan was reviewed and updated on 5/6/818. 2. How will you identify other residents having the potential to be affected by the same practice? " Residents who reside at Rochester East Heath Services that have use splints/braces have the same potential to be affected by the same deficient practice. " An audit of Residents with splints/braces was conducted on 5/8/18. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Facility staff were In-serviced on 5/7/18 or 5/8/18, related to the Minnesota Health Department findings of F-688 from the Revisit Survey that ended on 5/1/18. This in-service included the need to follow Physician□s Order for residents wearing splints or braces. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure that Residents of Rochester Health Services	

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{2 895}	Continued From page 7 be for a resident with an order from therapy to wear a palm guard that it should be put on when ordered." During interview on 5/1/18, at 9:28 a.m., director of nursing (DON) verified R23's left palm guard should have been put on with a.m. cares per the care plan. During interview on 5/1/18, at 10:00 a.m., certified occupational therapy aide (COTA)-D verified R23 should have a palm guard applied in the morning and off at night, "this is to help prevent further contractures." COTA-D further stated, "Those palm guards are essential to prevent further contractures of her left hand and to reduce pain when washing hands promoting resident comfort." Facility policy for splints and devices requested and was not received. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 895}	East□s Passive Range of motion program. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit #688-C) to monitor compliance of Passive Range of Motion. With the 3 residents who need passive range of motion; 3 times a week for one week; then 2 times a week for one week, and then weekly for a total of 12 weeks of audits. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	
{21565}	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of	{21565}		5/9/18

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{21565}	Continued From page 8 care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and record review, the facility failed to follow assessed recommendations for Medication Self Administration for 1 of 3 resident (R27) reviewed for self-administration of medications. Finding include: R27's Medication Self Administration assessment dated 3/22/18 reads, "Resident may self-administer medications WITH SUPERVISION." In addition, the facilities interdisciplinary team does not feel R27 is safe to self-administer. R27's current care plan reads, Self-medication administration: Resident may self-administer medications WITH SUPERVISION with intervention/tasks: "Staff will supervise administration." R27's Order Summary Report signed by physician dated 4/13/18, reads, "Resident may self-administer WITH SUPERVISION." Progress note dated 3/22/18, at 3:30 p.m. reads, "A self-administration of medication assessment today. At this time, resident may self-administer medications under the supervision of licensed staff members. Discussed findings with the resident who is alert and oriented x 3 and her own decision maker. She is agreeable to the findings.	{21565}	PLAN OF CORRECTION F554: Resident Self-administered Medication-Clinically Appropriate SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R27 was re-assessed on 5/7/2018 for safe Self Administration of Medications; Not leaving medications at bed side; Reason for taking medications; Acknowledgement of Adverse Side effects; and Identification of medications. " R27□s Medical Provider was notified of the findings that were obtained from the Safe Self Administration Assessment on 5/7/18; and a Physician□s order to self-administer medications was obtained. " R27□s Responsible Party was notified of the findings that were obtained from the Safe Self Administration Assessment on 5/7/18 and that a Physician□s order to self-administer medication was obtained. " R27 was reeducated on safety of self-administration of medication; not leaving medications at bed side; and knowledge base of adverse side effects	

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{21565}	Continued From page 9 Nursing staff also notified. Care plan and orders updated. Interview with R27 on 4/30/18, at 8:50 a.m. who said things are better. Then said, "They leave the medication for me to take and do not stay in room." Interview with administrator on 4/30/18, at 10:15 a.m. said the facility only had five residents who can self-administer medication and it is only for nebulizers, no oral medications are self-administered. During an observation of R27 on 4/30/18, at 11:49 a.m. there was a medication cup with oral pills sitting on her tray table. No staff were present at this time. R27 was able to name the medications, which included, one tablet iron, two Tylenol, two lactase, one tramadol and 1 potassium. On 5/1/18, at 8:33 a.m., during an interview with registered nurse (RN)-A concerning R27's medications left on tray table yesterday (4/30/18 at 11:49 a.m.) RN-A remembered she had left the medications again for R27 to take on her own. Interview on 5/1/18, at 12:41 p.m. with Director of Nursing (DON) regarding R27's medications being left for her to take independently with no supervision. The DON said if it says to be supervised during the taking of medications the nurse should stay with the resident until the medications are taken and not left for the resident to take later. Policy titled-"Self-administered medications" dated 12/16 reads Medications should not be kept at bedside unless they are able to be in a locked container that cannot be easily removed	{21565}	and identification of medications " R27□s Care Plan was reviewed and updated on 5/7/2018 related to R1□s findings of safe Self Administration per the Self Administration Assessment. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents at Rochester East Health Services who chose to self-administer medication have the same potential to be affected by the same deficient practice. " An audit was conducted on 5/8/2018 to assess Residents at Rochester Health Services East who chose to self-administer medications for safe Self Administration. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nurses and TMAs were in-serviced on 5/7/18 or 5/8/18, related to the Minnesota Health Department findings of F-554, from the Revisit Survey that ended on 5/1/18. This in-service included how to manage Residents who have been determined safe to Self-Administer medications per the Self-Administration Assessment; have a current Physician order to Self-Administer Medication; with a focus on following MAR & TAR documentation properly. Training was followed with a post test. " Residents who reside and choose to Self-Administer at Rochester East Health	

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{21565}	Continued From page 10 from the residents room. Keeping medications at bedside will be decided by the Administrator and DON. Under no circumstances will narcotics be kept at bedside. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{21565}	Services will be assessed for Self-Administer Medications Quarterly, Annual, with Significant Change of Condition, after Readmission, and PRN for continued safety per the Self-Administration Assessment. " Residents who choose to Self-Administer Medication at Rochester East Health Services will perform a return demonstration; and be able to verbalize education provide. " IDT will review residents that have been screened for Self-Administration of Medication to determine safety risk. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Resident□s of Rochester Health Services East□s are monitoring Residents who have been assessed to Self-Administer Medications. " The Director of Nursing and/or designee will complete a quality assurance tool for Self-Administration audit on residents who self-administer medication on all current residents 3 times a week for one week; then 2 times a week for one week, and then weekly for total of 12 weeks of audits. Director of Nursing or his/her designee performed random audits to monitor Safe Self Medication Administration. " Additional training may be scheduled	

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{21565}	Continued From page 11	{21565}	based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: VCL4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER EAST HEALTH SERVICES**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**
6. DATE OF SURVEY **03/02/2018** (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)
12/31

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

12.Total Facility Beds **116** (L18)
13.Total Certified Beds **116** (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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 03/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/06/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **09/01/1972** (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.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2018 (L33)

DETERMINATION APPROVAL

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

CCN: 24-5184

On February 5, 2018 we completed an abbreviated standard survey, the highest s/s was D. On March 2, 2018, we completed a standard survey and an investigation of complaint H5184097 was completed and found substantiated, the highest s/s was G. At the previous survey completed on 4/18/2017 there was an IJ and SQC at F225 and F226. As a result of our findings, we have imposed the Category 1 remedy of State monitoring, effective March 27, 2018.

In addition, we are recommending the following enforcement action to the CMS RO for imposition:

- CMP for deficiency cited at F688 and F689.
- DPNA, effective May 5, 2018.

The facility would also be subject to a loss of NATCEP to be effective May 5, 2018.

Electronically delivered

March 16, 2018

Mr. Jon Richardson, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Numbers S5184030, H5184097

Dear Mr. Richardson:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On March 2, 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. In addition, at the time of the March 2, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5184097.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), 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

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e.,

standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 21, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective May 21, 2018

- Civil money penalty for the deficiencies cited at F688, F689. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 21, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 21, 2018.

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.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Rochester East Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 21, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 2, 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 2, 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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

<u>This letter will replace the letter sent to your facility on March 16, 2018.</u>

Electronically delivered

March 22, 2018

Mr. Jon Richardson, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Numbers S5184030, H5184097

Dear Mr. Richardson:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On February 5, 2018, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, Office of Health Facility Complaints 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the attached CMS-2567 whereby corrections are required.

On March 2, 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. In addition, at the time of the March 2, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5184097. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

- State Monitoring effective March 27, 2018. (42 CFR 488.422)

Also, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 5, 2018. (42 CFR 488.417 (b))

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiencies cited at F688, F689. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2018.

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.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Rochester East Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 5, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction from the abbreviated standard survey completed on February 5, 2018 should be directed to:

Mike Kaehler, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: mike.kaehler@state.mn.us
Phone: (651) 201-4181
Fax: (651) 281-9796

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction from the standard survey completed on March 2, 2018 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

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,

- Include electronic acknowledgement signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 5, 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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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
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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

<u>This letter will replace the letter sent to your facility on March 22, 2018.</u>

Electronically delivered

April 9, 2018

Mr. Stephen Jobe, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Numbers S5184030, H5184097, H5184096

Dear Mr. Richardson:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On February 5, 2018, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, Office of Health Facility Complaints 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 and to completed an investigation of complaint number H5184096. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the attached CMS-2567 whereby corrections are required.

On March 2, 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. In addition, at the time of the March 2, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5184097. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

- State Monitoring effective March 27, 2018. (42 CFR 488.422)

Also, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 5, 2018. (42 CFR 488.417 (b))

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiencies cited at F688, F689. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2018.

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.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Rochester East Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 5, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction from the abbreviated standard survey completed on February 5, 2018 should be directed to:

Mike Kaehler, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: mike.kaehler@state.mn.us
Phone: (651) 201-4181
Fax: (651) 281-9796

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction from the standard survey completed on March 2, 2018 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

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,

- Include electronic acknowledgement signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 5, 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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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
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
	245184	A. BUILDING _____ B. WING _____	C 03/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 February 26, 27, 28, March 1, & 2, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS Rochester East Health Services is a Special Focus Facility (SFF) and received a Certification survey on February 26, 27, 28, March 1 & 2, 2018. An investigation of complaint H5184097 were completed. The complaint was substantiated and deficiency was cited at F689. The facility's plan of correction (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 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554		3/30/18

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

Electronically Signed | 03/28/2018

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F 554	Continued From page 1 Based on interview, observation and record review, the facility failed to verify a self-administration of medication order was in place before leaving medications in room for 1 of 1 resident (R27). Findings include: R27's admission form included a diagnosis of diabetes and depression. R27's quarterly Minimum Data set (MDS) an assessment dated 12/22/17 as being cognitively intact with a brief interview of mental status of 15. On 2/26/18, at 11:20 a.m. R27 voiced concern some nurses leave medications in her room while others tell her they cannot. Observation on 2/26/18, at 11:41 a.m. R27 had a medication cup sitting on tray table in her room. R27 said it contained Tylenol, tramadol (used for pain), baclofen (used for muscle spasm), lactase (used for lactose intolerance), and potassium. Medications were in room when entered, no staff present. R27 took while surveyor in room. Interview on 2/28/18, at 2:40 p.m. trained medication aide (TMA)-A said medications left for R27 to take on her own. TMA-A said R27 has a self-administration of medication order to take on own after set up. Interview on 2/28/18, at 3:28 p.m. registered nurse (RN)-D said R27 self-administration order never was put back in place after hospital stay. Had been discontinued on 2/19/18. RN-D also said there was no change in R27's cognition condition so another assessment would not be	F 554	F554: Resident Self-administered Medication-Clinically Appropriate SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R27 was assessed on 03/22/2018 for safe Self Administration of Medications. " R27□s Medical Provider was notified of the findings that were obtained from the Safe Self Administration Assessment on 3/22/18; and a Physician□s order to self-administer medications with supervision was obtained. " R27□s Responsible Party was notified of the findings that were obtained from the Safe Self Administration Assessment on 3/22/18 and that a Physician□s order to self-administer medication with supervision was obtained. " R27□s Care Plan was reviewed and updated on 03/22/2018 related to R1□s findings of safe Self Administration per the Self Administration Assessment . 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents at Rochester East Health Services who chose to self-administer medication have the same potential to be affected by the same deficient practice. " An audit was conducted on 03/22/2018 to assess Residents at	

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F 554	Continued From page 2 needed. R27 said on 3/1/18, at 8:33 a.m. that licensed practical nurse (LPN)-B left medication on her tray table to self-administer this morning. On 3/1/18, at 8:34 a.m. LPN-B was asked about how medication was handled for R27 this morning. LPN-B said medications were left on the tray table. LPN-B then said, R27 does not have an order to self -administer of medications. LPN-B said, "To be honest I know she does not" and R27 requested medication to be left to take later this a.m. R27's care plan review dated 6/21/17, identifies Self-medication administration: lidocaine ointment 5% only. R27's Medication self-administration assessment effective date 7/26/17, identified "all medications" can be self-administered. Interview on 2/28/18, at 4:23 p.m. with registered nurse consultant (RNC)-B verified R27 does not have a current order to self-administer medications. The prior self-administration order had been discontinued on 2/19/18. Policy review titled Medication Administration-Preparation and General Guidelines-Self-Administration of Medications dated 6/15 reads: For those resident who self-administer, the interdisciplinary team verifies the resident ability to self-administer medications by mean of a skill assessment conducted on a (quarterly) basis or when there is a significant change in condition.	F 554	Rochester Health Services East who chose to self-administer medications for safe Self Administration. (Exhibit #554-B). 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nurses and TMAs were In-serviced on 3/13/18 or 3/14/18, (Exhibit #554-C), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; and how to manage Residents who have been determined safe to Self-Administer medications per the Self Administration Assessment (Exhibit #554-A) and have a current Physician order. " A second in-service will be conducted on 03/28/2018 and 03/29/2018, related to the findings of Tag F554; the Policy Medication Administration Preparation and General Guidelines □ Self Administration of Medications; About not leaving medication in the Resident□s room or at bedside; and the Responsibilities of Administering medication if requested to perform a task outside of the approved guidelines of medication administration; and the need to Care Plan the specific directions when participating in setting up a Resident who is about to Self-Administer Medications as directed by the Physician□s Order. " Residents who reside and choose to self-administer at Rochester East Health Services will be assessed for Self-Administer Medications Quarterly,	

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F 554	Continued From page 3	F 554	Annual, with Significant Change of Condition, after Readmission, and PRN for continued safety per the Self Administration Assessment. (Exhibit # 554-A). " Residents admitted to and choose to self-administer medication at Rochester East Health Services will be assessed on Admission/Readmission, Quarterly, Annually, with Significant Change of Condition and PRN for Self-Administration of Medication. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Resident□s of Rochester Health Services East□s are monitoring Residents who have been assessed to Self-Administer Medications. " The Director of Nursing and/or designee will complete a quality assurance tool for Self-Administration audit on residents who self-administer medication (Exhibit # 554-D) on all current residents 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. Director of Nursing or his/her designee performed random audits to monitor Safe Self Medication Administration. " Additional training may be scheduled based on results of the quality assurance	

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F 554	Continued From page 4	F 554	review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	
F 578 SS=D	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	F 578		3/30/18

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F 578	Continued From page 5 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 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 record review, the facility failed to accurately identify preference for Health Care Directives for 1 of 1 resident (R8) reviewed for advanced directives. Findings include: R8 was readmitted to the facility on 2/5/18, according to the admission form, with diagnoses obtained from the electronic health record (EHR) including pneumonia, encephalopathy, hyperosmolality and hypernatremia (too much sodium and not enough water in the body) and a urinary tract infection. R8's quarterly Minimum Data Set (MDS), an	F 578	F578: Request/Refuse/Discontinue Treatment; Formulate Advance Directives SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " On 3/24/18, R8 Advanced Health Care Directives were reviewed and noted to be up. " On 3/24/18 R8□s Medical Provider was updated on the current signed Advanced Health Care Directives	

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F 578	Continued From page 6 assessment dated 11/21/17, indicated R8 had a brief interview for mental status (BIMS) score of 15, identifying R8 as having intact cognition. R8's EHR was reviewed on 2/27/18, at 12:29 p.m., and identified that R8's code status as do not resuscitate (DNR). The code status was noted to be ordered upon readmission from the acute care setting on 2/5/18. Review of R8's Physician Orders for Life-Sustaining Treatment (POLST) on 2/27/18, and dated 7/11/13, indicated R8 to be a full code. The care plan last revised on 1/8/18, indicated R8 as a full code. Nursing home physician visit notes dated 2/9/18, indicated R8 as a full code. During an interview on 2/28/18, at 9:58 a.m., regarding code status, R8 stated, "I honestly cannot tell you what I am, I just don't know." During an interview with nursing assistant (NA)-E, on 2/28/18, at 10:00 a.m., related to resident code status is identified, she stated she follows her care guide, dated 2/17/18, which indicated R8 to be a full code. During an interview with registered nurse (RN)-D, on 2/28/18, at 10:29 a.m., she verified the inconsistency between the EHR and the POLST and stated she would need to look into it. In an interview with nurse consultant (NC)-B on 3/2/18, at 8:52 a.m., she verified that there had been a discrepancy in code status and that it had been addressed. Facility policy revised 4/13, titled "Advanced Directives," indicate changes or revocations of a	F 578	implemented and placed in her medical record. " On 3/24/18 R8□s Responsible Party was updated on the current signed Advanced Health Care Directives implemented and placed in her medical record. " R8□s Care Plan was reviewed and updated on 03/24/2018 related to Advanced Health Care Directives Choices made by the Resident and Responsible Party. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " An audit was conducted on 03/21/2018 to assess Residents at Rochester Health Services East to ensure Advanced Health Care Directives are current and located in the Medical Record and match the Physician□s order and Care Plan. (Exhibit #578-A). 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nursing Staff were In-serviced on 3/13/18 or 3/14/18, (Exhibit #554-B), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; and the facility□s process of managing how it will obtain the Medical Provider□s signature and this document will be stored on the Medical Record; and that Advanced	

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F 578	Continued From page 7 directive must be submitted to the administrator in writing. Administrator may require new documents if changes are extensive. The care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan.	F 578	Health Care Directives will be reviewed at a minimum of every Quarter, Annually, with Significant Change of Condition and PRN. " A second in-service will be held on 03/28/2018 and 3/29/2018 for Social Services and Nursing Staff, related to the findings of Tag F578; the expectation that the Advance Directive, Physician□s Order, and Care Plan identify the same directives and are signed by the Medical Provider; the Policy on Advanced Directives; and social services and nursing staff□s responsibility related to the findings of this tag. " The facility implemented a revised Admission/Readmission Checklist (Exhibit F578-C) to monitor that the Resident□s Health Care Directives are obtained and placed in the Medical Record upon Admission/Readmission. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s Advanced Directives are reviewed and current on Admission, quarterly, annually, and PRN. " The Social Service Director and/or designee will complete a quality assurance tool for Advance Directive	

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F 578	Continued From page 8	F 578	(Exhibit #578-D) on three residents 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 -	F 656		3/30/18

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F 656	Continued From page 9 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a care plan for oral cares based on physician orders from a hospital dismissal summary for 1 of 1 resident (R67) reviewed for dental. Findings Include:	F 656	F656: Develop/Implement Comprehensive Care Plans SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient	

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F 656	Continued From page 10 During an interview on 2/26/18, 12:29 p.m. family member (FM)-A stated there was problems with brushing R67's teeth. FM-A stated there were orders to brush R67's teeth 3 to 5 times a day in the hospital dismissal summary and the only times he gets his teeth brushed is when I am here. FM-A stated because the nectar thick liquids had a lot of sugar in them R67 was to have his teeth brushed 3 to 5 times a day. FM-A stated she will set him up at night for dental cares before she leaves and comes back the next day and still sitting there untouched. R67's hospital dismissal summary dated 1/26/18, included, "ASPIRATION PRECAUTION: Good oral care 3-5 times a day." R67's physician orders were reviewed and lacked a physician order to brush teeth 3 to 5 times a day. R67's care plan, nursing assistant care guide and nursing assistant were reviewed and lacked direction to provide oral care 3-5 times a day. R67's care plan dated 1/30/18, instructed staff to provide oral care with an assist of one. R67's nursing assistant care guide updated 2/20/18, instructed staff to help with oral care twice a day. During an interview on 2/28/18, at 2:30 p.m. nursing assistant (NA)-C stated R67 was supposed to brush his teeth 5 times a day and stated his wife wanted his teeth brushed three times a day. NA-C stated R67 was capable to brush his own teeth after set up. NA-C stated when R67's wife is here she sets him up to brush	F 656	practice? " R67 is no longer a resident at Rochester East Health Services. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who are admitted to Rochester East Health Services have the same potential to be affected by the same deficient practice. " An audit of resident's oral care was conducted on 3/21/2018 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nursing Staff were In-serviced on 3/13/18 or 3/14/18, (Exhibit #656-B), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; related to the admission process, identifying orders and verifying them; and initiating and completing the care plan process. (Exhibit # 656-A). " CNA Staff were In-serviced on 3/20/18 or 3/21/18, (Exhibit #656-B), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18 " Staff education will occur on 03/28/18 and 03/29/2018 related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18 for	

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F 656	Continued From page 11 his teeth and when she is not here, we set him up and do it. During an interview on 3/1/18, at 1:33 p.m. nursing assistant (NA)-A stated she was not sure how often R67 was to have his teeth brushed a day. NA-A stated what I know is every morning and night we get residents washed up (which included oral cares). NA-A stated we set R67 up and he was able to take care of that (brushing teeth) on his own and stated I set him up in the morning for oral cares. During an interview on 3/1/18, at 4:06 a.m. (NA)-B stated she had R67 brush his teeth at bedtime. NA-B stated she set him up and R67 was able to brush his own teeth. NA-B said if his wife was here I do not bother with oral cares, as I believe she completes his evenings cares with him. During an interview on 3/1/18, at 3:32 p.m. registered nurse (RN)-A stated oral care 3-5 times a day should have been on the care plan and nursing assistant care guides. RN-A verified staff would not know they needed to complete oral care with R67 more than with morning and evenings cares if it was not care planned. During an interview on 3/1/18, at 3:43 p.m. the nurse consultant (NC)-B stated she would have expected oral cares 3-5 times a day to have been put in as an order and for this (oral cares) to have been completed per the hospital dismissal summary. NC-B stated oral cares 3-5 times a day should have been added to care plan and care guide for R67. NC-B stated R67 should have oral care provided as recommended in the hospital dismissal summary.	F 656	Tag F656; and the importance of oral care. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s are receiving oral care during AM and PM cares " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit # 656-B) related resident oral care during AM and PM care or as otherwise specified by medical provider; 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations.	

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F 656	Continued From page 12	F 656	" The facility administrator and/or designee will monitor that the tools are completed.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		3/30/18

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F 676	Continued From page 13 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and record view, the facility failed to follow through on a therapy recommended walking program for 1 of 1 resident (R67) reviewed for activities of daily living. Findings Include: During an interview on 2/26/18, at 12:29 p.m. family member (FM)-A stated the facility staff were not walking R67 like they should. FM-A stated staff were to be walking resident in the afternoon and evenings. I think they want him walking to meals. R67's Therapy Communication to Nursing Dated 2/22/18, indicated Patient will ambulate with a front wheeled walker 2-3 times a day with a lower extremity motion assist (LEMA) strap on his right leg. Step by step instructions taped on closet door how to put strap on. R67's nursing assistant documentation for walking in the corridor in electronic point of care was reviewed from 2/22/18 to 2/28/18, and revealed R67 had been walked two times on 2/28/18 since the walking had been implemented on 2/22/18. R67's care plan dated 2/27/18; included resident will ambulate with a front wheeled walker, 2-3 times a day with LEMA strap on right leg. Step by step instructions taped on closet door. LEMA	F 676	F676: Activities of Daily Living (ADL□s)/Maintain Abilities SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " Resident (R67) no longer resides at Rochester East Health Services. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents at Rochester East Health Services have the same potential to be affected by the same deficient practice " Therapy discharge recommendations as of 3/15/18 were implemented as indicated 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nursing Staff were In-serviced on 3/13/18 or 3/14/18, (Exhibit #656-A), related to the Minnesota Health Department findings from the Annual	

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F 676	Continued From page 14 strap is a brace. R67's nursing assistant care guide updated 2/20/18, included patient will ambulate with front wheeled walker 2-3 times a day with LEMA strap on right leg. Step by step instruction taped on closet door. During an interview on 2/28/18, 2:30 p.m. nursing assistant (NA)-C stated she has not been trained to walk with him by therapy. NA-C stated because she has not been trained, "I do not feel comfortable to walk with him." NA-C stated R67 had weakness on one side and there was a strap (LEMA) to wear on his leg to help with walking. NA-C stated she planned to ask his therapist for a demonstration of how to walk with him today. During an interview on 3/1/18, at 1:01 p.m. nursing assistant (NA)-A stated R67 was to be walked between two to three times a day if possible. NA-A stated for me on my shift I am supposed to walk him two times. I walked him to the dining room today and will walk back from lunch. NA-A stated if there was one aide, sometimes things happen and the walking is not done. NA-A stated today I was lucky to get it (walking) done. NA-A stated one half of the time she did not have time to walk him when she was working and stated she worked full times days. NA-A if there were cares she could complete by the end of her shift, she passed that on to the next shift. NA-A stated the unit was staffed with one to two aides depending on the needs of the residents and depending on the census. NA-A stated like anybody I think we could use more staff on the unit. NA-A stated there used to be criteria for staffing on the unit. NA-A stated staffing changed on the abilities of the residents	F 676	Survey that ended on 3/2/18; The need to implement and follow through on Therapy recommendations.; The need to complete rounds and identify any potential Activities of Daily Living care needs. Exhibit # 676-B). " CNA Staff were In-serviced on 3/20/18 or 3/21/18, (Exhibit #656-B), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; the need to report any potential deficits noted for the Residents they care for related to Activities of Daily Living. " A second in-service will be held on 3/28/18 and 3/29/18 related to the findings of F656; The importance of communication and follow thru on Therapy Recommendations; The need to utilize Tasks in PCC and Resident Care Guides to communicate the post Therapy interventions to prevent loss of function; and the facility policy Following Therapy Recommendations. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East related to following therapy discharge recommendations. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit Tag # 676-C)	

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F 676	Continued From page 15 and care needs that are currently on unit, which can go up and down and change continuously. During an interview on 3/1/18, at 4:08 p.m. nursing assistant (NA)-B stated we are supposed to be walking R67 to and from meals. NA-B stated staff document walk in corridor in point of care. NA-B stated if we get busy, R67 will take initiative and he will wheel himself to the dining room. NA-B stated if we catch him at the right moment, we are able to walk to meals. NA-B stated normally when I am here his wife is here and taking the initiative to help him. However, I do offer to walk him to bring him down to the dining room. NA-B stated normally it is just me when I work on first floor and it varies between 8 to 14 residents I might be taking care off. NA-B stated lately most of the resident have been pretty independent, but ability to get cares done can depend the resident's needs. NA-B Stated we try our best but sometimes the walking does not get done like it should. During an interview on 3/1/18, at 2:46 p.m. registered nurse (RN)-A stated he was aware R67 was on a walking program and had seen the therapy communication to nursing form. RN-A stated R67 was supposed to be walked a couple of times a day. RN-A stated the nurse on the floor is to make sure the staff were walking him. RN-A stated the aides were to document under tasks in the computer to make sure the walking was being done. RN-A verified the tasks in the computer indicated R67 had only been walked in the corridor on 2/28/18, since the walking program had been implemented by therapy on 2/22/18. RN-A stated my expectation is that they will walk R67 per the care guide and therapy recommendations. RN-A stated most importantly	F 676	related to follow through on Therapy Recommendations on three residents; 3 times a week for one week; then 2 times a week, for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	

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F 676	Continued From page 16 if it (walking) was not being done they (nursing assistants) need to communicate to the nurse on the floor, why it was not completed. RN-A stated I would expect staff to communicate if they did not have time to complete the task. During an interview on 3/1/18, at 3:39 p.m. the nurse consultant (NC)-B stated she expected R67 is walking program to be followed per the therapy recommendations and stated this should be documented in point of care. A policy was requested for following recommended therapy programs and was not provided.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nail care was provided to 3 of 5 residents (R12, R53, and R5) reviewed for activities of daily living (ADLs) and whom was dependent on staff for care. Findings include: R12's Admission Record identified an original admission date of 5/28/10, and a diagnoses of Alzheimer's disease, major depressive disorder, repeat falls, urinary tract infections, and weakness.	F 677	F677: ADL Care Provided for Dependent Residents SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R5, R12, R53 had nail and oral care on 03/22/2018. " R5, R12, R53□s MD was notified of findings of R1□s Nail and Oral Needs on	3/30/18

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F 677	Continued From page 17 R12's quarterly Minimum Data Set (MDS) an assessment dated 12/14/17, identified R12 to have a severe cognitive deficit and required one person extensive assist with personal hygiene. R12's care plan dated 10/17/11, identified R12 requires staff assist of 1 to do grooming tasks. R12 also often refuses to be washed up. Requested facility bath sheets for the last month regarding R12's information, however a note was received from staff that stated, "Destroyed after review." Facility document CNA (certified nursing assistant) Care Guides dated 2/13/18, identified R12 will get a bath on Monday a.m., and 1 assist with all ADLs. R12's treatment administration record dated 2/1/18-2/28/17, identified weekly bathing every Monday during the am. 2/19/18 and 2/26/18 were not documented as bath given. Document in PCC progress notes. Review of R12's progress notes identified on 1/22/17, at 1:58 p.m., R12 had received her scheduled bed bath with no resistance. R12 did not require nail care at this time. No other progress notes found identified any nail care completed or documented. During observation on 2/26/18, at 7:43 a.m., R12 is sitting by the side of her bed and noted to have soiled, long, untrimmed fingernails. During observation on 2/27/18, at 5:47 p.m., R12 is sitting up to the table in the dining room in her wheelchair eating her supper independently and	F 677	3/22/2018. " R5, R12, R53□s Responsible Party was notified of R1□s Nail and Oral Needs on 3/22/018. " R5, R12, R53□s Care Plan was reviewed and updated on 03/22/2018 related to R1□s Nail and Oral. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Resident at Rochester East Health Services have the same potential to be affected by the same deficient practice. " An audit was conducted on 03/21/2018 to assess Residents at Rochester Health Services East to assess Nail and Oral needs (Exhibit Tag # 677-A). 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nursing Staff were In-serviced on 3/13/18 or 3/14/18, (Exhibit #677-B), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; and proper and timely nail and oral care; and the need to complete rounds on ADL care needs to maintain compliance with Resident ADL care needs. " CNA Staff were In-serviced on 3/20/18 or 3/22/18, (Exhibit #677-C), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; and proper	

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F 677	Continued From page 18 is noted to have long, untrimmed fingernails with brown-looking substance under her fingernails on both hands. During observation and interview on 2/28/18, at 10:02 a.m., R12 is sitting in her wheelchair in her room in front of her window, wearing a gray velour sweat outfit, holding a red heart shaped pillow in her lap, and is noted to have long, untrimmed nails with brown substance underneath all of her fingernails. R12 stated, "My fingernails need to be clipped." During interview on 2/28/18, at 1:55 p.m., nursing assistant (NA)-I verified R12's fingernails are long, with a brown substance underneath them and stated her nail care should have been completed on Monday on her bath day, unless she refuses. If it is refused we tell the nurse and she would document the refusal in the chart. During interview on 2/28/18, at 2:15 p.m., licensed practical nurse (LPN)-C verified R12's fingernails are long, with a brown substance underneath them. Further verified R12's bath was on Monday and nail care should have been completed. R53's Admission Record identified an admission date of 5/10/17, and a diagnoses of Alzheimer's disease, aphasia (loss of ability to understand or express speech, caused by brain damage), after a cerebral infarction, type 2 diabetes mellitus, major depressive disorder, repeated falls, and weakness. R53's quarterly MDS an assessment dated	F 677	and timely nail and oral care; and the need to complete rounds on ADL care needs to maintain compliance with Resident ADL care needs. (Exhibit Tag # 677-C). " Oral Care will be provided daily with AM and PM care and prn for dependent residents. " Nail Care will be provided weekly with shower/bathing care and prn for dependent residents. " A second in-service will be held 3/28/2018 and 3/29/2018 related to the findings of F677; The expectation of Nail care being offered with bathing and prn; The expectation of oral care being offered with am and pm cares and prn; and that if a Resident refuse that staff are to reattempt and document with the effort to be focused on providing quality care as needed and to offer Residents personal preference; and the facility policy on Care of Fingernails/Toenails. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East are receiving appropriate Nail and Oral care for dependent residents. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit # 677-D) related to	

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F 677	Continued From page 19 1/23/18, identified R53 to have a severe cognitive deficit and requires one person extensive assist with personal hygiene. Care plan dated 5/9/17, identified R53 prefers to have a shower daily. Requested facility bath sheets for the last month and received a note stating, "Destroyed after review." Facility document CNA Care Guides dated 2/13/18, identified R12 will get a bath on Monday a.m. and Friday a.m., and 1 assist with all ADL's. R53's treatment administration record dated 2/1/18-2/28/17, identified weekly bathing every Monday and Friday during the a.m. On 2/16/18, not documented as bath given. If refused reproach x 3 and document in computer progress notes. Review of R53's progress notes identified on 1/22/17, at 1:49 p.m., R53 received his scheduled bed bath with minimal resistance. R53 has fingernail and toenail care. R53 has some scattered bruising on upper extremities and a few small scabs. No other progress notes identified any nail care was completed or documented. During observation on 2/26/18, at 8:08 a.m., R53 had been seated in his wheelchair located in the dining room. Fingernails were observed to be long with a brown substance underneath them all. During observation on 2/27/18, at 5:49 p.m., R53 is sitting up to the table in the dining room in his wheelchair eating her supper independently and is noted to have long, untrimmed fingernails with	F 677	nail and oral for 3 residents care; 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	

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F 677	Continued From page 20	F 677		

brown debris under his fingernails on both hands.

During interview on 2/28/18, at 1:43 p.m., nursing assistant (NA)-I Verified R53's fingernails are long with brown debris underneath them and states, "They should be cleaned out, he is diabetic, the nurse should have cleaned and trimmed his nails on Monday with his bath."

During interview on 2/28/18, at 2:04 p.m., licensed practical nurse (LPN)-C verified R53's fingernails are a little long, with a brown substance underneath them. Further verified R53's bath was on Monday, nail care should have been completed by the nurse at that time, and nothing was documented regarding nail care in the progress notes.

R5 was admitted to the facility on 7/25/14, according to his admission record. R5's quarterly Minimum Data Set (MDS) an assessment dated 11/17/18, indicated R5 needed extensive assist of one staff with personal hygiene needs. The brief interview for mental status (BIMS) assessment resulted in a score of 13 indicating R5 was cognitively intact.

R5 had been observed on 2/27/18, at 12:47 p.m., while seated in his wheelchair located in his room. Noted long fingernails on both hands and a brown substance under them.

On 2/28/28, at 9:33 a. m., R5 was observed sitting in his wheelchair in his room, he continued to have long nails with a brown substance under them.

R5's care plan, revised 4/3/17, indicated R5 required assist of one staff for personal hygiene.

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F 677	Continued From page 21 During an interview with R5 on 2/28/18, at 9:33 a.m., in regards to his current nail status, and he stated he preferred his nails short. During an interview with nursing assistant (NA)-E on 2/28/18, at 9:52 a.m., NA-E stated the R5 preferred a bed bath which he received on Mondays. She verified that R5's nails were long and they "definitely could use some attention." She stated they should have been taken care of on Monday. During an interview with registered nurse (RN)-D, it was verified that nail care is to be done on bath days. Bath sheets and progress notes reviewed did not identify any nail care had been performed in the month of February 2018. Facility policy, Care Of Fingernails/Toenails dated 12/2016, indicated, the purpose of this procedure are to clean the nail bed, keep nails trimmed, to prevent injuries and infections. 1. Nail care includes regular cleaning and trimming. 3. Unlicensed staff do not trim the nails of diabetic residents or residents with circulatory impairments. Notify the supervisor if the resident refuses the care.	F 677		
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	F 684		3/30/18

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F 684	Continued From page 22 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement specific parameters for administration of an as needed (PRN) seizure medication for 1 of 1 resident (R67) who was administered a PRN seizure medication. Findings Include: R67's Admission Record identified R67 was admitted to the facility on 1/26/18, with diagnoses of cerebral infarction, and unspecified convulsions. R67's neurology visit summary on 2/6/18, included, "We did tell the patient [R67] and his [family member (FM)-A] that his episodes of staring and unresponsiveness appear to be nonepileptic in nature based on his previous EEG [electroencephalogram] that showed no evidence of a seizure discharge during these, and therefore these are not going to be helped by antiepileptic medications. Probably these are due to cognitive changes related to his previous brain hemorrhage." R67's care plan included, Potential for Alteration in Neurological Status related to: Has a seizure disorder. Interventions included: Administer medication as ordered. After the seizure activity has ceased, monitor/document/report: decreased gag reflex, headache, incontinence, injury, behavior changes, confusion, poor coordination, weakness/paralysis of body parts, sleep disturbance. Allow the resident to sleep after a seizure and reorient upon awakening.	F 684	F684: Quality of Care SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " Resident (R67) no longer resides at Rochester East Health Services. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who reside at Rochester East Health Services who use prn medications have the same potential to be affected by the same deficient practice. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Licensed Nurses and Trained Medication Aides were In-serviced on 3/13/18 or 3/14/18, related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; proper use of PRN medications. (Exhibit Tag # 684-A). " A second in-service will be held 3/27/2018 and 3/28/2018 related to the findings of F684. The monitoring of the	

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F 684	Continued From page 23 R67's physician orders signed 2/27/18, included: Midazolam HCl Solution 5 MG/ML 2 ml in each nostril as needed for seizures Prolonged seizures over 3 minutes or more than 3 seizures in 1 hour. Give 1 ml in each nostril. R67's progress notes and medication administration record revealed the following: "2/24/2018 13:19 [1:19 p.m.] Orders - Administration Note Text: Midazolam HCl Solution 5 MG/ML 2 ml in each nostril as needed for seizures Prolonged seizures over 3 mins [minutes] or more than 3 seizures in 1 hour. Give 1 ml in each nostril." R67's progress note were reviewed for 2/24/18 regarding the as needed medication for seizures was given, and revealed no documentation had been completed regarding the need for the administration of the PRN seizure medication. When the lack of documentation was brought to the facility attention during the survey process, the facility had the nurse add a late entry progress note. The note read, "2/24/18 Late Entry: Note Text: Late Entry: Resident had seizure at the table in dining room at around 1245p. [12:45 p.m.] Writer was in medication room and CNA [certified nursing assistant] reported to writer that resident had a seizure. Writer didn't witness the process of seizure. Resident's tears were falling down when he stared up. When calling his name, resident was able to turn his head and respond to his name. [FM-A] witnessed the whole process. However,[FM-A] was not able to tell how long the seizure lasted. She also requested PRN seizure	F 684	use of PRN medication parameters; Obtaining new or changed Physician Orders during the 24-hr. report; The definition and care of a Seizure. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s Medications are available as per Physician□s Order. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit Tag # 755-B) on three residents who receive PRN medications: 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations.	

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F 684	Continued From page 24 medication Midazolam for resident. Resident continued eating lunch after seizure. Will continue to monitor." However, there was lack of type of seizure R67 had and if staring unresponsive the as needed medication was not to be given according to the notes from the neurologist dated 2/6/18. During an interview on 3/1/18, at 12:15 p.m. nurse consultant (NC)-B stated she expected the nurse to review the visit summary and communicate on the twenty-four hour board any care plan update. NC-B verified she would have expected the information to be shared with facility staff from the neurology visit on 2/6/16, that R67's episodes of staring and unresponsiveness appeared to be nonepileptic in nature based on his previous EEG that showed no evidence of a seizure discharge during these and therefor these are not going to be helped by antiepileptic medications. NC-B stated she would have expected the PRN order to specify parameters of when to administer Midazolam based on R67's symptoms. NC-B stated, "I think the primary thing here is to educate the nurse as to what constitutes a seizure." NC-B stated she would have expected education to be completed regarding R67's seizures after the neurology visit on 2/6/18 and stated education was not completed with facility staff. NC-B stated the nurse should have gotten the information and completed an observation of R67 to determine the need for the PRN seizure medication, when R67's wife reported he was having a seizure in the dining room. NC-B stated the PRN midazolam should not have been administered in hindsight.	F 684	" The facility administrator and/or designee will monitor that the tools are completed.	
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		3/30/18

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F 688	Continued From page 25 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement passive range of motion (PROM) and a palm guard per physician orders for 1 of 1 resident (R23) reviewed who had contractures. As a result, R23 sustained actual harm, a decline in functional range of motion (ROM) to the left wrist. Findings include: LACK OF ROM SERVICES AS ORDERED: R23's Admission Record document identified an admission date of 2/20/12, and diagnoses of left hand contractures (10/3/16), left ankle and foot contractures (10/3/16), and right ankle and foot contractures (9/13/16).	F 688	F-TAG 688: Increase/Prevent Decrease in ROM/Mobility SSD: G 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R23 was assessed on 03/22//2018 for passive range of motion and adaptive equipment needs. " R23□s MD was notified of findings of passive range of motion and adaptive equipment needs. " A Restorative Program was implemented on 03/22/2018 to address	

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F 688	Continued From page 26 An occupational therapy assessment identified in the Functional Limitation Assessment dated 4/18/17, to have R23's left upper extremities (LUE) to have a 1 percent (%)-19% impairment. An occupational therapy assessment identified in the Functional Limitation Assessment dated 3/2/18, to have R23's LUE to have 60% - 79% impairment. A quarterly Minimum Data Set (MDS) assessment dated 12/14/17, identified R23 to be severely cognitively impaired, with limited range of motion (ROM) in bilateral upper and lower extremities, contractures of the left hand and ankle, and contractures of the right ankle. R23's physician Order Review Report, identified an order initiated 7/27/16, included to do passive range of motion PROM to left upper extremity (LUE), focusing on wrist and fingers, per patient tolerance once a day. The 3rd West CNA (certified nursing assistant) Care Guides (contain services/treatments for residents assigned to the nursing assistant) dated 2/13/18, identified R23's Prevalon (heel protector) boots to be applied bilaterally to both lower extremities (LE) when in bed, and ortho booties when up in chair. There was no mention of (PROM) for LUE on the care guide. R23's Restorative Administrative Record (RAR), reviewed from 5/1/17, to 2/28/18, did not have documentation that LUE PROM had been completed as ordered. During an observation in the dining room on 2/26/18, at 8:20 a.m., R23 sat in a reclining	F 688	R1□s Mobility and Transfer Needs. " R23□s Responsible Party was notified of R1□s passive range of motion and adaptive equipment needs. " R23□s Care Plan was reviewed and updated on 03/22/2018 related to R23□s passive range of motion and adaptive equipment needs. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who reside at Rochester East Heath Services have the same potential to be affected by the same deficient practice. " An audit will be completed by 4/1/18 of Residents at Rochester East Health Services with those with contractures. (Exhibit #688-A) 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nursing Staff were In-serviced on 3/13/18 or 3/14/18, (Exhibit #688-B), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18. " CNA Staff were In-serviced on 3/20/18 or 3/22/18, (Exhibit #688-B), related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18. (Exhibit Tag	

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F 688	Continued From page 27 wheelchair with leg extenders. Both feet appeared to point downward and inward, and were resting in blue heel protectors. At 12:59 p.m. R23 was observed to be seated in the reclining wheelchair and leaning forward and to the right. During observation on 2/27/18, at 12:19 p.m., R23 was observed sitting in a reclining wheelchair with her legs extended straight out. Both feet were observed to point downward and inward, and the resident was wearing blue heel protectors. During observation on 2/28/18, at 9:51 a.m., R23 was seated in her reclining wheelchair with a blanket covering her lap, she had the blue heel protector on both feet. At 1:49 p.m. R23 was observed to be lying on her back in bed with her right knee bent. During observation on 3/1/18 at 11:07 a.m., R23 was observed in the dining room seated in her wheelchair. She was observed to have heel protectors on both feet. R23's care plan revised 4/3/17, read, "Patient to use BLE [Bilateral Lower Extremity] orthotics for ankles every day as tolerated and to remove orthotics if patient appears to be in distress/pain from orthotics. Please check skin integrity before and after orthotics are donned/doffed [on/off]. Perform light ROM to each ankle before donning to ensure proper placement of the device so the Achilles and back of calf are all the way back in the orthotic." Goals included: I will maintain my current level of physical functioning as long as possible. Additional interventions included: PROM to LUE focusing on wrists and fingers, per patient	F 688	# 688-C) " Residents live at Rochester East Health Service will be assessed to identify any residents with contracture needs and those who are identified with needs will be care planned to meet those needs by 4/1/18. " A second in-service will be conducted on 3/28/18 and 3/29/2018 related to the findings of F688; Passive Range of Motion and the use and expectation of devices to prevent the development of Contractures (i.e. palm guards, orthotics, and etc.); the facility policy on Restorative Nursing Care. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure that Residents of Rochester Health Services East□s Passive Range of motion program. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit #688-D) to monitor compliance of Passive Range of Motion. With the 3 residents who need passive range of motion; 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance	

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F 688	Continued From page 28 tolerance x 3 sets of 10 reps for 15 minutes. Goal: decrease risk of further contractures in LUE in order to provide comfort and reduce pain, and to ensure skin integrity and reduce risk of skin irritation. During an interview on 2/28/18, at 10:13 a.m. nursing assistant (NA)-F stated they have not had a restorative aide for about a year. At 10:44 a.m., NA-G stated when a resident is started on PROM, therapy would demonstrate how to complete it, and staff had to acknowledge the training. NA-G said this was usually documented in the communication book where staff would find their assignments to do restorative nursing. During an interview on 3/1/18, at 11:12 a.m., NA-H verified she'd gotten R23 out of bed that morning, but had not completed PROM. NA-H stated, "It says on my care plan that she does not get range of motion." During an interview on 3/1/18, at 10:53 a.m., licensed practical nurse (LPN)-C stated, "We have not had a restorative aide for about a year, we train our nursing assistants to do it, like ambulation and range of motion. I am not sure where the aides find the information on who is on restorative, I think it is on their care sheets [care plan sheets for the Na's]." During an interview on 3/1/18, at 11:16 a.m., trained medication aide (TMA)-B stated, "Our aides are not responsible for restorative nursing. The only person we have on this unit for ROM is [a different resident then R23]." During an interview on 3/1/18, at 2:02 p.m., certified occupational therapy aide (COTA)-D	F 688	review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	

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F 688	Continued From page 29	F 688		

verified R23 had been discharged from occupational therapy (OT) with a restorative program on 4/18/17.

During interview on 3/2/18, at 10:01 a.m., LPN-C verified R23 had not been getting PROM since April of 2017, because although the order got put in restorative, it was not on the treatment administration record (TAR) or on the CNA care sheet. LPN-C stated, "My expectation is to have passive range of motion done daily as ordered."

During an interview with COTA-D on 3/2/18, at 10:52 a.m., she said that the purpose of R23's PROM program was to prevent worsening of contractures and to prevent a decrease in the mobility of her left hand.

During an interview on 3/2/18, at 11:48 a.m. Physical Therapy Assistant (PTA)-A verified the PT (physical therapy) Discharge Summary dated 9/21/16, identified bilateral lower extremity (BLE) ROM continued to be limited, limiting patient's participation in mobility. PTA-A also verified there was no restorative program put in place to maintain lower extremity range of motion.

During an interview on 3/2/18, at 12:08 p.m., Licensed practical nurse (LPN)-C stated R23 did not currently have a range of motion program in place for her lower extremities.

The Occupational Therapy (OT) Plan of Care dated 3/2/18, included for R23 "now presents with a decline in functional ROM of L [left] wrist, metacarpophalangeal joints, proximal interphalangeal joints and the distal interphalangeal joints. The caregiver started noticing a decrease in ROM approximately two

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ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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weeks ago, they also report inconsistent use of palm guard, which has since resulted in the patient now requiring significantly more assistance for hygiene and joint mobility. Due to medical complexity, this patient will require skilled OT to assess appropriate and effective ROM program, educate caregiver on skin integrity, hygiene, wearing schedule of soft brace."

LACK OF CONSISTENT USE OF ORDERED LEFT PALM GUARD:
Doctors order dated 7/26/17, for R23 to wear a left palm guard in the morning following morning cares and hygiene; Remove after 4 hours and check for redness and irritation; Replace after 2 hours off, for 4 hours two times a day for palm guard, wear 4 hours two times a day.

A Therapy Communication note to nursing dated 4/7/17, identified recommendations for the resident to wear left palm guard during the day, off at night, to complete hygiene and range of motion, and stretching fingers out straight when taking palm guard on and off.

The 3rd West CNA (certified nursing assistant) Care Guides (contain services/treatments for residents assigned to the nursing assistant) dated 2/13/18, identified R23's to need a rolled wash cloth in left hand, palm guard on right.

During an observation in the dining room on 2/26/18, at 8:20 a.m., R23 sat in a reclining wheelchair with a palm protector in place on her left hand.

During observation on 2/27/18, at 12:19 p.m., R23 was observed sitting in a reclining wheelchair with no palm protector in her left hand.

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During observation on 2/28/18, at 9:51 a.m., R23 was seated in her reclining wheelchair with no left hand palm protector in place. At 1:49 p.m. R23 was observed to be lying on her back in bed with no palm guard on her left hand.

During observation on 3/1/18, at 11:07 a.m., R23 was observed in the dining room seated in her wheelchair. She was observed to have the left palm guard on with her fingers curled around it. When R23 was asked whether she could open her left hand, R23 was unable to do so.

R23's care plan revised 4/3/17, identified a focus area of contractures of hands, and need for wash cloth rolled in left hand and palm protector in right hand.

During an interview on 3/1/18, at 2:02 p.m., certified occupational therapy aide (COTA)-D verified R23 had been discharged from occupational therapy (OT) with a restorative program on 4/18/17, and to wear a left palm guard during the day and off at night.

The Occupational Therapy (OT) Plan of Care dated 3/2/18, identified R23 had a previous order to left palm guard to promote skin integrity and comfort. The plan indicated R23 " ...The caregiver started noticing a decrease in ROM approximately two weeks ago, they also report inconsistent use of palm guard, which has since resulted in the patient now requiring significantly more assistance for hygiene and joint mobility. Due to medical complexity, this patient will require skilled OT to assess appropriate and effective ROM program, educate caregiver on skin integrity, hygiene, wearing schedule of soft

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F 688	Continued From page 32 brace." The facility's policy Restorative Nursing Care dated 12/2016, included: "restorative nursing care is that which does not require the use of a qualified professional therapist to render such care. Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care plan. The facility's restorative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. Restorative nursing is provided daily for those residents who require such a service. Program includes assisting residents with their routine range of motion exercises."	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement, monitor and/or revise interventions to ensure efficacy for 3 of 3 residents (R54, R40 and R53) reviewed for accidents. This resulted in harm for R54 who sustained a fractured hip during a fall on 1/12/18.	F 689	F689: Free of Accident Hazards/Supervision/Devices SS: G 1. Corrective action(s) will be accomplished for those residents found to	3/30/18

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F 689	Continued From page 33 Findings include: R54's admission Minimum Data Set (MDS) assessment indicated R54 had been admitted to the facility 2/20/17, from the hospital after a fall with injury sustained in a different facility. In addition, the MDS indicated R54 had diagnoses including hypertension and diabetes. R54's quarterly MDS assessment dated 11/21/17, indicated R54 had experienced a fall with injury and needed extensive assistance of one staff member for bed mobility, and extensive assistance for transfers with two staff. The quarterly MDS also indicated a Brief Interview for Mental Status (BIMS) interview was attempted but the resident was unable to complete, so staff interview had been completed which identified R54 had long and short term memory loss. R54's significant change MDS assessment dated 1/23/18, indicated R54 had no previous falls (inaccurate coding), and required extensive assistance of two staff members for bed mobility and transfers. R54's progress notes were reviewed from 11/2017 to 2/28/18, and contained information in a situation, background, assessment/appearance and recommendation (SBAR's) format of the following falls: 11/3/17, R54 had a fall from bed with no injuries or bruises. Resident was found on the floor of her room laying down on her side. no injuries. Resident was assessed and no injuries found or bruises. Vital signs checked and was within normal, denies pain. Recommendations: will communicate with morning nurse to monitor,	F 689	have been affected by the deficient practice? " R40 is not at the facility at this time. She will be reassessed upon return to the facility. " R54 and R53 was assessed on 03/22/2018 related to his/her 03/22/2018 and his/her care plan has been updated with Fall prevention intervention implemented at the time of the Fall. " R54 and R53 MD was notified of findings of Fall history, risk, and current Fall Care Plan Interventions. " R54 and R53 Responsible Party was notified of Fall history, risk, and current Fall Care Plan Interventions. " R54 and R53□s Care Plan was reviewed and updated on 03/22/2018 related to Fall prevention intervention implemented at the time of the Fall. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who reside at Rochester East Health Services have the same potential to be affected by the same deficient practice. " An audit of Resident□s Fall Risk will be completed on 3/26/2018, and their care plans reviewed and updated 4/1/18. (Exhibit #689-A). 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does	

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F 689	Continued From page 34 Reminded resident to use the call light and don't get up by herself. Family notified. 11/17/17, R54 had been found on floor of her room, close to her roommate's bed. Resident stated she was trying to close the door of her room. Resident stated her right leg and head hurt. A small scrape was noticed on her coccyx. No other injuries noted. Resident had been confused all day. Resident was helped off the floor. Director of nursing, nurse practitioner, clinical manager, and family member were notified. Educated patient. Recommendations: (none were documented for this fall). Possible contributing factor for falls dated 11/21/17, Continuous low blood pressure readings. Resident with history of HTN (hypertension) and CHF (congested heart failure). Assessment (RN [registered nurse])/Appearance LPN [licensed practical nurse]): Lethargic, dizziness with position changes. Assessment: Resident continues to have blood pressure readings on AM shift ranging from systolic (highest reading) of 90 to 110. Response: Metoprolol (to lower blood pressure) being held at this time, request for provider review of necessity of medication. Blood pressure and pulse readings printed for provider review. Recommendations: "See above." 11/21/17, progress notes indicated the certified nurse practitioner (CNP) had visited R54 with a plan to stop torsemide (a diuretic used to lower blood pressure) and for staff to monitor blood pressure. The report also indicated the CNP had been updated on R54's prior falls. Possibly related to the 11/17/17, fall, resident complaining of right hip and leg pain, increased with weight bearing. Recommendations: Request for in house	F 689	not recur? " Nursing Staff were In-serviced on 3/13/18 or 3/14/18 (Exhibit #689-B) related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; Falls; and Fall prevention. " CNA Staff were In-serviced on 3/20/18 or 3/22/18 (Exhibit #689-C) related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; Falls; and Fall prevention. " Risk Management tab in Point Click Care will be used to ensure proper tracking/investigation, documentation, care plan update, Provider notification, and interventions are completed. " A second In-service will be conducted on 3/28/18 and 3/29/2018 related to the findings of F689; Assessment, Investigation, Immediate Intervention, and the facilities policy Prevention and Management Guidelines. " The IDT team will convene post fall during the week to oversee process. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents who reside at Rochester Health Care Services are assessed post fall and a fall intervention is implemented and care planned.	

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F 689	Continued From page 35 X-ray of right hip to rule out fracture from recent fall. On 11/28/17, the CNP visited R54 regarding leg/hip pain and ordered X-ray to rule out fracture. The limited evaluation clinical document included, X-ray results noted an addendum to report which revealed a possible fracture and will need a computerized tomography (CT) scan to confirm diagnosis of pelvic fracture. Sent to hospital on 11/29/17, had CT scan and report confirmed a right pubic bone (hip) fracture. A facility report initiated (FRI) an incident reported on 11/29/17, by the director of nursing in regards to the 11/17/17 incident with confirmed fracture of hip (11/29/17) to the Office of Facility Complaints (OHFC). The complaint registration form included the following information: "Description, A resident ([R54]) sustained a pelvic fracture identified on 11/27/2017 that the facility attributes to a fall that occurred on 11/17/2017. The facility assessment(s) did not identify the sign and symptoms of pelvic fracture." "Emergency Room for Outpatient CT scan. Results returned 11/29/17 showing pelvic fracture. Review of medications completed by consultant pharmacist. No recommended changes at this time. Falls Committee reviewed falls on 11/5/17. With fall on 11/3/17, resident fell while trying to self transfer out of bed but her feet slipped on the floor. Non-skid strips were added to the floor next to her bed. Falls committee reviewed falls again on 11/21/17 - resident said she was trying to get up to close her door. Sign is posted outside her room that her door is closed per her request at night. PT/OT to evaluate and treat as appropriate. Review of care plan completed with addition of the above changes added." Under description of harm it reads, "resident with pelvic fracture presumed from fall	F 689	" The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit Tag #689-D) on management of the Fall Prevention program 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	

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F 689	Continued From page 36 11/17/17." The facility sent an Investigation status to OHFC on 12/6/17, in regards to the incident reported on 11/29/17. The information contained the following: "[R54] has been a resident at the facility since 7/10/17. Her primary diagnoses are: malaise, type II diabetes, rheumatoid arthritis, chromic atria fibrillation, mild congestive impairment, and metastatic breast cancer. Last BIMS score was 10 on 10/9/17. Fall history includes: 11/3/17 @ 0527 [5:27 a.m.] with no injury, and 11/17/17 @ 2000 [8:00 p.m.] with pain in right hip at time of injury but then back to baseline on subsequent checks. Resident pain is monitored daily and she receives scheduled acetaminophen for pain from arthritis. On 11/27/17 resident had increased pain in right hip, especially with weight bearing or movement. SBAR completed and reviewed by nurse practitioner, x-ray ordered . Results recommended additional imaging for conclusive diagnosis. On 11/28/17 approval obtained from POA [power of attorney] to send resident for CT scan. Resident sent to St. Mary's Emergency Room for outpatient CT scan. Results returned 11/29/17 showing a pelvic fracture. Review of medications completed by consultant pharmacist. No recommended changes at this time. Falls Committee reviewed falls on 11/5/17. With fall on 11/3/17 resident fell while trying to self transfer out of bed but her feet slipped on the floor. Non-skid strips were added to the floor next to her bed. Falls committee reviewed falls again on 11/21/17 - resident said she was trying to get up to close her door. Sign is posted outside her room that her door is closed per her request at night. PT/OT to evaluate and treat as appropriate. Review of care plan completed with addition of the above changes added." Under description of	F 689		

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harm it reads, "resident with pelvic fracture presumed from fall 11/17/17."

1/12/18, R54 sustained another fall documentation included in the progress notes the SBAR format included: Fell to floor in resident room, pain all over sent in to emergency room and was admitted due to a hip fracture.

A facility reporting incident was submitted to the Office of Health Complaint (OHFC) on 1/15/18, regarding the fall with fracture incident on 1/12/18. The description of incident read, "Resident self transferred from her bed saying 'I heard [a persons first name] snoring.' on floor next to bed. Able to move all extremities. Pain increased during night while monitoring so resident sent to ER [emergency room] Saturday morning for further evaluation. Diagnosed with UTI [urinary tract infections] and encephalopathy [abnormal brain function] from the UTI. Now diagnoses with left pelvic rami fracture. Car plan being followed at time of fall. Plan is conservative management/pain management." Also included the incident was reviewed by pharmacist with no changes, fall committee review fall on 11/5/17 and 11/3/17, resident fell while trying to self transfer out of bed but her feet slipped on floor. Non-skid strips were added to the floor next to her bed. Also reviewed all form 11/21/17 and resident said she was trying to get up to close her door. No falls since 11/21/17 until 1/12/18. Care plan completed, review of room placement completed.

Mayo Rochester Emergency Department record dated 1/13/18, included under nursing assessment: Extremity Lower, Patient had a fall at 10:30 p.m. last evening unwitnessed at

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Rochester Health services East skilled nursing facility (SNF), states she had her slippers on and did hit her head. Under the History of present illness, it read, "[R54] was hospitalized January 13 through January 16, 2018 following a fall. CT scan demonstrated acute left superior and inferior pubic rami fractures, subacute right superior an inferior pubic rami fractures, and the chronic L2 vertebral body fracture. She was admitted for pain management..."

During observations of R54 in her room on 2/26/18, at 8:28 a.m., 2/27/18, at 12:16 p.m. and on 2/27/18, 4:08 p.m. there were no non-skid strips on floor next to her bed. The sign on door read to keep door "open" at night even though the fall intervention following the 11/27/17, incident directed the sign to say "closed."

Interview with registered nurse (RN)-D on 3/1/18 at 1:35 p.m. regarding the falls interventions of non-skid strips in front of R54's bed following the fall on 11/17/17, RN-D observed no non-skid strips next to R54's bed. At 1:45 p.m. following the interview with RN-D of no non-skid strips on R54's floor. Maintenance-A was observed to have placed non-skid strips on the floor in front of R54's bed.

R54's care plan with a focus of "Resident is at risk of falls r/t [related/to] History of falls, Pain." "Date initiated: 12/06/2017" included interventions of "Anticipate and meet the Resident's needs. Encourage the Resident to always call for assistance." "Call light in reach." "Defined parameter Mattress -(scooped side)." "Review information on past falls and attempt to determine cause of falls for prevention and to minimize injuries." Also added to care plan on

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3/1/18 after surveyor queried the use of safety strips "Zip/non-skip strips on floor at bedside."

Record review and interview with therapy on 3/1/18, at 4:23 p.m. physical therapy assistant (PTA)-G verified R54 last evaluated in October of 2017, and none since then.

Interview on 3/1/18, at 3:57 p.m. with nursing assistance (NA)-D stated R54 is a fall risk and receives fall risk interventions from the nurse. NA-D states they use routine interventions like gait belt. Clinical manager will update with new interventions. On review of the NA's care sheet (has information specific to resident cares/treatments) showed only use of gait belt and no other interventions to prevent falls.

Interview on 3/1/18, at 4:00 p.m. with licensed practical nurse (LPN)-A stated R54 is a fall risk, intervention would double check bed in low position, call light in reach. LPN-A stated would review care plan and proceeded to check the electronic care plan for R54. LPN-A said nurses always complete a SBAR and notify family, CNP, nurse manager and can put intervention in place after fall. Neuros completed on any fall unwitnessed or when a resident hits their head. LPN-A also added they start a post fall assessment and the report is very self-explanatory and is on the computer. The facility started a review of falls called a trip form.

Interview on 3/1/18, at 2:06 p.m. with CNP-F stated they are update with a SBAR notes but does not always include an update. CNP-F stated according to R54's note on 11/28/17, she had not been updated on the 11/3/17, and 11/17/17, falls until the hypotension episode on

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11/21/17. CNP-F's document dated 11/28/17, notes that there had not been a request for provider to evaluate.

Interview on 3/1/18, at 1:40 p.m. registered nurse consultants (RNC)-B, H, & J and Administrator were asked what the policy/procedure following a fall. This included investigation, assessment, develop interventions following each fall for R54. At 1:47 p.m. interview with administrator regarding further information regarding R54's falls. Administrator had post falls assessment completed after return from hospital emergency room with diagnosis of hip fracture dated 11/29/17 had not been added to R54's care plan or care sheets. Administrator was not aware the post falls interventions to prevent further falls had not been documented at time of post fall assessment until surveyor brought it to his attention. Administrator also said the safety strips are now in place for R54. Administrator verified the current policy/procedure had not been followed regarding R54's falls.

Follow up interviews with RNC-B on 3/1/18, at 3:31 p.m. regarding the requested information regarding the falls for the last four months. RNC-B said there was no more information found.

On 3/2/18, at 11:41 p.m. RNC-H verified the facility continued to look through charts and files and was not able to identify any of the facilities paper work or additional investigation paper work on R54 falls.
R40's current diagnoses according to the Diagnosis Report, dated 3/5/18, included Parkinson's disease, cerebral infarction, muscle weakness, delusional disorder, anxiety, and

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major depressive disorder.

R40's annual Minimum Data Set (MDS) an assessment dated 1/6/18, indicated severe cognitive impairment, extensive assistance of two persons for transfers and extensive assist of 1 person for ambulation and toileting, and two or more falls since the prior assessment.

During observation on 2/26/18, at 12:57 p.m., R40 is sitting in her wheelchair and propelling self out of the dining room while singing, "What a friend we have in Jesus."

During observation on 2/27/18, at 11:59 a.m., R40 is sitting in her wheelchair, wheeling self-down the hall away from the secured exit.

R40's care plan, last reviewed 1/2/18, indicated R40 was at risk for injury due to falls, history of falls. The goal listed was: resident will remain safe and injuries from falls will be minimized through her next review. Approaches included:
(1) attending staff listen for R40 in the am and assist with transfer out of bed as soon as possible,
(2) encourage resident to rest in the dining area/recliner room mid-day,
(3) grab bar to be installed on wall next to bathroom in residents room,
(4) offer to rest resident in the recliner chair with inconsolable yelling, agitation. [R40] is able to demonstrate placing foot rest up and down independently in recliner,
(5) reinitiate 3 day bowel and bladder diary as/when indicated,
(6) staff to stay with resident after assisting onto toilet until after successful transfer off toilet,
(7) toilet schedule before meals and at bedtime.

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3/6/17: also toilet at midnight,
(8) turn on Facility Channel music for resident to listen to when more anxious,
(9) when resident is especially anxious, encourage resident to wear sweaters/warmer clothing rather than blankets when in bed, and
(10) PT to evaluate and treat per increased difficulties with balance.

A Fall Risk Assessment was requested for R40 and was not received.

R40's Incident Reports, Post fall Assessments and Emergency Record revealed the following from 9/21/17 to 2/18/18, revealed the following:

9/21/17, at 2:40 p.m., R40 was heard screaming and was found lying on the floor in her room, stated that her right elbow hurt, no evidence of injury. Predisposing factors: impaired memory, transferring self, ambulating without assist. Interventions to prevent further falls: reeducation to resident. Care plan not updated.

Emergency department record dated 9/22/17, at 3:43 a.m., revealed, R40 presents after a fall from standing. This occurred earlier in the evening of 9/21/17. R40 denies any head trauma but reports hitting her right arm with the fall. R40 has a right upper arm laceration that will require repair with sutures. R40's CT scan showed fracture of the 9th and 10th ribs. Discharged back to the nursing home. Nursing assessment indicated, R40 had a fall 13 hours ago while trying to get up to the bathroom herself. R40 sustained bruising and a 5 centimeter laceration to right upper arm. Tenderness noted over the ribs on the right side.

There were falls recorded on 10/10/17, 10/20/17,

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10/21/17, 10/21/17, 10/22/17, 11/8/17, 11/11/17, 11/13/18, 11/15/17, 11/18/17, 11/24/17, 11/21/17, 1/21/18, 1/26/18, 1/29/18, 1/30/18, and 2/18/18. The falls were related to toileting needs, getting tangled in blankets, attempting to get out of bed alone, left alone on toilet, and transferring from bed to her wheelchair. Many falls lacked interventions developed after fall and the care plan had not been updated.

During interview on 3/2/18, at 12:11 p.m., (LPN)-C stated R40 was moved to this secured unit on 1/17/17 after her last stroke and has had several falls over the last year. I have not always completed a post fall assessment after each fall. The floor staff should be identifying an immediate intervention after each fall and they have not been doing that. Further stated there is not always a new intervention added to the care plan. "I got behind in November, 2017, we had 48 falls on this secured unit. I told the director of nursing that I was behind." LPN-C verified R40's fall on 9/21/17, was not properly assessed, and she did end up in the emergency room, ER 13 hours later with a laceration to her right upper arm and 2 fractured ribs. The fractured ribs and the sutures on her right upper arm were not documented in the progress notes. "We did do a root cause analysis in the interdisciplinary team, (IDT) meetings, but the interventions were not always implemented timely."

Interview on 3/2/18, at 12:41 p.m., registered nurse (RN)-E stated the fall system has not been followed, incident reports and post fall assessments are not always being filled out, and interventions are not always put in place or being implemented. "My expectation is that when a fall occurs, an assessment should be done timely to

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determine the cause of the fall, appropriate interventions need to be put in place immediately, and the falls need to be reviewed at a later date to determine their effectiveness." RN-E further stated there should be thorough documentation of falls in the medical record, with an injury to include monitoring, treatment, and reporting to appropriate delegations.

R53 was admitted to the facility on 4/29/17 according to the admission form. The electronic medical record (EMR) identified diagnoses of Alzheimer's disease, aphasia (unable to speak), stroke, muscle weakness, abnormal gait (balance), and repeated falls.

R53's quarterly Minimum Data Set (MDS) an assessment dated 1/28/18, identified R53 as having severe cognitive impairment, requiring extensive assist of one with walking, and unsteady only stabilizing with human assistance.

During an observation on 3/2/18, at 12:42 p.m. R53's wheelchair was sitting empty in the hallway and R53 was walking down the hall slowly, holding the attached railing. His knees are slightly bent and he is unsteady. No staff was present or in view of R53.

During an interview with licence practical nurse (LPN)-K on 3/1/18 at 2:10 p.m., regarding R53's falls from 10/2017 to 2/2018, LPN-K reviewed examples of revised fall interventions in place and included, keep in the dining room during meals, encourage fluids, monitor for urinary tract infection, alternate choices for snacks, and more frequent toileting. LPN-K verified that none of the interventions were on the care plan or the nursing assistant (NA) care sheet and that the staff would

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F 689	Continued From page 45 not know to follow the revised interventions. LPN-K stated she updated care plans sporadically when she can find the time. A facility policy dated 12/16 "Care Plans-Comprehensive" identified that assessment of residents is ongoing and care plans are revised as information about the resident and the resident's condition change. Facility policy, Fall Prevention and Management Guidelines, dated 2/2017, indicated the facility will maintain a fall prevention and management program. In as much as it is in the power of the facility, the facility will prevent and /or manage the residents risk for falls. The elderly are at an increased risk for falls related to several different factors. The facility will implement a fall program for residents determined to be at risk for falls in order to better manage these factors and prevent and/or manage as much as possible the resident from falling and/or sustaining injuries related to falling.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		3/30/18

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F 755	Continued From page 46 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available to be administered as prescribed by the physician, for 1 of 1 resident (R67) who was prescribed critical time sensitive medications. Findings Include: R67's Admission Record identified R67 was admitted to the facility on 1/26/18, with diagnoses of cerebral infarction, and unspecified convulsions. R67's physician orders signed 2/27/18, included: Zonisamide Capsule 100 MG Give 2 capsule by mouth in the evening for seizures, Zonisamide Capsule 100 MG Give 1 capsule by mouth in the morning for seizures and LamoTRIgine Tablet	F 755	F755: Pharmacy Scvs/Procedures/Pharmacist/Records SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " Resident (R67) no longer resides at Rochester East Health Services. 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who reside at Rochester	

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F 755	Continued From page 47 100 MG Give 1.5 tablet by mouth two times a day related to UNSPECIFIED CONVULSIONS. R67's progress notes and medication administration record revealed the following missed seizure medication doses: "2/11/2018 22:57 [10:57 p.m.] Orders - Administration Note Note Text: Zonisamide Capsule 100 MG Give 2 capsule by mouth in the evening for seizures run out of medication. Pharmacy called and meds will be deliver tonight" "2/12/2018 09:28 [9:28 a.m.] Orders - Administration Note Note Text: Zonisamide Capsule 100 MG Give 1 capsule by mouth in the morning for seizures. This medication is unavailable. Was not sent from pharmacy. Did attempt to contact pharmacy, but phone calls were not answered. Spoke with CM [clinical manger] and he will call pharmacy" "2/14/2018 18:28 [6:28 p.m.] Orders - Administration Note Note Text: LamoTRIgine Tablet 100 MG Give 1.5 tablet by mouth two times a day related to UNSPECIFIED CONVULSIONS [R56] Pharmacy is delivering this medication later during the night." "2/22/2018 08:53 [8:53 a.m.] Orders - Administration Note Note Text: LamoTRIgine Tablet 100 MG Give 1.5 tablet by mouth in the morning related to UNSPECIFIED CONVULSIONS (R56) medication not available, reordered today." R67's progress notes were reviewed and there was no documentation in regards to the physician having been notified of the missed seizure	F 755	East Health Services have the same potential to be affected by the same deficient practice. " An audit was conducted on 03/22/2018 to assess Residents at Rochester Health Service. Resident who have seizure Medications will have them monitored for availability. (Exhibit #755-A). 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Licensed Nurses and Trained Medical Assistants were In-serviced on 3/13/18 or 3/14/18 (Exhibit #755-B) related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; Missed Medications; and actions required in the event a medication is not available. " Unit Managers will make daily rounds to identify any potentially medication conflict. " A second In-service will be conducted on 3/28/18 and 3/29/18 related to the findings of F755; Missed Medications; and actions required in the event a medication is not available. " 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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F 755	Continued From page 48 medication to receive direction on what should be done for R67 for monitoring or follow-up related to the missed critical seizure medications. R67's medication error reports were requested for the missed doses of seizure medications and revealed medication error reports had not been completed for the missed doses of seizure medication. R67's care plan included, Potential for Alteration in Neurological Status related to: Has a seizure disorder. Interventions included: Administer medication as ordered. During an interview on 2/28/18, at 11:56 AM with the nurse consultant (NC)-B and director of nurses (DON), the DON stated she expected medications that are ordered to be here and available to be administered to the residents. The DON stated when a medication was not available to be administered, we start by calling the pharmacy to determine if it (the medication) was in the automated dispensing unit (ADU) machine in the facility and if it is there, we have the pharmacy release it. If the medication was not available in the ADU we would determine when it was scheduled for delivery. If the medication was not planned to be in the delivery or if some reason cannot be delivered the staff are to use the local back up pharmacy. If the medication that was not available was a critical medication and the facility did not have it, they would notify a provider to inform them the medication was not available and for direction on what the facility should do. The DON and NC-B both stated seizure medications were critical medications. The DON stated they (R67) needed to receive the seizure medication as ordered to maintain the	F 755	" The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s Medications are available as per Physician□s Order. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit Tag # 755-C). Residents with prescription seizure medication will be monitored for medication availability; 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	

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appropriate blood levels to prevent seizures. Both the DON and NC-B verified the missed doses of seizure medications on the MAR. The DON stated she was not aware of R67 had missed doses of seizure medication and stated medication error reports were not turned into her. The DON stated medication error reports should have been completed for these missed doses. The DON stated the physician should have been made aware of the missed doses of seizure medications and stated she expected a progress note to have been completed by the nurse.

During an interview on 2/28/18, at 12:31 p.m. registered nurse (RN)-C stated if I see the medication is not in the cart, I would call the pharmacy to see if the medication was not dispensed and if there was an issue dispensing the medication for the ADU. I would review the chart to see if the medication was still a current order. RN-C stated I would call the pharmacy back and ask if the medication was from the ADU or from a card. I would ask them to dispense the medication from the ADU or if it comes from the cart would ask them to stat the medication, which gives us a four-hour window. RN-C stated if it a critical medication would look in the ekit (emergency medication kit) to see if it is in there. If it were a critical medication like a seizure medication, I would ask the pharmacy to have a backup pharmacy send it to us. If we have a medication that was not available, I would contact the physician to let them know they have missed this medication and ask them what they would like us to do. RN-C stated she would fill out a medication error report on a critical medication and stated seizure medications were critical medications. RN-C stated if a resident had a scheduled medication that was given to prevent

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seizures and if they do not receive that medication there is the possibility the resident will have seizures.

During an interview on 2/28/18, at 3:23 p.m. registered nurse (RN)-B stated she would check the e-kit and call our pharmacy and have them deliver the medication if it was not available. RN-B stated I would talk to my clinical manager and see if I could get that medication in town from a different pharmacy. RN-B stated she was not sure if the facility had a backup pharmacy. RN-B stated she would check to see if the facility had a backup pharmacy and would let this writer know. RN-B stated I would try all options to get the medication so it would be available and if I was not able to get it (the medication) it would be medication error. RN-B stated it was really important to give seizure medications on time as a resident could have a seizure if they did not get them. RN-B stated we could call the doctor on call to get direction to see if they have another solution.

During an interview on 2/28/18, at 4:27 p.m. registered nurse (RN)-B stated we are able to use any pharmacy in town as our backup pharmacy.

During an interview on 2/28/18, at 12:41 p.m. nurse practitioner (NP)-A stated if R67 did not receive his seizure medication as ordered he is at risk of having a seizure. NP-A stated she was unaware of R67's missed doses of seizure medication and stated she should have been made aware of this. NP-A stated as soon as they (facility staff) missed a dose they should have called the provider and notified them of the medication error, as they (the missed doses) could have adverse side effects, the provider

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F 755	Continued From page 51 would keep closer eye on the patient and follow up on the resident's condition. The Unavailable Medications policy dated 6/15, included, " ...The facility must make every effort to ensure that medications are available to meet the needs of each resident ..." The Medication Errors and Drug Reactions policy undated, included, "All medication errors and drug reactions must be promptly reported to the Director of Nursing, attending physician and the pharmacist."	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		3/30/18

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 53 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a complete medical record to include an admission note and a comprehensive plan of care for 1 of 1 resident (R96) reviewed for discharge. Findings include: R96's Admission Record document dated 10/27/17, identified an admit date of 10/27/17, with diagnoses of acute on chronic combined systolic and diastolic heart failure, edema, malignant neoplasm of the bone, lung and breast, and muscle weakness. On asking for R96's comprehensive care plan it was learned that there had not been one completed following admission and the one provided to the surveyor was dated 3/1/18. R96's discharge date was 12/4/18, according to progress notes. Review of R96's progress notes from admission of 10/27/17 to 12/4/17 had not included an admission note regarding resident needs and cares that need to be met before the comprehensive assessments and comprehensive care plan is completed. R96's progress note dated 12/4/17, identified R96 was discharged back to home. Interview on 3/1/18, at 12:06 p.m., with registered nurse (RN)-E stated, "I would have expected there to be an admission note," and verified there had not been an admission note which should contain why R96 was in the facility based on progress notes of her medical record. Further verified R96 should have had a comprehensive care plan developed to address functional rehab	F 842	F842: Resident Records □ Identifiable Information SS: D 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R96 no longer resides at Rochester East Health Services 2. How will you identify other residents having the potential to be affected by the same deficient practice? " Residents who reside at Rochester East Health Services had the same potential to be affected by the same deficient practice. " An audit was conducted on 03/13/2018 to assess Residents at Rochester Health Services East who have been admitted in the last 7 days to current have admission note and initial care plan within 48 hours. (Exhibit Tag # 842-A) 3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Nursing staff and unit manager, will	

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	245184	A. BUILDING _____ B. WING _____	C 03/02/2018

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ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 842	Continued From page 54 potential, incontinence, falls, and pressure ulcers. RN-E stated, "Based on the information in the chart and medical record I do not have a clear picture of why [R96] was here." Facility policy Admission Notes, dated 12/2016, revealed when a resident is admitted to the nursing unit, the admitting nurse must document the following information (as each may apply) in the nurse's notes, admission form, or other appropriate place, as designated by facility protocol: a. the date and the time of the residents admission, b. the residents sex, age, race and marital status, c. from where the resident was admitted, d. reason for the admission, e. the admitting diagnosis, f. the general condition of the resident upon admission: head to toe assessment and a skin assessment, g. the time the attending physician was notified of the residents admission, h. the time the physicians orders were received and verified, i. description of any lab work completed or the time the specimens were sent to the lab, j. the presence of catheters, dressings etc.., k. the time the dietary department was notified of the diet order, l. the time the medications were ordered from the pharmacy, m. a brief description of any disabilities (i.e. blind, deaf, hemiplegia, speech impairment, paralysis, mobility etc.), n. any known allergies, o. prosthesis required (glasses, dentures, hearing aide, artificial limbs, eye etc.), p. the height and the weight of the resident, q. a statement indicating that the nursing history and preliminary assessment is completed and has been started, r. notation of any signs or symptoms of an infectious or communicable disease, s. notation as to whether or not advance directives apply, t. signature and title of the person recording the data.	F 842	ensure all the completion of the admission checklist which now contains an admission note and initial care plan. " Licensed Nurses and Trained Medical Assistants were In-serviced on 3/13/18 or 3/14/18 related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18 (Exhibit # 842-B); and actions required for completion of the admission. " A second in-service will be conducted on 03/28/18 and 3/29/2018 related to the findings of F842; completion of an admission note and comprehensive care plan; the revised Admission . 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure Residents of Rochester Health Services East□s are on Admission, implementing the Initial Care Plan followed by completion of the Comprehensive Care Plan. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit # 842-C) on new Admission/Readmissions 3 times a week for one week; then 2 times a week for one week, and then weekly for two weeks. " Additional training may be scheduled based on results of the quality assurance review.	

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F 842	Continued From page 55	F 842	" As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations. compliance with facility policy and state and federal regulations. " The facility administrator and/or designee will monitor that the tools are completed.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		3/30/18

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F 880	Continued From page 56 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 57 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, including signs/symptoms of infections to prevent the spread of communicable disease and infections. In addition, the facility failed to implement water testing to reduce the risk of a Legionella (a bacterium) in the facility water system to prevent cases and outbreaks of Legionnaires' disease (a serious type of pneumonia). This deficient practice had the potential to affect all 91 residents who resided in the facility, staff and visitors. Findings Include: Review of the monthly infection control tracking and trending from 4/2017 through 2/2018, revealed the facility had no documentation that they had analyzed data or identified trends to determine corrective action to prevent the spread of the infections for January 2018 or February 2018. The facility was unable to provide any further logs or tracking tools for infections in the facility and was unable to provide documentation that they had tracked infections for January 2018 or	F 880	F880: Infection Prevention & Control SS: F 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " The facilities Infection Control Logs have been returned to current status as of 3/1/18. " The facilities H2O testing program for Legionnaires programs was completed as of 3/26/2018 " 2. How will you identify other residents having the potential to be affected by the same deficient practice? " An audit was conducted on 03/01/2018 to assess completion of Infection Control Log is in place and current. (Exhibit #880-A). " Results of water testing for Legionella program will be compled in two weeks. 3. What measures will be put into place or what systemic changes will you make	

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F 880	Continued From page 58 February 2018. During an interview on 2/28/18, at 9:33 a.m. the director of nursing (DON) stated she had been unable to print the infection control logs from her computer for the months January 2018 and February 2018 as she was having problems with her computer. Surveyor stated she did not have to print the infection control logs off her computer for review, that they could be viewed from her computer screen. The DON then stated she was unable to get into the infection control files to even pull them up for surveyor review. During an interview on 3/1/18, at 7:06 a.m. the nurse consultant (NC)-B stated the facility had been unable to locate any documentation regarding infection control for the months of January and February of 2018. NC-B stated there had been no tracking, trending or analysis of infections since previous infection control nurse left facility employment in December 2018. The nurse consultant stated they had looked through the DON's computer files and stated they were unable to find any information that this had been done. The policy titled Surveillance for Infections revised December 2012, indicated the Infection Control Officer or Designee will conduct ongoing surveillance for Healthcare-Associated Infections and other epidemiological significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventable interventions. LACK OF IMPLEMENTING WATER TESTING AS A COMPONENT OF LEGIONELLA	F 880	to ensure that the deficient practice does not recur? " Licensed Nurses and Trained Medical Assistants were In-serviced on 3/13/18 or 3/14/18 related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; Infection Control logs and H2O testing Legionnaires Program. (Exhibit # 880-C). " CNA Staff were In-serviced on 3/20/18 or 3/21/18 related to the Minnesota Health Department findings from the Annual Survey that ended on 3/2/18; Infection Control and H2O testing Legionnaires Program. (Exhibit # 880-C). " A second staff training will be held on 3/28/18 and 3/29/2018 related to the findings of F880; Infection Control and Legionnaires Program; and the facility policy on Surveillance of Infections. " Infection Control Program has a designated Infection Control Preventionist has been assigned to manage the program. " The Legionnaires program has been assigned to be managed Maintenance. With samples of the water obtained 3/26.208 with a two week turn around on the test results with NalcoWater 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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F 880	Continued From page 59 INFECTIONS PREVENTION: During an interview on 2/27/18, at 3:07 p.m. the senior executive director stated the facility had completed the assessment for Legionella prevention, but have not completed the water testing. The senior executive director stated the facility would be working with Minnesota Valley Testing Laboratories for completion of water testing and stated we will have a contract with them to manage the program for the facility.	F 880	" The facility has implemented a Quality Assurance Program to ensure the Infection Control Program in being monitored as evidence by current Infection Control Logs. " The facility has implemented a Quality Assurance Program to ensure the H2O testing program for Legionnaires in being monitored as evidence by current H2O testing Logs. " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit #880-E) Will monitor updating of infection control surveillance log; weekly times 4 weeks. " The Maintenance Director and/or designee will manage the ongoing compliance of the Legionnaires program with testing per company policy. " Additional training may be scheduled based on results of the quality assurance review. " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed and modified as necessary by the QAPI committee. All deficient practices along with findings of investigations will be reviewed monthly in QAPI meetings for three months to ensure compliance with facility policy and state and federal regulations.	

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F 880	Continued From page 60	F 880	" The facility administrator and/or designee will monitor that the tools are completed.	

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on February 27, 2018. At the time of this survey, Rochester East Health Services 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) Standard 101, Life Safety Code (LSC), Chapter 18 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/26/2018

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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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2018**

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us, and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Rochester East Health Services is a 3-story building with a full basement. The building was constructed in 1968 and was determined to be of Type II (222) construction.

The building has a fully sprinkler system The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 116 beds and had a census of 91 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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K 291 K 291 SS=D	Continued From page 2 Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility emergency lighting documentation did not provide all of the required information in accordance with 7.9, 18.2.9.1, 19.2.9.1 Findings Include: On facility tour between 09:00 AM and 12:30 PM on 2/27/2018, during documentation review it was revealed that the emergency light testing did not have the locations of the emergency lights and who performed the tests. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291 K 291	A description of what has been, or will be done to correct the deficiency. All emergency lighting was labeled based off location in the building as either stairwell landings hallway, and floor level. The emergency lighting units are marked in visible permeant sharpie writing identifying their location. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur. The facility TELS system has been updates for monthly audits of all emergency lighting with the location of all lighting, and lighting location has been placed on the audit form. Administrator and maintenance have verified initial marking of emergency lighting and monthly audit sheet. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	3/26/18

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K 291	Continued From page 3	K 291	Director of Maintenance, David Wegman will bring audit results to safety committee, which will report up into QAPI for the next three months.	

Electronically delivered
March 16, 2018

Mr. Jon Richardson, Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: State Nursing Home Licensing Orders - Project Numbers S5184030, H5184097

Dear Mr. Richardson:

The above facility was surveyed on February 26, 2018 through March 2, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5184097. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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
	00953	A. BUILDING: _____ B. WING _____	C 03/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 26, 27, 28, March 1, & 2, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, an investigation of complaint H5184097 was completed at the time of the licensing survey. The complaint was substantiated and an order was issued at MN Rule 4658.0520 Subp. 1.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a care plan for oral cares based on physician orders from a hospital dismissal summary for 1 of 1 resident (R67) reviewed for dental. Findings Include: During an interview on 2/26/18, 12:29 p.m. family member (FM)-A stated there was problems with brushing R67's teeth. FM-A stated there were	2 560	completed	3/30/18

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2 560	Continued From page 3 orders to brush R67's teeth 3 to 5 times a day in the hospital dismissal summary and the only times he gets his teeth brushed is when I am here. FM-A stated because the nectar thick liquids had a lot of sugar in them R67 was to have his teeth brushed 3 to 5 times a day. FM-A stated she will set him up at night for dental cares before she leaves and comes back the next day and still sitting there untouched. R67's hospital dismissal summary dated 1/26/18, included, "ASPIRATION PRECAUTION: Good oral care 3-5 times a day." R67's physician orders were reviewed and lacked a physician order to brush teeth 3 to 5 times a day. R67's care plan, nursing assistant care guide and nursing assistant were reviewed and lacked direction to provide oral care 3-5 times a day. R67's care plan dated 1/30/18, instructed staff to provide oral care with an assist of one. R67's nursing assistant care guide updated 2/20/18, instructed staff to help with oral care twice a day. During an interview on 2/28/18, at 2:30 p.m. nursing assistant (NA)-C stated R67 was supposed to brush his teeth 5 times a day and stated his wife wanted his teeth brushed three times a day. NA-C stated R67 was capable to brush his own teeth after set up. NA-C stated when R67's wife is here she sets him up to brush his teeth and when she is not here, we set him up and do it. During an interview on 3/1/18, at 1:33 p.m.	2 560		

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2 560	Continued From page 4	2 560		

nursing assistant (NA)-A stated she was not sure how often R67 was to have his teeth brushed a day. NA-A stated what I know is every morning and night we get residents washed up (which included oral cares). NA-A stated we set R67 up and he was able to take care of that (brushing teeth) on his own and stated I set him up in the morning for oral cares.

During an interview on 3/1/18, at 4:06 a.m. (NA)-B stated she had R67 brush his teeth at bedtime. NA-B stated she set him up and R67 was able to brush his own teeth. NA-B said if his wife was here I do not bother with oral cares, as I believe she completes his evenings cares with him.

During an interview on 3/1/18, at 3:32 p.m. registered nurse (RN)-A stated oral care 3-5 times a day should have been on the care plan and nursing assistant care guides. RN-A verified staff would not know they needed to complete oral care with R67 more than with morning and evenings cares if it was not care planned.

During an interview on 3/1/18, at 3:43 p.m. the nurse consultant (NC)-B stated she would have expected oral cares 3-5 times a day to have been put in as an order and for this (oral cares) to have been completed per the hospital dismissal summary. NC-B stated oral cares 3-5 times a day should have been added to care plan and care guide for R67. NC-B stated R67 should have oral care provided as recommended in the hospital dismissal summary.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A

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2 560	Continued From page 5 monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations;	2 625		3/30/18

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2 625	Continued From page 6 J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to maintain a complete medical record to include an admission note and a comprehensive plan of care for 1 of 1 resident (R96) reviewed for discharge. Findings include: R96's Admission Record document dated 10/27/17, identified an admit date of 10/27/17, with diagnoses of acute on chronic combined systolic and diastolic heart failure, edema, malignant neoplasm of the bone, lung and breast, and muscle weakness. On asking for R96's comprehensive care plan it was learned that there had not been one completed following admission and the one provided to the surveyor was dated 3/1/18. R96's discharge date was 12/4/18, according to	2 625	completed	

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2 625	Continued From page 7 progress notes. Review of R96's progress notes from admission of 10/27/17 to 12/4/17 had not included an admission note regarding resident needs and cares that need to be met before the comprehensive assessments and comprehensive care plan is completed. R96's progress note dated 12/4/17, identified R96 was discharged back to home. Interview on 3/1/18, at 12:06 p.m., with registered nurse (RN)-E stated, "I would have expected there to be an admission note," and verified there had not been an admission note which should contain why R96 was in the facility based on progress notes of her medical record. Further verified R96 should have had a comprehensive care plan developed to address functional rehab potential, incontinence, falls, and pressure ulcers. RN-E stated, "Based on the information in the chart and medical record I do not have a clear picture of why [R96] was here." Facility policy Admission Notes, dated 12/2016, revealed when a resident is admitted to the nursing unit, the admitting nurse must document the following information (as each may apply) in the nurse's notes, admission form, or other appropriate place, as designated by facility protocol: a. the date and the time of the residents admission, b. the residents sex, age, race and marital status, c. from where the resident was admitted, d. reason for the admission, e. the admitting diagnosis, f. the general condition of the resident upon admission: head to toe assessment and a skin assessment, g. the time the attending physician was notified of the residents admission, h. the time the physicians orders were received and verified, i. description of any lab work completed or the time the specimens were sent to the lab, j. the presence of catheters, dressings	2 625		

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2 625	Continued From page 8 etc.., k. the time the dietary department was notified of the diet order, l. the time the medications were ordered from the pharmacy, m. a brief description of any disabilities (i.e. blind, deaf, hemiplegia, speech impairment, paralysis, mobility etc.), n. any known allergies, o. prosthesis required (glasses, dentures, hearing aide, artificial limbs, eye etc.), p. the height and the weight of the resident, q. a statement indicating that the nursing history and preliminary assessment is completed and has been started, r. notation of any signs or symptoms of an infectious or communicable disease, s. notation as to whether or not advance directives apply, t. signature and title of the person recording the data. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could review with licensed staff the facility's policy and procedure regarding review of resident clinical record documents, to ensure necessary information including an admission note and a comprehensive plan of care is included in the medical record, and education was provided to licensed staff. The director of nursing or designee could train licensed staff and perform audits to ensure each resident clinical record is complete to include an admission note and a comprehensive plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		3/30/18

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2 830	Continued From page 9 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement specific parameters for administration of an as needed (PRN) seizure medication for 1 of 1 resident (R67) who was administered a PRN seizure medication. Also failed to implement, monitor and/or revise interventions to ensure efficacy for 3 of 3 residents (R54, R40 and R53) reviewed for accidents. Findings Include: R67's Admission Record identified R67 was admitted to the facility on 1/26/18, with diagnoses of cerebral infarction, and unspecified convulsions. R67's neurology visit summary on 2/6/18, included, "We did tell the patient [R67] and his [family member (FM)-A] that his episodes of staring and unresponsiveness appear to be nonepileptic in nature based on his previous EEG [electroencephalogram] that showed no evidence of a seizure discharge during these, and therefore these are not going to be helped by antiepileptic	2 830	completed	

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2 830	Continued From page 10 medications. Probably these are due to cognitive changes related to his previous brain hemorrhage." R67's care plan included, Potential for Alteration in Neurological Status related to: Has a seizure disorder. Interventions included: Administer medication as ordered. After the seizure activity has ceased, monitor/document/report: decreased gag reflex, headache, incontinence, injury, behavior changes, confusion, poor coordination, weakness/paralysis of body parts, sleep disturbance. Allow the resident to sleep after a seizure and reorient upon awakening. R67's physician orders signed 2/27/18, included: Midazolam HCl Solution 5 MG/ML 2 ml in each nostril as needed for seizures Prolonged seizures over 3 minutes or more than 3 seizures in 1 hour. Give 1 ml in each nostril. R67's progress notes and medication administration record revealed the following: "2/24/2018 13:19 [1:19 p.m.] Orders - Administration Note Text: Midazolam HCl Solution 5 MG/ML 2 ml in each nostril as needed for seizures Prolonged seizures over 3 mins [minutes] or more than 3 seizures in 1 hour. Give 1 ml in each nostril." R67's progress note were reviewed for 2/24/18 regarding the as needed medication for seizures was given, and revealed no documentation had been completed regarding the need for the administration of the PRN seizure medication. When the lack of documentation was brought to the facility attention during the survey process, the facility had the nurse add a late entry	2 830		

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2 830	Continued From page 11	2 830		

progress note. The note read, "2/24/18 Late Entry: Note Text: Late Entry: Resident had seizure at the table in dining room at around 1245p. [12:45 p.m.] Writer was in medication room and CNA [certified nursing assistant] reported to writer that resident had a seizure. Writer didn't witness the process of seizure. Resident's tears were falling down when he stared up. When calling his name, resident was able to turn his head and respond to his name. [FM-A] witnessed the whole process. However,[FM-A] was not able to tell how long the seizure lasted. She also requested PRN seizure medication Midazolam for resident. Resident continued eating lunch after seizure. Will continue to monitor." However, there was lack of type of seizure R67 had and if staring unresponsive the as needed medication was not to be given according to the notes from the neurologist dated 2/6/18.

During an interview on 3/1/18, at 12:15 p.m. nurse consultant (NC)-B stated she expected the nurse to review the visit summary and communicate on the twenty-four hour board any care plan update. NC-B verified she would have expected the information to be shared with facility staff from the neurology visit on 2/6/16, that R67's episodes of staring and unresponsiveness appeared to be nonepileptic in nature based on his previous EEG that showed no evidence of a seizure discharge during these and therefor these are not going to be helped by antiepileptic medications. NC-B stated she would have expected the PRN order to specify parameters of when to administer Midazolam based on R67's symptoms. NC-B stated, "I think the primary thing here is to educate the nurse as to what constitutes a seizure." NC-B stated she would have expected education to be completed

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2 830	Continued From page 12	2 830		

regarding R67's seizures after the neurology visit on 2/6/18 and stated education was not completed with facility staff. NC-B stated the nurse should have gotten the information and completed an observation of R67 to determine the need for the PRN seizure medication, when R67's wife reported he was having a seizure in the dining room. NC-B stated the PRN midazolam should not have been administered in hindsight.

R54's admission Minimum Data Set (MDS) assessment indicated R54 had been admitted to the facility 2/20/17, from the hospital after a fall with injury sustained in a different facility. In addition, the MDS indicated R54 had diagnoses including hypertension and diabetes.

R54's quarterly MDS assessment dated 11/21/17, indicated R54 had experienced a fall with injury and needed extensive assistance of one staff member for bed mobility, and extensive assistance for transfers with two staff. The quarterly MDS also indicated a Brief Interview for Mental Status (BIMS) interview was attempted but the resident was unable to complete, so staff interview had been completed which identified R54 had long and short term memory loss.

R54's significant change MDS assessment dated 1/23/18, indicated R54 had no previous falls (inaccurate coding), and required extensive assistance of two staff members for bed mobility and transfers.

R54's progress notes were reviewed from 11/2017 to 2/28/18, and contained information in a situation, background, assessment/appearance and recommendation (SBAR's) format of the following falls:

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2 830	Continued From page 13 11/3/17, R54 had a fall from bed with no injuries or bruises. Resident was found on the floor of her room laying down on her side. no injuries. Resident was assessed and no injuries found or bruises. Vital signs checked and was within normal, denies pain. Recommendations: will communicate with morning nurse to monitor, Reminded resident to use the call light and don't get up by herself. Family notified. 11/17/17, R54 had been found on floor of her room, close to her roommate's bed. Resident stated she was trying to close the door of her room. Resident stated her right leg and head hurt. A small scrape was noticed on her coccyx. No other injuries noted. Resident had been confused all day. Resident was helped off the floor. Director of nursing, nurse practitioner, clinical manager, and family member were notified. Educated patient. Recommendations: (none were documented for this fall). Possible contributing factor for falls dated 11/21/17, Continuous low blood pressure readings. Resident with history of HTN (hypertension) and CHF (congested heart failure). Assessment (RN [registered nurse])/Appearance LPN [licensed practical nurse]): Lethargic, dizziness with position changes. Assessment: Resident continues to have blood pressure readings on AM shift ranging from systolic (highest reading) of 90 to 110. Response: Metoprolol (to lower blood pressure) being held at this time, request for provider review of necessity of medication. Blood pressure and pulse readings printed for provider review. Recommendations: "See above." 11/21/17, progress notes indicated the certified nurse practitioner (CNP) had visited R54 with a plan to stop torsemide (a diuretic used to lower	2 830		

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2 830	Continued From page 14	2 830		

blood pressure) and for staff to monitor blood pressure. The report also indicated the CNP had been updated on R54's prior falls. Possibly related to the 11/17/17, fall, resident complaining of right hip and leg pain, increased with weight bearing. Recommendations: Request for in house X-ray of right hip to rule out fracture from recent fall. On 11/28/17, the CNP visited R54 regarding leg/hip pain and ordered X-ray to rule out fracture. The limited evaluation clinical document included, X-ray results noted an addendum to report which revealed a possible fracture and will need a computerized tomography (CT) scan to confirm diagnosis of pelvic fracture. Sent to hospital on 11/29/17, had CT scan and report confirmed a right pubic bone (hip) fracture.

A facility report initiated (FRI) an incident reported on 11/29/17, by the director of nursing in regards to the 11/17/17 incident with confirmed fracture of hip (11/29/17) to the Office of Facility Complaints (OHFC). The complaint registration form included the following information:
"Description, A resident ([R54]) sustained a pelvic fracture identified on 11/27/2017 that the facility attributes to a fall that occurred on 11/17/2017. The facility assessment(s) did not identify the sign and symptoms of pelvic fracture."
"Emergency Room for Outpatient CT scan. Results returned 11/29/17 showing pelvic fracture. Review of medications completed by consultant pharmacist. No recommended changes at this time. Falls Committee reviewed falls on 11/5/17. With fall on 11/3/17, resident fell while trying to self transfer out of bed but her feet slipped on the floor. Non-skid strips were added to the floor next to her bed. Falls committee reviewed falls again on 11/21/17 - resident said she was trying to get up to close her door. Sign is posted outside her room that her door is closed

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2 830	Continued From page 15 per her request at night. PT/OT to evaluate and treat as appropriate. Review of care plan completed with addition of the above changes added." Under description of harm it reads, "resident with pelvic fracture presumed from fall 11/17/17." The facility sent an Investigation status to OHFC on 12/6/17, in regards to the incident reported on 11/29/17. The information contained the following: "[R54] has been a resident at the facility since 7/10/17. Her primary diagnoses are: malaise, type II diabetes, rheumatoid arthritis, chromic atria fibrillation, mild congestive impairment, and metastatic breast cancer. Last BIMS score was 10 on 10/9/17. Fall history includes: 11/3/17 @ 0527 [5:27 a.m.] with no injury, and 11/17/17 @ 2000 [8:00 p.m.] with pain in right hip at time of injury but then back to baseline on subsequent checks. Resident pain is monitored daily and she receives scheduled acetaminophen for pain from arthritis. On 11/27/17 resident had increased pain in right hip, especially with weight bearing or movement. SBAR completed and reviewed by nurse practitioner, x-ray ordered . Results recommended additional imaging for conclusive diagnosis. On 11/28/17 approval obtained from POA [power of attorney] to send resident for CT scan. Resident sent to St. Mary's Emergency Room for outpatient CT scan. Results returned 11/29/17 showing a pelvic fracture. Review of medications completed by consultant pharmacist. No recommended changes at this time. Falls Committee reviewed falls on 11/5/17. With fall on 11/3/17 resident fell while trying to self transfer out of bed but her feet slipped on the floor. Non-skid strips were added to the floor next to her bed. Falls committee reviewed falls again on 11/21/17 - resident said she was trying to get up to close her door. Sign is posted outside her room	2 830		

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2 830	Continued From page 16	2 830		

that her door is closed per her request at night. PT/OT to evaluate and treat as appropriate. Review of care plan completed with addition of the above changes added." Under description of harm it reads, "resident with pelvic fracture presumed from fall 11/17/17."

1/12/18, R54 sustained another fall documentation included in the progress notes the SBAR format included: Fell to floor in resident room, pain all over sent in to emergency room and was admitted due to a hip fracture.

A facility reporting incident was submitted to the Office of Health Complaint (OHFC) on 1/15/18, regarding the fall with fracture incident on 1/12/18. The description of incident read, "Resident self transferred from her bed saying 'I heard [a persons first name] snoring.' on floor next to bed. Able to move all extremities. Pain increased during night while monitoring so resident sent to ER [emergency room] Saturday morning for further evaluation. Diagnosed with UTI [urinary tract infections] and encephalopathy [abnormal brain function] from the UTI. Now diagnoses with left pelvic rami fracture. Car plan being followed at time of fall. Plan is conservative management/pain management." Also included the incident was reviewed by pharmacist with no changes, fall committee review fall on 11/5/17 and 11/3/17, resident fell while trying to self transfer out of bed but her feet slipped on floor. Non-skid strips were added to the floor next to her bed. Also reviewed all form 11/21/17 and resident said she was trying to get up to close her door. No falls since 11/21/17 until 1/12/18. Care plan completed, review of room placement completed.

Mayo Rochester Emergency Department record

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2 830	Continued From page 17 dated 1/13/18, included under nursing assessment: Extremity Lower, Patient had a fall at 10:30 p.m. last evening unwitnessed at Rochester Health services East skilled nursing facility (SNF), states she had her slippers on and did hit her head. Under the History of present illness, it read, "[R54] was hospitalized January 13 through January 16, 2018 following a fall. CT scan demonstrated acute left superior and inferior pubic rami fractures, subacute right superior an inferior pubic rami fractures, and the chronic L2 vertebral body fracture. She was admitted for pain management..." During observations of R54 in her room on 2/26/18, at 8:28 a.m., 2/27/18, at 12:16 p.m. and on 2/27/18, 4:08 p.m. there were no non-skid strips on floor next to her bed. The sign on door read to keep door "open" at night even though the fall intervention following the 11/27/17, incident directed the sign to say "closed." Interview with registered nurse (RN)-D on 3/1/18 at 1:35 p.m. regarding the falls interventions of non-skid strips in front of R54's bed following the fall on 11/17/17, RN-D observed no non-skid strips next to R54's bed. At 1:45 p.m. following the interview with RN-D of no non-skid strips on R54's floor. Maintenance-A was observed to have placed non-skid strips on the floor in front of R54's bed. R54's care plan with a focus of "Resident is at risk of falls r/t [related/to] History of falls, Pain." "Date initiated: 12/06/2017" included interventions of "Anticipate and meet the Resident's needs. Encourage the Resident to always call for assistance." "Call light in reach." "Defined parameter Mattress -(scooped side)." "Review information on past falls and attempt to	2 830		

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determine cause of falls for prevention and to minimize injuries." Also added to care plan on 3/1/18 after surveyor queried the use of safety strips "Zip/non-skip strips on floor at bedside."

Record review and interview with therapy on 3/1/18, at 4:23 p.m. physical therapy assistant (PTA)-G verified R54 last evaluated in October of 2017, and none since then.

Interview on 3/1/18, at 3:57 p.m. with nursing assistance (NA)-D stated R54 is a fall risk and receives fall risk interventions from the nurse. NA-D states they use routine interventions like gait belt. Clinical manager will update with new interventions. On review of the NA's care sheet (has information specific to resident cares/treatments) showed only use of gait belt and no other interventions to prevent falls.

Interview on 3/1/18, at 4:00 p.m. with licensed practical nurse (LPN)-A stated R54 is a fall risk, intervention would double check bed in low position, call light in reach. LPN-A stated would review care plan and proceeded to check the electronic care plan for R54. LPN-A said nurses always complete a SBAR and notify family, CNP, nurse manager and can put intervention in place after fall. Neuros completed on any fall unwitnessed or when a resident hits their head. LPN-A also added they start a post fall assessment and the report is very self-explanatory and is on the computer. The facility started a review of falls called a trip form.

Interview on 3/1/18, at 2:06 p.m. with CNP-F stated they are update with a SBAR notes but does not always include an update. CNP-F stated according to R54's note on 11/28/17, she had not been updated on the 11/3/17, and

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2 830	Continued From page 19 11/17/17, falls until the hypotension episode on 11/21/17. CNP-F's document dated 11/28/17, notes that there had not been a request for provider to evaluate. Interview on 3/1/18, at 1:40 p.m. registered nurse consultants (RNC)-B, H, & J and Administrator were asked what the policy/procedure following a fall. This included investigation, assessment, develop interventions following each fall for R54. At 1:47 p.m. interview with administrator regarding further information regarding R54's falls. Administrator had post falls assessment completed after return from hospital emergency room with diagnosis of hip fracture dated 11/29/17 had not been added to R54's care plan or care sheets. Administrator was not aware the post falls interventions to prevent further falls had not been documented at time of post fall assessment until surveyor brought it to his attention. Administrator also said the safety strips are now in place for R54. Administrator verified the current policy/procedure had not been followed regarding R54's falls. Follow up interviews with RNC-B on 3/1/18, at 3:31 p.m. regarding the requested information regarding the falls for the last four months. RNC-B said there was no more information found. On 3/2/18, at 11:41 p.m. RNC-H verified the facility continued to look through charts and files and was not able to identify any of the facilities paper work or additional investigation paper work on R54 falls. R40's current diagnoses according to the Diagnosis Report, dated 3/5/18, included Parkinson's disease, cerebral infarction, muscle	2 830		

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2 830	Continued From page 20 weakness, delusional disorder, anxiety, and major depressive disorder. R40's annual Minimum Data Set (MDS) an assessment dated 1/6/18, indicated severe cognitive impairment, extensive assistance of two persons for transfers and extensive assist of 1 person for ambulation and toileting, and two or more falls since the prior assessment. During observation on 2/26/18, at 12:57 p.m., R40 is sitting in her wheelchair and propelling self out of the dining room while singing, "What a friend we have in Jesus." During observation on 2/27/18, at 11:59 a.m., R40 is sitting in her wheelchair, wheeling self-down the hall away from the secured exit. R40's care plan, last reviewed 1/2/18, indicated R40 was at risk for injury due to falls, history of falls. The goal listed was: resident will remain safe and injuries from falls will be minimized through her next review. Approaches included: (1) attending staff listen for R40 in the am and assist with transfer out of bed as soon as possible, (2) encourage resident to rest in the dining area/recliner room mid-day, (3) grab bar to be installed on wall next to bathroom in residents room, (4) offer to rest resident in the recliner chair with inconsolable yelling, agitation. [R40] is able to demonstrate placing foot rest up and down independently in recliner, (5) reinitiate 3 day bowel and bladder diary as/when indicated, (6) staff to stay with resident after assisting onto toilet until after successful transfer off toilet, (7) toilet schedule before meals and at bedtime.	2 830		

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2 830	Continued From page 21 3/6/17: also toilet at midnight, (8) turn on Facility Channel music for resident to listen to when more anxious, (9) when resident is especially anxious, encourage resident to wear sweaters/warmer clothing rather than blankets when in bed, and (10) PT to evaluate and treat per increased difficulties with balance. A Fall Risk Assessment was requested for R40 and was not received. R40's Incident Reports, Post fall Assessments and Emergency Record revealed the following from 9/21/17 to 2/18/18, revealed the following: 9/21/17, at 2:40 p.m., R40 was heard screaming and was found lying on the floor in her room, stated that her right elbow hurt, no evidence of injury. Predisposing factors: impaired memory, transferring self, ambulating without assist. Interventions to prevent further falls: reeducation to resident. Care plan not updated. Emergency department record dated 9/22/17, at 3:43 a.m., revealed, R40 presents after a fall from standing. This occurred earlier in the evening of 9/21/17. R40 denies any head trauma but reports hitting her right arm with the fall. R40 has a right upper arm laceration that will require repair with sutures. R40's CT scan showed fracture of the 9th and 10th ribs. Discharged back to the nursing home. Nursing assessment indicated, R40 had a fall 13 hours ago while trying to get up to the bathroom herself. R40 sustained bruising and a 5 centimeter laceration to right upper arm. Tenderness noted over the ribs on the right side. There were falls recorded on 10/10/17, 10/20/17, 10/21/17, 10/21/17, 10/22/17, 11/8/17, 11/11/17,	2 830		

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2 830	Continued From page 22 11/13/18, 11/15/17, 11/18/17, 11/24/17, 11/21/17, 1/21/18, 1/26/18, 1/29/18, 1/30/18, and 2/18/18. The falls were related to toileting needs, getting tangled in blankets, attempting to get out of bed alone, left alone on toilet, and transferring from bed to her wheelchair. Many falls lacked interventions developed after fall and the care plan had not been updated. During interview on 3/2/18, at 12:11 p.m., (LPN)-C stated R40 was moved to this secured unit on 1/17/17 after her last stroke and has had several falls over the last year. I have not always completed a post fall assessment after each fall. The floor staff should be identifying an immediate intervention after each fall and they have not been doing that. Further stated there is not always a new intervention added to the care plan. "I got behind in November, 2017, we had 48 falls on this secured unit. I told the director of nursing that I was behind." LPN-C verified R40's fall on 9/21/17, was not properly assessed, and she did end up in the emergency room, ER 13 hours later with a laceration to her right upper arm and 2 fractured ribs. The fractured ribs and the sutures on her right upper arm were not documented in the progress notes. "We did do a root cause analysis in the interdisciplinary team, (IDT) meetings, but the interventions were not always implemented timely." Interview on 3/2/18, at 12:41 p.m., registered nurse (RN)-E stated the fall system has not been followed, incident reports and post fall assessments are not always being filled out, and interventions are not always put in place or being implemented. "My expectation is that when a fall occurs, an assessment should be done timely to determine the cause of the fall, appropriate interventions need to be put in place immediately,	2 830		

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and the falls need to be reviewed at a later date to determine their effectiveness." RN-E further stated there should be thorough documentation of falls in the medical record, with an injury to include monitoring, treatment, and reporting to appropriate delegations.

R53 was admitted to the facility on 4/29/17 according to the admission form. The electronic medical record (EMR) identified diagnoses of Alzheimer's disease, aphasia (unable to speak), stroke, muscle weakness, abnormal gait (balance), and repeated falls.

R53's quarterly Minimum Data Set (MDS) an assessment dated 1/28/18, identified R53 as having severe cognitive impairment, requiring extensive assist of one with walking, and unsteady only stabilizing with human assistance.

During an observation on 3/2/18, at 12:42 p.m. R53's wheelchair was sitting empty in the hallway and R53 was walking down the hall slowly, holding the attached railing. His knees are slightly bent and he is unsteady. No staff was present or in view of R53.

During an interview with licence practical nurse (LPN)-K on 3/1/18 at 2:10 p.m., regarding R53's falls from 10/2017 to 2/2018, LPN-K reviewed examples of revised fall interventions in place and included, keep in the dining room during meals, encourage fluids, monitor for urinary tract infection, alternate choices for snacks, and more frequent toileting. LPN-K verified that none of the interventions were on the care plan or the nursing assistant (NA) care sheet and that the staff would not know to follow the revised interventions. LPN-K stated she updated care plans sporadically when she can find the time.

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2 830	Continued From page 24 A facility policy dated 12/16 "Care Plans-Comprehensive" identified that assessment of residents is ongoing and care plans are revised as information about the resident and the resident's condition change. Facility policy, Fall Prevention and Management Guidelines, dated 2/2017, indicated the facility will maintain a fall prevention and management program. In as much as it is in the power of the facility, the facility will prevent and /or manage the residents risk for falls. The elderly are at an increased risk for falls related to several different factors. The facility will implement a fall program for residents determined to be at risk for falls in order to better manage these factors and prevent and/or manage as much as possible the resident from falling and/or sustaining injuries related to falling. SUGGESTED METHOD FOR CORRECTION: The DON and/or designee could review with staff the facility's policy and procedure regarding review of resident visit summaries to ensure necessary information and education was provided to facility staff from physician visits. Also provide education to staff responsible for resident cares/treatments to follow the care plan and assess falls and develop falls interventions. The director of nursing or designee could train staff and perform audits to ensure each resident is receiving appropriate nursing care based on information in physician visit summaries. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		

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2 860	Continued From page 25	2 860		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nail care was provided to 3 of 5 residents (R12, R53, and R5) reviewed for activities of daily living (ADLs) and whom was dependent on staff for care. Findings include: R12's Admission Record identified an original admission date of 5/28/10, and a diagnoses of Alzheimer's disease, major depressive disorder, repeat falls, urinary tract infections, and weakness. R12's quarterly Minimum Data Set (MDS) an assessment dated 12/14/17, identified R12 to have a severe cognitive deficit and required one person extensive assist with personal hygiene. R12's care plan dated 10/17/11, identified R12 requires staff assist of 1 to do grooming tasks. R12 also often refuses to be washed up. Requested facility bath sheets for the last month regarding R12's information, however a note was received from staff that stated, "Destroyed after review."	2 860	completed	3/30/18

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2 860	Continued From page 26 Facility document CNA (certified nursing assistant) Care Guides dated 2/13/18, identified R12 will get a bath on Monday a.m., and 1 assist with all ADLs. R12's treatment administration record dated 2/1/18-2/28/17, identified weekly bathing every Monday during the am. 2/19/18 and 2/26/18 were not documented as bath given. Document in PCC progress notes. Review of R12's progress notes identified on 1/22/17, at 1:58 p.m., R12 had received her scheduled bed bath with no resistance. R12 did not require nail care at this time. No other progress notes found identified any nail care completed or documented. During observation on 2/26/18, at 7:43 a.m., R12 is sitting by the side of her bed and noted to have soiled, long, untrimmed fingernails. During observation on 2/27/18, at 5:47 p.m., R12 is sitting up to the table in the dining room in her wheelchair eating her supper independently and is noted to have long, untrimmed fingernails with brown-looking substance under her fingernails on both hands. During observation and interview on 2/28/18, at 10:02 a.m., R12 is sitting in her wheelchair in her room in front of her window, wearing a gray velour sweat outfit, holding a red heart shaped pillow in her lap, and is noted to have long, untrimmed nails with brown substance underneath all of her fingernails. R12 stated, "My fingernails need to be clipped." During interview on 2/28/18, at 1:55 p.m., nursing	2 860		

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2 860	Continued From page 27 assistant (NA)-I verified R12's fingernails are long, with a brown substance underneath them and stated her nail care should have been completed on Monday on her bath day, unless she refuses. If it is refused we tell the nurse and she would document the refusal in the chart. During interview on 2/28/18, at 2:15 p.m., licensed practical nurse (LPN)-C verified R12's fingernails are long, with a brown substance underneath them. Further verified R12's bath was on Monday and nail care should have been completed. R53's Admission Record identified an admission date of 5/10/17, and a diagnoses of Alzheimer's disease, aphasia (loss of ability to understand or express speech, caused by brain damage), after a cerebral infarction, type 2 diabetes mellitus, major depressive disorder, repeated falls, and weakness. R53's quarterly MDS an assessment dated 1/23/18, identified R53 to have a severe cognitive deficit and requires one person extensive assist with personal hygiene. Care plan dated 5/9/17, identified R53 prefers to have a shower daily. Requested facility bath sheets for the last month and received a note stating, "Destroyed after review." Facility document CNA Care Guides dated 2/13/18, identified R12 will get a bath on Monday a.m. and Friday a.m., and 1 assist with all ADL's.	2 860		

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2 860	Continued From page 28 R53's treatment administration record dated 2/1/18-2/28/17, identified weekly bathing every Monday and Friday during the a.m. On 2/16/18, not documented as bath given. If refused reproach x 3 and document in computer progress notes. Review of R53's progress notes identified on 1/22/17, at 1:49 p.m., R53 received his scheduled bed bath with minimal resistance. R53 has fingernail and toenail care. R53 has some scattered bruising on upper extremities and a few small scabs. No other progress notes identified any nail care was completed or documented. During observation on 2/26/18, at 8:08 a.m., R53 had been seated in his wheelchair located in the dining room. Fingernails were observed to be long with a brown substance underneath them all. During observation on 2/27/18, at 5:49 p.m., R53 is sitting up to the table in the dining room in his wheelchair eating her supper independently and is noted to have long, untrimmed fingernails with brown debris under his fingernails on both hands. During interview on 2/28/18, at 1:43 p.m., nursing assistant (NA)-I Verified R53's fingernails are long with brown debris underneath them and states, "They should be cleaned out, he is diabetic, the nurse should have cleaned and trimmed his nails on Monday with his bath." During interview on 2/28/18, at 2:04 p.m., licensed practical nurse (LPN)-C verified R53's fingernails are a little long, with a brown substance underneath them. Further verified R53's bath was on Monday, nail care should have been completed by the nurse at that time, and nothing was documented regarding nail care in	2 860		

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2 860	Continued From page 29 the progress notes. R5 was admitted to the facility on 7/25/14, according to his admission record. R5's quarterly Minimum Data Set (MDS) an assessment dated 11/17/18, indicated R5 needed extensive assist of one staff with personal hygiene needs. The brief interview for mental status (BIMS) assessment resulted in a score of 13 indicating R5 was cognitively intact. R5 had been observed on 2/27/18, at 12:47 p.m., while seated in his wheelchair located in his room. Noted long fingernails on both hands and a brown substance under them. On 2/28/28, at 9:33 a. m., R5 was observed sitting in his wheelchair in his room, he continued to have long nails with a brown substance under them. R5's care plan, revised 4/3/17, indicated R5 required assist of one staff for personal hygiene. During an interview with R5 on 2/28/18, at 9:33 a.m., in regards to his current nail status, and he stated he preferred his nails short. During an interview with nursing assistant (NA)-E on 2/28/18, at 9:52 a.m., NA-E stated the R5 preferred a bed bath which he received on Mondays. She verified that R5's nails were long and they "definitely could use some attention." She stated they should have been taken care of on Monday. During an interview with registered nurse (RN)-D, it was verified that nail care is to be done on bath days. Bath sheets and progress notes reviewed did not identify any nail care had been performed	2 860		

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2 860	Continued From page 30 in the month of February 2018. Facility policy, Care Of Fingernails/Toenails dated 12/2016, indicated, the purpose of this procedure are to clean the nail bed, keep nails trimmed, to prevent injuries and infections. 1. Nail care includes regular cleaning and trimming. 3. Unlicensed staff do not trim the nails of diabetic residents or residents with circulatory impairments. Notify the supervisor if the resident refuses the care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring nail care for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to	2 895		3/30/18

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2 895	Continued From page 31 increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement passive range of motion (PROM) and a palm guard per physician orders for 1 of 1 resident (R23) reviewed who had contractures. As a result, R23 sustained actual harm, a decline in functional range of motion (ROM) to the left wrist. Findings include: LACK OF ROM SERVICES AS ORDERED: R23's Admission Record document identified an admission date of 2/20/12, and diagnoses of left hand contractures (10/3/16), left ankle and foot contractures (10/3/16), and right ankle and foot contractures (9/13/16). An occupational therapy assessment identified in the Functional Limitation Assessment dated 4/18/17, to have R23's left upper extremities (LUE) to have a 1 percent (%)-19% impairment. An occupational therapy assessment identified in the Functional Limitation Assessment dated 3/2/18, to have R23's LUE to have 60% - 79% impairment. A quarterly Minimum Data Set (MDS) assessment dated 12/14/17, identified R23 to be severely cognitively impaired, with limited range of motion (ROM) in bilateral upper and lower extremities, contractures of the left hand and ankle, and contractures of the right ankle.	2 895	completed	

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2 895	Continued From page 32 R23's physician Order Review Report, identified an order initiated 7/27/16, included to do passive range of motion PROM to left upper extremity (LUE), focusing on wrist and fingers, per patient tolerance once a day. The 3rd West CNA (certified nursing assistant) Care Guides (contain services/treatments for residents assigned to the nursing assistant) dated 2/13/18, identified R23's Prevalon (heel protector) boots to be applied bilaterally to both lower extremities (LE) when in bed, and ortho booties when up in chair. There was no mention of (PROM) for LUE on the care guide. R23's Restorative Administrative Record (RAR), reviewed from 5/1/17, to 2/28/18, did not have documentation that LUE PROM had been completed as ordered. During an observation in the dining room on 2/26/18, at 8:20 a.m., R23 sat in a reclining wheelchair with leg extenders. Both feet appeared to point downward and inward, and were resting in blue heel protectors. At 12:59 p.m. R23 was observed to be seated in the reclining wheelchair and leaning forward and to the right. During observation on 2/27/18, at 12:19 p.m., R23 was observed sitting in a reclining wheelchair with her legs extended straight out. Both feet were observed to point downward and inward, and the resident was wearing blue heel protectors. During observation on 2/28/18, at 9:51 a.m., R23 was seated in her reclining wheelchair with a blanket covering her lap, she had the blue heel	2 895		

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2 895	Continued From page 33	2 895		

protector on both feet. At 1:49 p.m. R23 was observed to be lying on her back in bed with her right knee bent.

During observation on 3/1/18 at 11:07 a.m., R23 was observed in the dining room seated in her wheelchair. She was observed to have heel protectors on both feet.

R23's care plan revised 4/3/17, read, "Patient to use BLE [Bilateral Lower Extremity] orthotics for ankles every day as tolerated and to remove orthotics if patient appears to be in distress/pain from orthotics. Please check skin integrity before and after orthotics are donned/doffed [on/off]. Perform light ROM to each ankle before donning to ensure proper placement of the device so the Achilles and back of calf are all the way back in the orthotic." Goals included: I will maintain my current level of physical functioning as long as possible. Additional interventions included: PROM to LUE focusing on wrists and fingers, per patient tolerance x 3 sets of 10 reps for 15 minutes. Goal: decrease risk of further contractures in LUE in order to provide comfort and reduce pain, and to ensure skin integrity and reduce risk of skin irritation.

During an interview on 2/28/18, at 10:13 a.m. nursing assistant (NA)-F stated they have not had a restorative aide for about a year. At 10:44 a.m., NA-G stated when a resident is started on PROM, therapy would demonstrate how to complete it, and staff had to acknowledge the training. NA-G said this was usually documented in the communication book where staff would find their assignments to do restorative nursing.

During an interview on 3/1/18, at 11:12 a.m., NA-H verified she'd gotten R23 out of bed that

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2 895	Continued From page 34	2 895		

morning, but had not completed PROM. NA-H stated, "It says on my care plan that she does not get range of motion."

During an interview on 3/1/18, at 10:53 a.m., licensed practical nurse (LPN)-C stated, "We have not had a restorative aide for about a year, we train our nursing assistants to do it, like ambulation and range of motion. I am not sure where the aides find the information on who is on restorative, I think it is on their care sheets [care plan sheets for the Na's]."

During an interview on 3/1/18, at 11:16 a.m., trained medication aide (TMA)-B stated, "Our aides are not responsible for restorative nursing. The only person we have on this unit for ROM is [a different resident then R23]."

During an interview on 3/1/18, at 2:02 p.m., certified occupational therapy aide (COTA)-D verified R23 had been discharged from occupational therapy (OT) with a restorative program on 4/18/17.

During interview on 3/2/18, at 10:01 a.m., LPN-C verified R23 had not been getting PROM since April of 2017, because although the order got put in restorative, it was not on the treatment administration record (TAR) or on the CNA care sheet. LPN-C stated, "My expectation is to have passive range of motion done daily as ordered."

During an interview with COTA-D on 3/2/18, at 10:52 a.m., she said that the purpose of R23's PROM program was to prevent worsening of contractures and to prevent a decrease in the mobility of her left hand.

During an interview on 3/2/18, at 11:48 a.m.

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2 895	Continued From page 35 Physical Therapy Assistant (PTA)-A verified the PT (physical therapy) Discharge Summary dated 9/21/16, identified bilateral lower extremity (BLE) ROM continued to be limited, limiting patient's participation in mobility. PTA-A also verified there was no restorative program put in place to maintain lower extremity range of motion. During an interview on 3/2/18, at 12:08 p.m., Licensed practical nurse (LPN)-C stated R23 did not currently have a range of motion program in place for her lower extremities. The Occupational Therapy (OT) Plan of Care dated 3/2/18, included for R23 "now presents with a decline in functional ROM of L [left] wrist, metacarpophalangeal joints, proximal interphalangeal joints and the distal interphalangeal joints. The caregiver started noticing a decrease in ROM approximately two weeks ago, they also report inconsistent use of palm guard, which has since resulted in the patient now requiring significantly more assistance for hygiene and joint mobility. Due to medical complexity, this patient will require skilled OT to assess appropriate and effective ROM program, educate caregiver on skin integrity, hygiene, wearing schedule of soft brace." LACK OF CONSISTENT USE OF ORDERED LEFT PALM GUARD: Doctors order dated 7/26/17, for R23 to wear a left palm guard in the morning following morning cares and hygiene; Remove after 4 hours and check for redness and irritation; Replace after 2 hours off, for 4 hours two times a day for palm guard, wear 4 hours two times a day. A Therapy Communication note to nursing dated 4/7/17, identified recommendations for the	2 895		

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2 895	Continued From page 36	2 895		

resident to wear left palm guard during the day, off at night, to complete hygiene and range of motion, and stretching fingers out straight when taking palm guard on and off.

The 3rd West CNA (certified nursing assistant) Care Guides (contain services/treatments for residents assigned to the nursing assistant) dated 2/13/18, identified R23's to need a rolled wash cloth in left hand, palm guard on right.

During an observation in the dining room on 2/26/18, at 8:20 a.m., R23 sat in a reclining wheelchair with a palm protector in place on her left hand.

During observation on 2/27/18, at 12:19 p.m., R23 was observed sitting in a reclining wheelchair with no palm protector in her left hand.

During observation on 2/28/18, at 9:51 a.m., R23 was seated in her reclining wheelchair with no left hand palm protector in place. At 1:49 p.m. R23 was observed to be lying on her back in bed with no palm guard on her left hand.

During observation on 3/1/18, at 11:07 a.m., R23 was observed in the dining room seated in her wheelchair. She was observed to have the left palm guard on with her fingers curled around it. When R23 was asked whether she could open her left hand, R23 was unable to do so.

R23's care plan revised 4/3/17, identified a focus area of contractures of hands, and need for wash cloth rolled in left hand and palm protector in right hand.

During an interview on 3/1/18, at 2:02 p.m., certified occupational therapy aide (COTA)-D

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2 895	Continued From page 37 verified R23 had been discharged from occupational therapy (OT) with a restorative program on 4/18/17, and to wear a left palm guard during the day and off at night. The Occupational Therapy (OT) Plan of Care dated 3/2/18, identified R23 had a previous order to left palm guard to promote skin integrity and comfort. The plan indicated R23 " ...The caregiver started noticing a decrease in ROM approximately two weeks ago, they also report inconsistent use of palm guard, which has since resulted in the patient now requiring significantly more assistance for hygiene and joint mobility. Due to medical complexity, this patient will require skilled OT to assess appropriate and effective ROM program, educate caregiver on skin integrity, hygiene, wearing schedule of soft brace." The facility's policy Restorative Nursing Care dated 12/2016, included: "restorative nursing care is that which does not require the use of a qualified professional therapist to render such care. Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care plan. The facility's restorative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. Restorative nursing is provided daily for those residents who require such a service. Program includes assisting residents with their routine range of motion exercises." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide passive range of	2 895		

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2 895	Continued From page 38 motion services and splint programs to residents' dependant on facility staff to prevent further decrease in range of motion, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent residents with limited mobility to ensure their mobility needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on interview and record view, the facility failed to follow through on a therapy recommended walking program for 1 of 1	2 915	Completed	3/30/18

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2 915	Continued From page 39 resident (R67) reviewed for activities of daily living. Findings Include: During an interview on 2/26/18, at 12:29 p.m. family member (FM)-A stated the facility staff were not walking R67 like they should. FM-A stated staff were to be walking resident in the afternoon and evenings. I think they want him walking to meals. R67's Therapy Communication to Nursing Dated 2/22/18, indicated Patient will ambulate with a front wheeled walker 2-3 times a day with a lower extremity motion assist (LEMA) strap on his right leg. Step by step instructions taped on closet door how to put strap on. R67's nursing assistant documentation for walking in the corridor in electronic point of care was reviewed from 2/22/18 to 2/28/18, and revealed R67 had been walked two times on 2/28/18 since the walking had been implemented on 2/22/18. R67's care plan dated 2/27/18; included resident will ambulate with a front wheeled walker, 2-3 times a day with LEMA strap on right leg. Step by step instructions taped on closet door. LEMA strap is a brace. R67's nursing assistant care guide updated 2/20/18, included patient will ambulate with front wheeled walker 2-3 times a day with LEMA strap on right leg. Step by step instruction taped on closet door. During an interview on 2/28/18, 2:30 p.m. nursing assistant (NA)-C stated she has not been trained	2 915		

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2 915	Continued From page 40	2 915		

to walk with him by therapy. NA-C stated because she has not been trained, "I do not feel comfortable to walk with him." NA-C stated R67 had weakness on one side and there was a strap (LEMA) to wear on his leg to help with walking. NA-C stated she planned to ask his therapist for a demonstration of how to walk with him today.

During an interview on 3/1/18, at 1:01 p.m. nursing assistant (NA)-A stated R67 was to be walked between two to three times a day if possible. NA-A stated for me on my shift I am supposed to walk him two times. I walked him to the dining room today and will walk back from lunch. NA-A stated if there was one aide, sometimes things happen and the walking is not done. NA-A stated today I was lucky to get it (walking) done. NA-A stated one half of the time she did not have time to walk him when she was working and stated she worked full times days. NA-A if there were cares she could complete by the end of her shift, she passed that on to the next shift. NA-A stated the unit was staffed with one to two aides depending on the needs of the residents and depending on the census. NA-A stated like anybody I think we could use more staff on the unit. NA-A stated there used to be criteria for staffing on the unit. NA-A stated staffing changed on the abilities of the residents and care needs that are currently on unit, which can go up and down and change continuously.

During an interview on 3/1/18, at 4:08 p.m. nursing assistant (NA)-B stated we are supposed to be walking R67 to and from meals. NA-B stated staff document walk in corridor in point of care. NA-B stated if we get busy, R67 will take initiative and he will wheel himself to the dining room. NA-B stated if we catch him at the right moment, we are able to walk to meals. NA-B

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2 915	Continued From page 41 stated normally when I am here his wife is here and taking the initiative to help him. However, I do offer to walk him to bring him down to the dining room. NA-B stated normally it is just me when I work on first floor and it varies between 8 to 14 residents I might be taking care off. NA-B stated lately most of the resident have been pretty independent, but ability to get cares done can depend the resident's needs. NA-B Stated we try our best but sometimes the walking does not get done like it should. During an interview on 3/1/18, at 2:46 p.m. registered nurse (RN)-A stated he was aware R67 was on a walking program and had seen the therapy communication to nursing form. RN-A stated R67 was supposed to be walked a couple of times a day. RN-A stated the nurse on the floor is to make sure the staff were walking him. RN-A stated the aides were to document under tasks in the computer to make sure the walking was being done. RN-A verified the tasks in the computer indicated R67 had only been walked in the corridor on 2/28/18, since the walking program had been implemented by therapy on 2/22/18. RN-A stated my expectation is that they will walk R67 per the care guide and therapy recommendations. RN-A stated most importantly if it (walking) was not being done they (nursing assistants) need to communicate to the nurse on the floor, why it was not completed. RN-A stated I would expect staff to communicate if they did not have time to complete the task. During an interview on 3/1/18, at 3:39 p.m. the nurse consultant (NC)-B stated she expected R67 is walking program to be followed per the therapy recommendations and stated this should be documented in point of care.	2 915		

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2 915	Continued From page 42 A policy was requested for following recommended therapy programs and was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding resident ambulation services. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, including signs/symptoms of infections to prevent the spread of communicable disease and infections. In addition, the facility failed to implement water testing to reduce the risk of a Legionella (a bacterium) in the facility water system to prevent cases and outbreaks of Legionnaires' disease (a serious type of pneumonia). This deficient practice had the	21375	Completed	3/30/18

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21375	Continued From page 43 potential to affect all 91 residents who resided in the facility, staff and visitors. Findings Include: Review of the monthly infection control tracking and trending from 4/2017 through 2/2018, revealed the facility had no documentation that they had analyzed data or identified trends to determine corrective action to prevent the spread of the infections for January 2018 or February 2018. The facility was unable to provide any further logs or tracking tools for infections in the facility and was unable to provide documentation that they had tracked infections for January 2018 or February 2018. During an interview on 2/28/18, at 9:33 a.m. the director of nursing (DON) stated she had been unable to print the infection control logs from her computer for the months January 2018 and February 2018 as she was having problems with her computer. Surveyor stated she did not have to print the infection control logs off her computer for review, that they could be viewed from her computer screen. The DON then stated she was unable to get into the infection control files to even pull them up for surveyor review. During an interview on 3/1/18, at 7:06 a.m. the nurse consultant (NC)-B stated the facility had been unable to locate any documentation regarding infection control for the months of January and February of 2018. NC-B stated there had been no tracking, trending or analysis of infections since previous infection control nurse left facility employment in December 2018. The nurse consultant stated they had looked through	21375		

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the DON's computer files and stated they were unable to find any information that this had been done.

The policy titled Surveillance for Infections revised December 2012, indicated the Infection Control Officer or Designee will conduct ongoing surveillance for Healthcare-Associated Infections and other epidemiological significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventable interventions.

LACK OF IMPLEMENTING WATER TESTING AS A COMPONENT OF LEGIONELLA INFECTIONS PREVENTION:

During an interview on 2/27/18, at 3:07 p.m. the senior executive director stated the facility had completed the assessment for Legionella prevention, but have not completed the water testing. The senior executive director stated the facility would be working with Minnesota Valley Testing Laboratories for completion of water testing and stated we will have a contract with them to manage the program for the facility.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service the infection control nurse on the need to track and trend infections. In addition the senior executive director could in-service responsible staff on water testing for legionaries.

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

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21550	Continued From page 45	21550		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available to be administered as prescribed by the physician, for 1 of 1 resident (R67) who was prescribed critical time sensitive medications. Findings Include: R67's Admission Record identified R67 was admitted to the facility on 1/26/18, with diagnoses of cerebral infarction, and unspecified convulsions. R67's physician orders signed 2/27/18, included: Zonisamide Capsule 100 MG Give 2 capsule by mouth in the evening for seizures, Zonisamide Capsule 100 MG Give 1 capsule by mouth in the morning for seizures and LamoTRIgine Tablet 100 MG Give 1.5 tablet by mouth two times a day related to UNSPECIFIED CONVULSIONS. R67's progress notes and medication administration record revealed the following missed seizure medication doses: "2/11/2018 22:57 [10:57 p.m.] Orders - Administration Note Note Text: Zonisamide Capsule 100 MG Give 2 capsule by mouth in the evening for seizures run out of medication.	21550	Completed	3/30/18

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21550	Continued From page 46 Pharmacy called and meds will be deliver tonight" "2/12/2018 09:28 [9:28 a.m.] Orders - Administration Note Note Text: Zonisamide Capsule 100 MG Give 1 capsule by mouth in the morning for seizures. This medication is unavailable. Was not sent from pharmacy. Did attempt to contact pharmacy, but phone calls were not answered. Spoke with CM [clinical manger] and he will call pharmacy" "2/14/2018 18:28 [6:28 p.m.] Orders - Administration Note Note Text: LamoTRIgine Tablet 100 MG Give 1.5 tablet by mouth two times a day related to UNSPECIFIED CONVULSIONS [R56] Pharmacy is delivering this medication later during the night." "2/22/2018 08:53 [8:53 a.m.] Orders - Administration Note Note Text: LamoTRIgine Tablet 100 MG Give 1.5 tablet by mouth in the morning related to UNSPECIFIED CONVULSIONS (R56) medication not available, reordered today." R67's progress notes were reviewed and there was no documentation in regards to the physician having been notified of the missed seizure medication to receive direction on what should be done for R67 for monitoring or follow-up related to the missed critical seizure medications. R67's medication error reports were requested for the missed doses of seizure medications and revealed medication error reports had not been completed for the missed doses of seizure medication. R67's care plan included, Potential for Alteration in Neurological Status related to: Has a seizure	21550		

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21550	Continued From page 47 disorder. Interventions included: Administer medication as ordered. During an interview on 2/28/18, at 11:56 AM with the nurse consultant (NC)-B and director of nurses (DON), the DON stated she expected medications that are ordered to be here and available to be administered to the residents. The DON stated when a medication was not available to be administered, we start by calling the pharmacy to determine if it (the medication) was in the automated dispensing unit (ADU) machine in the facility and if it is there, we have the pharmacy release it. If the medication was not available in the ADU we would determine when it was scheduled for delivery. If the medication was not planned to be in the delivery or if some reason cannot be delivered the staff are to use the local back up pharmacy. If the medication that was not available was a critical medication and the facility did not have it, they would notify a provider to inform them the medication was not available and for direction on what the facility should do. The DON and NC-B both stated seizure medications were critical medications. The DON stated they (R67) needed to receive the seizure medication as ordered to maintain the appropriate blood levels to prevent seizures. Both the DON and NC-B verified the missed doses of seizure medications on the MAR. The DON stated she was not aware of R67 had missed doses of seizure medication and stated medication error reports were not turned into her. The DON stated medication error reports should have been completed for these missed doses. The DON stated the physician should have been made aware of the missed doses of seizure medications and stated she expected a progress note to have been completed by the nurse.	21550		

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21550	Continued From page 48 During an interview on 2/28/18, at 12:31 p.m. registered nurse (RN)-C stated if I see the medication is not in the cart, I would call the pharmacy to see if the medication was not dispensed and if there was an issue dispensing the medication for the ADU. I would review the chart to see if the medication was still a current order. RN-C stated I would call the pharmacy back and ask if the medication was from the ADU or from a card. I would ask them to dispense the medication from the ADU or if it comes from the cart would ask them to stat the medication, which gives us a four-hour window. RN-C stated if it a critical medication would look in the ekit (emergency medication kit) to see if it is in there. If it were a critical medication like a seizure medication, I would ask the pharmacy to have a backup pharmacy send it to us. If we have a medication that was not available, I would contact the physician to let them know they have missed this medication and ask them what they would like us to do. RN-C stated she would fill out a medication error report on a critical medication and stated seizure medications were critical medications. RN-C stated if a resident had a scheduled medication that was given to prevent seizures and if they do not receive that medication there is the possibility the resident will have seizures. During an interview on 2/28/18, at 3:23 p.m. registered nurse (RN)-B stated she would check the e-kit and call our pharmacy and have them deliver the medication if it was not available. RN-B stated I would talk to my clinical manager and see if I could get that medication in town from a different pharmacy. RN-B stated she was not sure if the facility had a backup pharmacy. RN-B stated she would check to see if the facility had a backup pharmacy and would let this writer know.	21550		

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RN-B stated I would try all options to get the medication so it would be available and if I was not able to get it (the medication) it would be medication error. RN-B stated it was really important to give seizure medications on time as a resident could have a seizure if they did not get them. RN-B stated we could call the doctor on call to get direction to see if they have another solution.

During an interview on 2/28/18, at 4:27 p.m. registered nurse (RN)-B stated we are able to use any pharmacy in town as our backup pharmacy.

During an interview on 2/28/18, at 12:41 p.m. nurse practitioner (NP)-A stated if R67 did not receive his seizure medication as ordered he is at risk of having a seizure. NP-A stated she was unaware of R67's missed doses of seizure medication and stated she should have been made aware of this. NP-A stated as soon as they (facility staff) missed a dose they should have called the provider and notified them of the medication error, as they (the missed doses) could have adverse side effects, the provider would keep closer eye on the patient and follow up on the resident's condition.

The Unavailable Medications policy dated 6/15, included, " ...The facility must make every effort to ensure that medications are available to meet the needs of each resident ..."

The Medication Errors and Drug Reactions policy undated, included, "All medication errors and drug reactions must be promptly reported to the Director of Nursing, attending physician and the pharmacist."

SUGGESTED METHOD FOR CORRECTION:

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21550	Continued From page 50 The DON and/or designee could review with staff the facility's policy and procedure regarding the ordering of medications within a specified time period. A member of the nursing staff could randomly review medication carts and medication rooms to ensure all medications have been and received in a timely manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21550		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to verify a self-administration of medication order was in place before leaving medications in room for 1 of 1 resident (R27). Findings include: R27's admission form included a diagnosis of diabetes and depression. R27's quarterly Minimum Data set (MDS) an assessment dated 12/22/17 as being cognitively intact with a brief interview of mental status of 15. On 2/26/18, at 11:20 a.m. R27 voiced concern	21565	Completed	3/30/18

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some nurses leave medications in her room while others tell her they cannot.

Observation on 2/26/18, at 11:41 a.m. R27 had a medication cup sitting on tray table in her room. R27 said it contained Tylenol, tramadol (used for pain), baclofen (used for muscle spasm), lactase (used for lactose intolerance), and potassium. Medications were in room when entered, no staff present. R27 took while surveyor in room.

Interview on 2/28/18, at 2:40 p.m. trained medication aide (TMA)-A said medications left for R27 to take on her own. TMA-A said R27 has a self-administration of medication order to take on own after set up.

Interview on 2/28/18, at 3:28 p.m. registered nurse (RN)-D said R27 self-administration order never was put back in place after hospital stay. Had been discontinued on 2/19/18. RN-D also said there was no change in R27's cognition condition so another assessment would not be needed.

R27 said on 3/1/18, at 8:33 a.m. that licensed practical nurse (LPN)-B left medication on her tray table to self-administer this morning.

On 3/1/18, at 8:34 a.m. LPN-B was asked about how medication was handled for R27 this morning. LPN-B said medications were left on the tray table. LPN-B then said, R27 does not have an order to self -administer of medications. LPN-B said, "To be honest I know she does not" and R27 requested medication to be left to take later this a.m.

R27's care plan review dated 6/21/17, identifies Self-medication administration: lidocaine ointment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	C 03/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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
21565	Continued From page 52 5% only. R27's Medication self-administration assessment effective date 7/26/17, identified "all medications" can be self-administered. Interview on 2/28/18, at 4:23 p.m. with registered nurse consultant (RNC)-B verified R27 does not have a current order to self-administer medications. The prior self-administration order had been discontinued on 2/19/18. Policy review titled Medication Administration-Preparation and General Guidelines-Self-Administration of Medications dated 6/15 reads: For those resident who self-administer, the interdisciplinary team verifies the resident ability to self-administer medications by mean of a skill assessment conducted on a (quarterly) basis or when there is a significant change in condition. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the required assessment and physician order for self administration before medications can be self administered safely. Also to monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		