### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICALD CERTIFICATION AND TRANSMITTAL	
PART I - TO RE COMPLETED BY THE STATE SURVEY ACENCY	

Facility ID: 00953

MEDICARE/MEDICAID PROVID     (L1)	NO.	3. NAME AND AD (L3) ROCHESTE (L4) 501 EIGHTE (L5) ROCHESTE 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	ER EAST HEA H AVENUE SO ER, MN	ALTH SER' OUTHEAS	(L6) 55904  02 (L7) 13 PTIP 22 CLIA 14 CORF	4. TYPE OF ACTION  1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Of FISCAL YEAR ENDING	2. Recertification 4. CHOW 6. Complaint 9. Other
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	116 (L18) 116 (L17)	B. Not in Compl	nce With equirements e Based On: cceptable POC	am	And/Or Approved Waivers Of  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SN  5. Life Safety Code	6. Scope of Serv	vices Limit ctor
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 116 (L37) (L38)  16. STATE SURVEY AGENCY REM	19 SNF (L39)	ICF (L42) BLE SHOW LTC CA	(L43)	DATE):	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
17. SURVEYOR SIGNATURE  Jennifer Kolsrud, HFE  PA			6/05/2018 BY HCFA RE	(L19)	18. STATE SURVEY AGENCY  Kamala Fiske-Downing, I		Date: list 08/27/2018 (L20
19. DETERMINATION OF ELIGIBII	JTY		IPLIANCE WITI		21. 1. Statement of Final	ncial Solvency (HCFA-2572)	
1. Facility is Eligible to I	Participate		IPLIANCE WITI ITS ACT:		21. 1. Statement of Final	ol Interest Disclosure Stmt (F	
_X 1. Facility is Eligible to I	Participate	RIGH MENT 24		H CIVIL	21. 1. Statement of Final 2. Ownership/Contre 3. Both of the Above  26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimburse	e: (L  D INVOLUNT  05-Fail to M  ement 06-Fail to M	30)
2. Facility is Eligible to I 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 09/01/1972	Participate  (L21)  23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATT A. Suspension	RIGH MENT 24 3 DATE	ITS ACT:  I. LTC AGREEN ENDING DA	H CIVIL	21. 1. Statement of Final 2. Ownership/Control 3. Both of the Above  26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure	: (L    INVOLUNT	.30)  CARY eet Health/Safety
2. Facility is Eligible to I 2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION  09/01/1972  (L24)  25. LTC EXTENSION DATE:	Participate  (L21)  23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATT A. Suspension B. Rescind St	MENT 24 B DATE  VE SANCTIONS of Admissions:	I. LTC AGREEM ENDING DAY (L25) (L44) (L45)	H CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above  26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimburse  03-Risk of Involuntary Termination	: (L    INVOLUNT	30)  SARY eet Health/Safety eet Agreement



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

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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:

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

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

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

<u>Substandard Quality of Care</u> - 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;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

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

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

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

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

### 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

Email: eva.iocn@state.mn

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:

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

Department of Health and Human

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Kumalu Fiske Downing

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



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

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

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/MEDICALD CERTIFICATION AND TRANSMITTAL	
PART I - TO RE COMPLETED BY THE STATE SURVEY ACENCY	

Facility ID: 00953

MEDICARE/MEDICAID PROVII     (L1)	NO.	3. NAME AND AE (L3) ROCHESTE (L4) 501 EIGHTE (L5) ROCHESTE 7. PROVIDER/SU 01 Hospital	ER EAST HEA H AVENUE SO ER, MN	LTH SERV		4. TYPE OF ACTION:  1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Co	2. Recertification 4. CHOW 6. Complaint 9. Other
6. DATE OF SURVEY 05/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	01/2018 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds	116 (L18) 116 (L17)	X B. Not in Com	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code  * Code: B*	6. Scope of Servi	ces Limit tor
14. LTC CERTIFIED BED BREAKD  18 SNF 18/19 SNF  116  (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM  17. SURVEYOR SIGNATURE	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE)  17. SURVEYOR SIGNATURE  Date:					⁄ APPROVAL	Date:
Jennifer Kolsrud, HFE NE II  06/05/2018 (L19)							
Jennifer Kolsrud, HFE	NE II	0	6/05/2018	(L19)	Kamala Fiske-Downing.	Enforcement Specialis	st 08/24/2018 <sub>(L20)</sub>
				(L19)	Kamala Fiske-Downing.  OFFICE OR SINGLE S	•	st 08/24/2018 <sub>(L20)</sub>
	ART II - TO BE ( ILITY  Participate	COMPLETED E		EGIONAL	OFFICE OR SINGLE S  21. 1. Statement of Fina	TATE AGENCY  ncial Solvency (HCFA-2572)  ol Interest Disclosure Stmt (HC	(L20
PA  19. DETERMINATION OF ELIGIBI  _X 1. Facility is Eligible to	ART II - TO BE ( ILITY  Participate	20. COM RIGH MENT 24	BY HCFA RE	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Control	TATE AGENCY  ncial Solvency (HCFA-2572)  ol Interest Disclosure Stmt (HC  e:  (L3)  INVOLUNTA	(L20 CFA-1513)
PA  19. DETERMINATION OF ELIGIBI  X 1. Facility is Eligible to 2. Facility is not Eligib  22. ORIGINAL DATE OF PARTICIPATION	ART II - TO BE ( ILITY  Participate  le (L21)  23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATI A. Suspension	20. COMPLETED E 20. COM RIGH MENT 24	BY HCFA RE IPLIANCE WITH ITS ACT:	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION VOLUNTARY 00	rate Agency  ncial Solvency (HCFA-2572)  ol Interest Disclosure Stmt (HCE)  : (L3)  INVOLUNTA  05-Fail to Medement 06-Fail to Medement	(L20 CFA-1513)  60) ARY et Health/Safety et Agreement
PA  19. DETERMINATION OF ELIGIBI  X 1. Facility is Eligible to 2. Facility is not Eligib  22. ORIGINAL DATE  OF PARTICIPATION  09/01/1972  (L24)  25. LTC EXTENSION DATE:	ART II - TO BE ( ILITY  Participate  ole (L21)  23. LTC AGREEM  BEGINNING  (L41)  27. ALTERNATI  A. Suspension  B. Rescind Su	20. COMPLETED E  20. COM RIGH  MENT 24  DATE  VE SANCTIONS of Admissions:	BY HCFA RE IPLIANCE WITH ITS ACT:  I. LTC AGREEM ENDING DAT (L25)  (L44)  (L45)	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	TATE AGENCY  ncial Solvency (HCFA-2572)  ol Interest Disclosure Stmt (HC  e:  (L3)  INVOLUNTA  05-Fail to Med  on  OTHER  07-Provider S	(L20 CFA-1513)  60) ARY et Health/Safety et Agreement



Protecting, Maintaining and Improving the Health of All Minnesotans

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

```
Rochester East Health Services
May 17, 2018
Page 2
```

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

Rochester East Health Services
May 17, 2018
Page 3
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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

### 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:

Rochester East Health Services May 17, 2018 Page 4

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

Rochester East Health Services May 17, 2018 Page 6

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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

Kamala Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 06/05/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245184	B. WING		R-C <b>05/01/2018</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/01/2010
ROCHESTER EAST HEALTH SERVICES				501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIUE DEFICIENCY)	D BE COMPLÉTION
E 000	Initial Comments		E 0	00	
{F 000}	No deficiencies we survey. INITIAL COMMEN	ere noted at the time of the	{F 00	10}	
{F 554} SS=D	Focus Facility (SFF certification revisit (and May 1, 2018, a corrected all the cit exited March 2, 20.  An investigation of substantiated at F6 March 2, 2018 and this PCR.  Because you are esignature is not requage of the CMS-2 submission of the Everification of compresident Self-Adm CFR(s): 483.10(c)(Self-Adm CFR(s): 483.10(c)(This REQUIREMED by: Based on observative eview, the facility frecommendations is	complaint H5184097 was 89 during the survey exited was found corrected during  nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance. in Meds-Clinically Approp 7)  right to self-administer interdisciplinary team, as (b)(2)(ii), has determined that cally appropriate. NT is not met as evidenced tion, interview and record ailed to follow assessed for Medication Self of 3 resident (R27) reviewed	{F 55	PLAN OF CORRECTION  F554: Resident Self-administered Medication-Clinically Appropriate SS: D	5/9/18
			l		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

06/05/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING		R-	C 1/ <b>2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	1 00/0	7172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 554}	dated 3/22/18 readself-administer med SUPERVISION." In interdisciplinary teaself-administer.  R27's current care administration: Resmedications WITH intervention/tasks: administration."  R27's Order Summ physician dated 4/1 self-administer WITH self-administer WITH regress note date "A self-administration and the self-administration."	self Administration assessment is, "Resident may dications WITH addition, the facilities im does not feel R27 is safe to plan reads, Self-medication sident may self-administer SUPERVISION with "Staff will supervise ary Report signed by 3/18, reads, "Resident may TH SUPERVISION."  If a 3/22/18, at 3:30 p.m. reads, on of medication assessment resident may self-administer the supervision of licensed cussed findings with the and oriented x 3 and her own is agreeable to the findings. Notified. Care plan and orders on 4/30/18, at 8:50 a.m. who is take and do not stay in mistrator on 4/30/18, at 10:15 youly had five residents who medication and it is only for	{F 554	1. Corrective action(s) will be accomplished for those residents in have been affected by the deficient practice?  "R27 was re-assessed on 5/7/2 safe Self Administration of Medicar Not leaving medications at bed sid Reason for taking medications; Acknowledgement of Adverse Side effects; and Identification of medicing R27 s Medical Provider was not the findings that were obtained in Safe Self Administration Assessment 5/7/18; and a Physician is order to self-administer medications was only R27 s Responsible Party was notified of the findings that were of from the Safe Self Administration Assessment on 5/7/18 and that a Physician is order to self-administration Assessment on 5/7/18 and that a Physician is order to self-administration was obtained.  "R27 was reeducated on safety self-administration of medication; leaving medications at bed side; a knowledge base of adverse side e and identification of medications  "R27 s Care Plan was reviewed updated on 5/7/2018 related to R1 findings of safe Self Administration Self Administration Assessment.  2. How will you identify other resinaving the potential to be affected same deficient practice?	t 2018 for tions; e; e ations. notified from the ent on obtained. Extrained er of not not ffects ed and s per the dents	
	self-administered.			" Residents at Rochester Fast H	lealth	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X3) A. BUILDING			SURVEY PLETED			
		245184	B. WING			R-	-C <b>01/2018</b>
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	05/0	71/2016
10.00.2 01 111	OVIDEN ON OUT LIEN				501 EIGHTH AVENUE SOUTHEAST		
ROCHEST	ER EAST HEALTH S	SERVICES			ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
t I I I I I I I I I I I I I I I I I I I	a.m. there was a mostiting on her tray ta his time. R27 was a which included, one actase, one tramadon 5/1/18, at 8:33 a egistered nurse (Rimedications left on at 11:49 a.m.) RN-/he medications againterview on 5/1/18, Nursing (DON) regardent for her to supervision. The DOS supervised during the nurse should stay whe medications are taken to take later.  Policy titled-"Self-active tat bedside unleaded to the container that rom the residents redside will be decided edited be decided as the decided will be decided to the	on of R27 on 4/30/18, at 11:49 edication cup with oral pills able. No staff were present at able to name the medications, tablet iron, two Tylenol, two lol and 1 potassium.  I.m., during an interview with N)-A concerning R27's tray table yesterday (4/30/18 A remembered she had left ain for R27 to take on her own.  at 12:41 p.m. with Director of arding R27's medications take independently with no DN said if it says to be ne taking of medications the with the resident until the en and not left for the resident definitions should not be easily removed oom. Keeping medications at ded by the Administrator and cumstances will narcotics be	{F 55	54}	Services who chose to self-administ medication have the same potential affected by the same deficient pract." An audit was conducted on 5/8 to assess Residents at Rochester & Services East who chose to self-administer medications for safe Administration.  3. What measures will be put into or what systemic changes will you into ensure that the deficient practice not recur?  "Nurses and TMAs were in-served 5/7/18 or 5/8/18, related to the Minit Health Department findings of F-55 the Revisit Survey that ended on 5/7 This in-service included how to make sidents who have been determined for Self-Administer medications the Self-Administer Medication; with a second following MAR & TAR document properly. Training was followed with post test.  "Residents who reside and choose the Self-Administer Medications Quarter Annual, with Significant Change of Condition, after Readmission, and for continued safety per the Self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication at Rochester Health Services will perform a demonstration; and be able to verboth self-Administer Medication.	It to be stice. /2018 Health e Self place make e does viced on nesota 54, from /1/18. nage ned s per tt; have focus tation th a pse to Health erly, PRN	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245184	B. WING			R-	-C <b>01/2018</b>
NAME OF	PROVIDER OR SUPPLIER	240104	1		REET ADDRESS, CITY, STATE, ZIP CODE	05/0	J1/2016
IVAIVIL OI	THOUBERTON SOLT EIEN				1 EIGHTH AVENUE SOUTHEAST		
ROCHES	STER EAST HEALTH S	SERVICES			OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 554}	Continued From pa	ge 3	{F 5	54}	education provide.  " IDT will review residents that he been screened for Self-Administrat Medication to determine safety risk.  4. How will you monitor the correct action(s) to ensure the deficient provide will not recur, i.e., what quality assurance monitoring residents of Rochester Health Selected sare monitoring Residents whave been assessed to Self-Administration and to residents whose left and to residents who self-administration and to residents who self-administration on all current residents a week for one week; then 2 times for one week, and then weekly for the self-administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.  " Additional training may be schelated to monitor Safe Self Medicated Administration.	ion of  ctive actice urance  Quality ervices tho ister  on eter 3 times a week otal of rsing or n ion eduled urance  ag lity d and	

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER.		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING				-C <b>01/2018</b>
NAME OF E	PROVIDER OR SUPPLIER	2-10-10-1			TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/0	01/2016
NAME OF I	THO VIDEN ON SOLT EIEN						
ROCHES	TER EAST HEALTH S	SERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 554}	Continued From page	ge 4	(F 55	54}	with findings of investigations will be reviewed monthly in QAPI meetings three months to ensure compliance facility policy and state and federal regulations.  "The facility administrator and/of designee will monitor that the tools completed.	s for e with r	
{F 656} SS=D	CFR(s): 483.21(b)( §483.21(b) Compre	Comprehensive Care Plan  I)  hensive Care Plans acility must develop and	{F 65	56}	·		5/9/18
	implement a compricare plan for each rights set for §483.10(c)(3), that is objectives and time medical, nursing, an needs that are identical assessment. The codescribe the following (i) The services that or maintain the residency physical, mental, and required under §483 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. findings of the PASA	ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and ncludes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive emprehensive care plan must are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and the would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 33.10(c)(6).  services or specialized es the nursing facility will					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245184	B. WING			R-	
	245164	b. WING			05/0	01/2018
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER EAST HEALTH SI	EBVICES		50	01 EIGHTH AVENUE SOUTHEAST		
HOCHESTER EAST HEALTH SI	LITVICES		R	OCHESTER, MN 55904		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
resident's representa  (A) The resident's go desired outcomes.  (B) The resident's pr future discharge. Fac whether the resident community was asse local contact agencie entities, for this purp (C) Discharge plans plan, as appropriate, requirements set for section. This REQUIREMEN' by: Based on observation review, the facility fac for 1 of 3 residents (I need).  Finding include:  R26's admission she Dysphagia (a difficult infarction (stroke).  R26's current care p dentures and require oral care. As well as difficulty as related to left side. R26 has m nectar-thickened liqu  R26's Treatment adr includes R26 needs brushing her teeth, a bed. Focus on areas	th the resident and the ative(s)- pals for admission and reference and potential for cilities must document 's desire to return to the ressed and any referrals to research and/or other appropriate research and any referrals to research and any referrals to research and any referrals to research and record and record and record and record and record respectively.  To is not met as evidenced respectively and record respectively and record respectively.  The included a diagnosis of respectively and remains and record respectively.  The included a diagnosis of respectively and remains and record respectively.  The included a diagnosis of respectively and remains and respectively.  The included a diagnosis of respectively and remains and respectively.  The included a diagnosis of respectively and respectively.	{F 65	56}	F656: Develop/Implement Comprehensive Care Plans SS: D  1. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice?  " On 5/8/18, R26 was re-assessed her overall clinical status is unchan R26 s oral status remains at base " R26 s Medical Provider was ure 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 status remaining at baseline on 5/8  " R26 s Care Plan was reviewed updated on 5/7/2018 on oral care services.  2. How will you identify other residence.	ed and ged. line. pdated is oral 1/18. d and status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				SURVEY PLETED
		245184	B. WING			R- 05/0	-C <b>)1/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904	1 03/0	71/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 656}	R26 was seated at finished eating her continued to be in continued to	of R26 on 5/1/18, at 845 a.m. the dining table and had breakfast. At 9:44 a.m. R26 dining room.  ursing assistant (NA)-B on in. who stated most resident before breakfast only a few teeth brushed after breakfast cluded in the list given by  A-A on 5/1/18, at 10:10 a.m. get their teeth brushed after ing about R26 NA-A stated she 26 before breakfast.  /18, at 10:16 a.m. Licensed N)-A said no residents are eare by the nurses, however, in when residents have g LPN-A regarding oral cares becked the doctors orders and order for brushing teeth after re bed time. LPN-A said she lA-A and NA-B if they had in following breakfast. But me.	{F 6	56}	having the potential to be affected same deficient practice?  "Residents who are admitted to Rochester East Health Services has same potential to be affected by the deficient practice.  "An audit of resident's oral care conducted on 5/6/18 and 5/7/18.  3. What measures will be put into or what systemic changes will you to ensure that the deficient practice not recur?  "Facility staff were In-serviced of 5/7/18 or 5/8/18, related to the Min Health Department findings of F-68 the Revisit Survey that ended on 5 related to oral cares and proper documentation of Oral care post completion of oral care.  "Nursing Staff will document An cares per physician order, when care physician order, when care physician physician physician physician phy	was  place make does  nesota form /1/18,  M/PM are is  ctive actice urance  Quality idents s are PM	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245184	B. WING				-C
NAME OF 5	200//055 05 01 1551 155	245164	b. Willa		FREET ADDRESS SITY STATE TID SORE	05/0	01/2018
NAME OF F	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER EAST HEALTH S	SERVICES			01 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684 SS=D	applies to all treatm facility residents. Be assessment of a re- that residents receiv accordance with pro- practice, the compre	care fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered	{F 65		assurance tool, related resident ora during AM and PM care or as other specified by medical provider; 3 tim week for one week; then 2 times a for one week, and then weekly for the 12 weeks of audits.  "Additional training may be schebased on results of the quality assureview.  "As part of the facility is on-going Quality Assurance and Process Improvement (QAPI) program, facing policy and procedures are analyzed modified as necessary by the QAP committee. All deficient practices a with findings of investigations will be reviewed monthly in QAPI meetings three months to ensure compliance facility policy and state and federal regulations.  "The facility administrator and/ordesignee will monitor that the tools completed.	wise nes a week total of eduled urance ng lity d and l along e s for e with	5/9/18
	care plan, and the r	531451115 CHUICES.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING		R- <b>05</b> /0	·C 01/ <b>2018</b>
NAME OF PROVIDER OR SUPPLIER  ROCHESTER EAST HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		7.7.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	This REQUIREMEI by: Based on interview facility failed to imp administration of armigraine medicatio who had chronic m Findings Include: R92's Admission R admitted to the faci of Hemiplegia (para following a cerebra the dominant left si R92's care plan, da potential for alteratichronic headaches Administer medicat document for effectiveness of pa for compliance, efferestiveness of pa for compliance, efferesident satisfaction and impact on cognitive sa	And document review, the lement specific parameters for in two as needed (PRN) ins for 1 of 1 resident (R92) igraine headaches.  ecord identified R67 was lity on 9/12/05, with diagnoses alysis on one side of the body) I infarction (stroke) affecting de, and headache.  Interventions included, on in comfort related to an incomfort related to interventions included: itions as ordered. Monitor and tiveness. Evaluate the in regime as needed. Review ectiveness, dosing schedules, in, impact on functional ability inition.  Iders signed 4/23/18, included: g: give 1 capsule by mouth as the headaches. Administer for atter than level 7 and take with of 6 capsules per week. 2. Ite 10 mg: give 1 tablet by or migraine headache, "MUST OPROFEN, AS ORDERED, and by Ketoprofen after 2 hours. Jurs. Maximum 2 tablets in 24	F 684	F684: Quality of Care SS: D  1. Corrective action(s) will be accomplished for those residents have been affected by the deficient practice?  "R92 was re-assessed and her clinical status remains at baseline influence noted related to the use on 5/7/2018.  "R92 s current order for Ketophas been reviewed and adjust and written without < and > abbreviation  "R92 s Medical Provider was of her continued baseline status.  "R92 s is responsible for hers is aware of her own clinical status.  "R92 s Care Plan was reviewed updated on 5/7/2018.  2. How will you identify other residual to be affected same deficient practice?  "Residents who reside at Roch East Health Services who use promedications have the same potential affected by the same deficient practicent or what systemic changes will you to ensure that the deficient practic not recur?  "Facility staff were In-serviced"	r over with no of prn orofen d is now ons. notified elf and ded and idents by the ester tial to be ctice.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245184	B. WING			-C <b>01/2018</b>	
NAME OF PROVIDER OR SUPPLIER  ROCHESTER EAST HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	April, 2018 was revifollowing: April 27, given with level 5 p April 2, 22, and 24, prior.  During an interview licensed practical rhad a headache shwas unclear if the othan pain level of 7 10 being worst pair used a symbol ">" written out. After clorder read greater verified R92 receiv 28, with a pain level Further verified R92, 22, and 28, with which was ordered affective to give Rizuring an interview director of nursing receive her as neewithin the specified physician. DON st nurses administering parameters is they prn medications as	riewed and revealed the and 28, 2018, Ketoprofen was ain. Rizatriptan was given on without getting the Ketoprofen of 5/1/18, at 12:08 p.m., aurse (LPN)-A stated if R92 are could have Ketoprofen, but order said more than or less (of a 1 to 10 pain scale with a ever), because the order of greater than versus being arification that the medical (>) than a level 7 pain, LPN-A and Ketoprofen on April 27 and all of 5 and shouldn't have. 2 received Rizatriptan on April but first giving Ketoprofen to be given first and if not exatriptan.  If on 5/1/18, at 12:26 pm, (DON) verified R92 did not ded headache medication a parameters as ordered by the ated, "My expectation for the ag prn medications with (residents) should be given written by the doctor."	F 68	5/7/18 or 5/8/18, related to the Nealth Department findings for from the Revisit Survey that end 5/1/18; proper use of PRN mediand to administer Medications a Physician s Orders.  4. How will you monitor the coaction(s) to ensure the deficient will not recur, i.e., what quality a program will be put into place?  "The facility has implemente Assurance Program to ensure Residents of Rochester Health East s Medications are availab as per Physician s Order.  "The Director of Nursing and designee will complete a quality assurance tool on three residen receive PRN medications: 3 tim for one week; then 2 times a we week, and then weekly for a tota weeks of audits.  "Additional training may be s based on results of the quality a review.  "As part of the facility s on-Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program, find policy and procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI) program and Procedures are analy modified as necessary by the Quality Assurance and Process Improvement (QAPI)	F-684 ded on ications; is per  rrective practice ssurance  d a Quality Services le  //or ts who es a week ek for one al of 12 cheduled issurance going facility rzed and API es along ill be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
						R-C		
		245184	B. WING			05/0	01/2018	
NAME OF F	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BUCHES	TER EAST HEALTH S	SERVICES		50	01 EIGHTH AVENUE SOUTHEAST			
HOUTES	TER EAST HEALING	SERVICES		R	OCHESTER, MN 55904			
(X4) ID PREFIX TAG			ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From pa	ge 10	F 6	84	three months to ensure compliance facility policy and state and federal regulations.  " The facility administrator and/o designee will monitor that the tools completed.	r		
{F 688} SS=D	Increase/Prevent D CFR(s): 483.25(c)(	ecrease in ROM/Mobility 1)-(3)	{F 68	38}			5/9/18	
	resident who enters range of motion does range of motion unle condition demonstration of motion is unavoid §483.25(c)(2) A resemble motion receives appropriate assistance to maint the maximum practice reduction in mobility This REQUIREMENTS.	acility must ensure that a the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range dable; and defined with limited range of propriate treatment and erange of motion and/or to rease in range of motion.  Ident with limited mobility eservices, equipment, and ain or improve mobility with icable independence unless a gris demonstrably unavoidable.			E-TAG 688: Increase/Prevent Dec	rease		
	review, the facility fa	ion, interview and record ailed to implement a palm orders for 1 of 1 resident by had contractures.			F-TAG 688: Increase/Prevent Deci in ROM/Mobility SSD: D	rease		
	Findings include:				Corrective action(s) will be accomplished for those residents for	ound to		
	R23's Admission Re	ecord document identified an			have been affected by the deficient			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING		R- <b>05</b> /0	C <b>)1/2018</b>
NAME OF PROVIDER OR SUPPLIER  ROCHESTER EAST HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE  501 EIGHTH AVENUE SOUTHEAST  ROCHESTER, MN 55904			7172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
{F 688}	admission date of hand contractures  R23's physician provealed: "R23 has hand especially. Signand."  A quarterly Minimulassessment dated severely cognitively of motion (ROM) in extremities, contraction ankle, and contraction R23's treatment and dated April, 2018, it with a.m. care and R23's current care have a physical furself-care impairmed Intervention: apply remove with p.m. of During observation R23 is sitting in he wheelchair) chair unroom and has left produced being assisted with aide (TMA)-A. R23 in place.  During an interview nursing assistant (	2/20/12, and diagnoses of left (10/3/16).  ogress note dated 3/8/18, a severe contractures of her left he has a palm guard for the left he has a palm guard for the left he has a palm guard for the left has a palm guard lower cures of the left hand and tures of the left hand and tures of the right ankle.  Idministration record (TAR) dentified: Apply left palm guard remove with p.m. care.  Inctioning deficit related to the left upper arm contractures." palm guard with a.m. care and	{F 688	Practice?  "R23 was assessed on 5/8/18 overall clinical status and adaptive equipment needs. "R23 s Medical Provider was related to her overall clinical status remains at baseline with continued her adaptive device on 5/8/18.  "R23 s Responsible Party was updated related to her overall clinical status remains at baseline with couse of her adaptive device on 5/8/ "R23 s Care Plan was review updated on 5/6/818.  2. How will you identify other residented on 5/6/818.  2. How will you identify other residented same practice?  "Residents who reside at Roch East Heath Services that have use splints/braces have the same pote be affected by the same deficient management."  An audit of Residents with splints/braces was conducted on 5/6/818.  3. What measures will be put into or what systemic changes will you to ensure that the deficient practic not recur?  "Facility staff were In-serviced of 5/7/18 or 5/8/18, related to the Mir Health Department findings of F-6 the Revisit Survey that ended on 5 This in-service included the need of Physician is Order for residents with splints or residents with solve and solve the same potential to be affected by the same deficient management.	updated and use of secal national and and sed	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
045104		-			R-C		
	245184	B. WING			05/0	01/2018	
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHESTER FAST HEALTH SE	ROCHESTER EAST HEALTH SERVICES			01 EIGHTH AVENUE SOUTHEAST			
HOOHESTER EAST HEALITISE	IIVIOLO		R	ROCHESTER, MN 55904			
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
she has been up for a put it on her."  During interview on 5 practical nurse (LPN) have left palm guard should be. LPN-B stabe for a resident with wear a palm guard th ordered."  During interview on 5 of nursing (DON) verishould have been put care plan.  During interview on 5 occupational therapy should have a palm gand off at night, "this contractures." COTA palm guards are essecontractures of her lewhen washing hands comfort."	der up today and I forgot, a while now, I should have and verified it ated, "My expectation would an order from therapy to at it should be put on when when while now with a.m., director fied R23's left palm guard to no with a.m. cares per the while now with a.m., certified aide (COTA)-D verified R23 uard applied in the morning is to help prevent further bential to prevent further thand and to reduce pain promoting resident with and devices requested while now while now have a should ha	{F 68	88}	splints or braces.  4. How will you monitor the correct action(s) to ensure the deficient prowill not recur, i.e., what quality assurancer program to ensure that Residents of Rochester Health Ser East s Passive Range of motion program.  "The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit #688-C) to compliance of Passive Range of M With the 3 residents who need pas range of motion; 3 times a week for week; then 2 times a week for one and then weekly for a total of 12 we audits.  "Additional training may be schebased on results of the quality assureview.  "As part of the facility s on-goin Quality Assurance and Process Improvement (QAPI) program, facipolicy and procedures are analyzed modified as necessary by the QAP committee. All deficient practices a with findings of investigations will b reviewed monthly in QAPI meetings three months to ensure compliance facility policy and state and federal regulations.	actice urance  Quality vices  monitor otion. sive r one week, eeks of eduled urance  lity d and l along e s for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING				-C <b>01/2018</b>	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/1	01/2010	
ROCHESTER EAST HEALTH SERVICES					01 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)			PROVIDER'S PLAN OF CORRECTION  X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
{F 688}	Continued From pa		{F 6		" The facility administrator and/o designee will monitor that the tools completed.	r		



Protecting, Maintaining and Improving the Health of All Minnesotans

### 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

Rochester East Health Services May 25, 2018 Page 2

### 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.

Rochester East Health Services May 25, 2018 Page 3

Sincerely,

Kumalu Fishe 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 Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED		
	00953		B. WING			R-C <b>05/01/2018</b>	
NAME OF	PROVIDER OR SUPPLIER	00300	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 03/1	31/2010
ROCHES	STER EAST HEALTH S	SERVICES		TH AVENUE TER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{2 000}	Initial Comments			{2 000}			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDI	ER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber and mum	nether a violation has	ssued on, it is cited violation dance rule of been ag celow. re to idered upon rule will the item				
	that may result from orders provided tha the Department witl	hearing on any asses n non-compliance with t a written request is i hin 15 days of receipt ant for non-compliance	n these made to of a				
	30, May 1, 2018. Di	rs: visit was completed ouring this visit it was following citations we					
		nt investigation H518 at MN Rule 4658.052					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/05/18 **Electronically Signed** 

TITLE

STATE FORM 6899 VCL412 If continuation sheet 1 of 12

	NT OF DEFICIENCIES N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING		R- <b>05/0</b>	C <b>1/2018</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	ROCHESTER EAST HEALTH SERVICES 501 EIG ROCHE			SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
{2 000}	2018. During this or complaint was foun  The uncorrected cit	ng survey exited on March 2, n-site licensing visit the d corrected.  ations will remain in effect and	{2 000}			
{2 830}	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	{2 830}			5/9/18
	by: This licensing order  Based on observati review, the facility fa for 1 of 3 residents need. Also based o review, the facility fa parameters for adm needed (PRN) migr	ent is not met as evidenced was not corrected due to: on, interview and record ailed to assist with oral care (R26) according to assessed in interview and document ailed to implement specific inistration of an two as aine medications for 1 of 1 had chronic migraine		F656: Develop/Implement Compre Care Plans SS: D  1. Corrective action(s) will be accomplished for those residents f have been affected by the deficient practice?  " On 5/8/18, R26 was re-assessed overall clinical status is unchanged."	ound to t and her	

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 2 of 12

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R-C	
		00953	B. WING		05/01/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
{2 830}	Continued From pa	ge 2	{2 830}			
{Z 630}	Finding include:  R26's admission sh Dysphagia (a difficult infarction (stroke).  R26's current care dentures and required oral care. As well as difficulty as related left side. R26 has mectar-thickened licked. R26's Treatment actincludes R26 needs brushing her teeth, bed. Focus on area morning and at bed 12/20/16.  During observation R26 was seated at finished eating her continued to be in continued to the incontinued to the i	plan includes R26 wears resone staff assistance for s swallowing and self-feeding to limited physical strength on mechanical soft diet with puid.  Imministration records (TAR) assistance twice daily after breakfast and before as above the gum line. Every time for dental care start date of R26 on 5/1/18, at 845 a.m. the dining table and had breakfast. At 9:44 a.m. R26 lining room.  Insing assistant (NA)-B on an who stated most resident efore breakfast only a few teeth brushed after breakfast cluded in the list given by  A-A on 5/1/18, at 10:10 a.m. get their teeth brushed after about R26 NA-A stated she 26 before breakfast.	{2 830}	R26 s oral status remains at base "R26 s Medical Provider was upon the overall clinical and oral status remaining at baseline on 5/8/18. "R26 s Responsible Party was upon the overall clinical and oral stat remaining at baseline on 5/8/18. "R26 s Care Plan was reviewed updated on 5/7/2018 on oral care 2. How will you identify other resid having the potential to be affected same deficient practice?  "Residents who are admitted to Rochester East Health Services have potential to be affected by the deficient practice. "An audit of resident's oral care word conducted on 5/6/18 and 5/7/18.  3. What measures will be put into what systemic changes will you meansure that the deficient practice or recur?  "Facility staff were In-serviced on or 5/8/18, related to the Minnesota Department findings of F-656 from Revisit Survey that ended on 5/1/1 related to oral cares and proper documentation of Oral care post completion of oral care.  "Nursing Staff will document AM/Ficares per physician order, when cares per physician order physican provides per phy	dated on pdated us and status. ents by the ave the ne same as place or ake to does not 5/7/18 health in the 8, ents are is tive	
	stated no residents breakfast. On askin gave oral care to R. An interview on 5/1, practical nurse (LPI	get their teeth brushed after ig about R26 NA-A stated she 26 before breakfast.		" Nursing Staff will document AM/F cares per physician order, when completed and validated.	are is tive actice	

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 3 of 12

NAME OF PROVIDER OR SUPPLIER  **ROCHESTER EAST HEALTH SERVICES**  **ROCHESTER EAST HEALTH SERVICES**  **SOLEMENT**  **ROCHESTER EAST HEALTH SERVICES**  **SOLEMENT**  **ROCHESTER, MN 55904**  **ROCHESTER, MN 55904**  **ROCHESTER, MN 55904**  **ROCHESTER, MN 55904**    PREGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX TAG**    Candidate of the continued From page 3   (2 830)   Program will be put into place?   CROSS-REFERENCE TO THE APPROPRIATE DATE DATE DEFICIENCY)   DEFICIENCY   TAG   CROSS-REFERENCE TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DEFICIENCY   CROSS-REFERENCE TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ROCHESTER EAST HEALTH SERVICES  SOI EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904    (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   (EACH CORRECTIVE ACTOON TO COMPLETE TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED   (EACH CORRECTIVE ACTOON TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED   (EACH CORRECTIVE ACTOON TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED   (EACH CORRECTIVE ACTOON TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED   (EACH CORRECTIVE ACTOON TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED   (EACH CORRECTIVE ACTOON TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED   (EACH CORRECTIVE ACTOON TO CROSS-REFERENCED TO THE APPROPRIATE DEFI				A. BOILDING		B-(	C
CALL   Compact   Call		00953					
(2830) 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	NAME OF PRO	OVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX TAG   REGULATORY OR LSC IDENTIFY OR LACTORY OR LSC IDENTIFY OR LS	BOCHESTER EAST HEALTH SERVICES						
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	PRÉFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
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.	In de for for the Racion for the Rac	nurses may monitoral lentures. On asking or R26, LPN-A che ound R26 had an organization of R26 had an expect of R27 had a contential for alteration of Hemiplegia (para collowing a cerebral had be a care plan, day the dominant left side of Hemiplegia (para collowing a cerebral had be a care plan, day the dominant left side of Hemiplegia (para collowing a cerebral had be a care plan, day the dominant left side of the reduction of R26 had a collowing a cerebral document for effect of the reduction of R26 had a collowing a collowing a cerebral document for effect of the reduction of R26 had a maximum of R26 had a maximum of R27 had a seeded for migraine reduction of R28 ha	r when residents have g LPN-A regarding oral cares ocked the doctors orders and order for brushing teeth after re bed time. LPN-A said she IA-A and NA-B if they had in following breakfast. But me.  Stor of Nurses on 5/1/18, at esidents are being monitored expect nurses to make sure inpleted as ordered.  Secord identified R67 was lity on 9/12/05, with diagnoses alysis on one side of the body) Infarction (stroke) affecting de, and headache.  Sted 3/14/16, included, on in comfort related to interventions included: ions as ordered. Monitor and tiveness. Evaluate the in regime as needed. Review ectiveness, dosing schedules, in, impact on functional ability nition.  Sers signed 4/23/18, included: g: give 1 capsule by mouth as the headaches. Administer for after than level 7 and take with of 6 capsules per week. 2. Ite 10 mg: give 1 tablet by or migraine headache, "MUST OPROFEN, AS ORDERED,		program will be put into place?  "The facility has implemented a CAssurance Program to ensure Resof Rochester Health Services East receiving oral care during AM and cares  "The Director of Nursing and/or dwill complete a quality assurance to related resident oral care during APM care or as otherwise specified medical provider; 3 times a week for one and then weekly for total of 12 week audits.  "Additional training may be sched based on results of the quality assurance and Process Improvem (QAPI) program, facility policy and procedures are analyzed and mode necessary by the QAPI committee deficient practices along with finding investigations will be reviewed mode QAPI meetings for three months to compliance with facility policy and and federal regulations.  "The facility administrator and/or designee will monitor that the tools."	esignee cool, M and by for one e week, eks of  Uled curance  Quality nent lified as a All ngs of nthly in o ensure state	

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 4 of 12

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  00953		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING		R- <b>05</b> /0	-C <b>11/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ROCHES	ROCHESTER EAST HEALTH SERVICES  501 EIGH ROCHES			SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	Continued From page 4		{2 830}			
	hours, 4 tablets in 1	week.				
	April, 2018 was revi following: April 27, given with level 5 pa	dministration record (MAR) for iewed and revealed the and 28, 2018, Ketoprofen was ain. Rizatriptan was given on without getting the Ketoprofen				
	licensed practical n had a headache sh was unclear if the o than pain level of 7 10 being worst pain used a symbol ">" o written out. After cla order read greater (verified R92 receive 28, with a pain leve Further verified R92 2, 22, and 28, without the classic state of the classic	5/1/18, at 12:08 p.m., urse (LPN)-A stated if R92 e could have Ketoprofen, but rder said more than or less (of a 1 to 10 pain scale with ever), because the order of greater than versus being arification that the medical (>) than a level 7 pain, LPN-A ed Ketoprofen on April 27 and I of 5 and shouldn't have. 2 received Rizatriptan on April out first giving Ketoprofen to be given first and if not atriptan.				
	director of nursing ( receive her as need within the specified physician. DON stanurses administerin parameters is they	on 5/1/18, at 12:26 pm, DON) verified R92 did not ded headache medication parameters as ordered by the ated, "My expectation for the g prn medications with (residents) should be given written by the doctor."				
	A policy on PRN me requested and not p	edication administration was provided.				
	will be reviewed at t	der/s will remain in effect and the next onsite visit. Also				

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 5 of 12

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R-	_	
	00953					1/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ROCHESTER FAST HEALTH SERVICES			TH AVENUE TER, MN 559	SOUTHEAST 904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 830}	Continued From pa	ge 5	{2 830}				
	penalty assessmen	t/s.					
{2 895}	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	{2 895}			5/9/18	
	that is directed towa through positioning implemented and m comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which					
	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.						
	by: This licensing order Based on observatireview, the facility fa	ent is not met as evidenced  was not corrected due to:  on, interview and record ailed to implement a palm a orders for 1 of 1 resident		F-TAG 688: Increase/Prevent Dec ROM/Mobility SSD: D	rease in		
	(R23) reviewed who Findings include:	er physician orders for 1 of 1 resident eviewed who had contractures.  1. Corrective action(s accomplished for those have been affected by practice?					
	admission date of 2 hand contractures (R23's physician prorevealed: "R23 has	ecord document identified an algorithm (20/12, and diagnoses of left 10/3/16).  In agress note dated 3/8/18, severe contractures of her left e has a palm guard for the left		" R23 was assessed on 5/8/18 overall clinical status and adaptive equipment needs. " R23 s Medical Provider was related to her overall clinical status remains at baseline with continued her adaptive device on 5/8/18.	updated		

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 6 of 12

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. DOILDING		R-C
	00953				05/01/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ROCHES	ROCHESTER EAST HEALTH SERVICES 501 EIGH ROCHES			SOUTHEAST 904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{2 895}	5) Continued From page 6		{2 895}		
	severely cognitively of motion (ROM) in extremities, contract	m Data Set (MDS) 3/12/18, identified R23 to be impaired, with limited range bilateral upper and lower ctures of the left hand and ures of the right ankle.		" R23 s Responsible Party was updated related to her overall clini status remains at baseline with co use of her adaptive device on 5/8/ " R23 s Care Plan was review updated on 5/6/818.	cal ntinued 18.
	dated April, 2018, id	ministration record (TAR) dentified: Apply left palm guard remove with p.m. care.		2. How will you identify other res having the potential to be affected same practice?	
	have a physical fun self-care impairmer Intervention: apply remove with p.m. c			" Residents who reside at Roch East Heath Services that have use splints/braces have the same pote be affected by the same deficient " An audit of Residents with splints/braces was conducted on the same deficient of the	ential to practice.
	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.			3. What measures will be put int or what systemic changes will you ensure that the deficient practice or recur?	make to
	sitting in her broda being assisted with	on 5/1/18, at 9:04 a.m., R23 is chair up to the table while eating by trained medication does not have left palm guard		" Facility staff were In-serviced 5/7/18 or 5/8/18, related to the Mir Health Department findings of F-6 the Revisit Survey that ended on 5	nnesota 88 from 5/1/18.
	nursing assistant (Nonthave left palm came the one who go	on 5/1/18, at 9:15 a.m., NA)-C verified that R23 does guard in place. NA-C stated, "I t her up today and I forgot, r a while now, I should have		This in-service included the need. Physician s Order for residents w splints or braces.  4. How will you monitor the correaction(s) to ensure the deficient probability will not recur, i.e., what quality assembles program will be put into place?	ective ractice
	practical nurse (LPI have left palm guar	5/1/18, at 9:20 a.m., licensed N)-B verified R23 does not d in place and verified it stated. "My expectation would		" The facility has implemented a Assurance Program to ensure tha Residents of Rochester Health Se	t

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 7 of 12

	IENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00050		B. WING		R-		
	00953				05/0	1/2018	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 55	SOUTHEAST 904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 895}	Continued From page 7		{2 895}				
	wear a palm guard ordered."  During interview on	th an order from therapy to that it should be put on when 5/1/18, at 9:28 a.m., director erified R23's left palm guard		East s Passive Range of motion program.  " The Director of Nursing and/o designee will complete a quality assurance tool (Exhibit #688-C) to			
		ut on with a.m. cares per the		compliance of Passive Range of M With the 3 residents who need parange of motion; 3 times a week for	<i>l</i> lotion. ssive		
	occupational therap should have a palm and off at night, "thi contractures." COT palm guards are es contractures of her	5/1/18, at 10:00 a.m., certified by aide (COTA)-D verified R23 guard applied in the morning s is to help prevent further TA-D further stated, "Those sential to prevent further left hand and to reduce paints promoting resident		week; then 2 times a week for one and then weekly for a total of 12 waudits.  " Additional training may be schbased on results of the quality asserview.	e week, veeks of neduled		
	comfort."	lints and devices requested		" As part of the facility s on-go Quality Assurance and Process Improvement (QAPI) program, fact policy and procedures are analyzed modified as necessary by the QAF	cility ed and		
	will be reviewed at t	der/s will remain in effect and the next onsite visit. Also will be reviewed for possible t/s.		committee. All deficient practices with findings of investigations will reviewed monthly in QAPI meeting three months to ensure compliant facility policy and state and federa regulations.	along oe gs for ee with		
				" The facility administrator and/designee will monitor that the tools completed.			
{21565}	MN Rule 4658.1325 Medications Self Ac	5 Subp. 4 Administration of Imin	{21565}			5/9/18	
	self-administer med	inistration. A resident may lications if the comprehensive nt and comprehensive plan of					

Minnesota Department of Health

CIENCIES CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING.	<del></del>	D.	_
00953					1/ <b>2018</b>
OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROCHESTER EAST HEALTH SERVICES					
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
S) Continued From page 8					
required in 05 indicate en order fr	parts 4658.0400 and this practice is safe and there om the attending physician.				
by: This licensing order was not corrected due to:			PLAN OF CORRECTION		
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.			F554: Resident Self-administered Medication-Clinically Appropriate SS: D	j	
dedication Size/18 read inister med VISION." In siplinary tean inister.  surrent care tration: Resions WITH tion/tasks: tration."  rder Summer dated 4/1 inister WITH tionister WITH this time, this time, tons under mbers. Dis	s, "Resident may dications WITH addition, the facilities am does not feel R27 is safe to plan reads, Self-medication sident may self-administer SUPERVISION with "Staff will supervise hary Report signed by 3/18, reads, "Resident may FH SUPERVISION."  add 3/22/18, at 3:30 p.m. reads, on of medication assessment resident may self-administer the supervision of licensed cussed findings with the		have been affected by the deficier practice?  " R27 was re-assessed on 5/7/2 safe Self Administration of Medical Not leaving medications at bed sid Reason for taking medications; Acknowledgement of Adverse Sid effects; and Identification of medical R27 s Medical Provider was of the findings that were obtained Safe Self Administration Assessm 5/7/18; and a Physician s order to self-administer medications was of the findings that were obtained Safe Self Administration Assessm 5/7/18 and that a Physician s ord self-administer medication was obtained Safe Self Administration of medication; R27 was reeducated on safety self-administration of medication;	e cations. notified from the ent on botained. ser to ottained. y of not	
in the second of	COTION  OR SUPPLIER  ST HEALTH:  SUMMARY STA  CH DEFICIENCY  JLATORY OR L  ed From parequired in  105 indicate ten order from  N Requirem  ensing orde  on observat the facility from the facili	O0953  OR SUPPLIER  STREET AD  501 EIGH ROCHES'  SUMMARY STATEMENT OF DEFICIENCIES SCH DEFICIENCY MUST BE PRECEDED BY FULL JUATORY OR LSC IDENTIFYING INFORMATION)  ed From page 8  required in parts 4658.0400 and 105 indicate this practice is safe and there ten order from the attending physician.  If Requirement is not met as evidenced ensing order was not corrected due to:  On observation, interview and record the facility failed to follow assessed mendations for Medication Self stration for 1 of 3 resident (R27) reviewed administration of medications.  include:  Medication Self Administration assessment 1/22/18 reads, "Resident may minister medications WITH VISION." In addition, the facilities ciplinary team does not feel R27 is safe to minister.  urrent care plan reads, Self-medication tration: Resident may self-administer tions WITH SUPERVISION with atton/tasks: "Staff will supervise tration."  Order Summary Report signed by an dated 4/13/18, reads, "Resident may minister WITH SUPERVISION."  Is note dated 3/22/18, at 3:30 p.m. reads, administration of medication assessment at this time, resident may self-administer tions under the supervision of licensed embers. Discussed findings with the	O0953  B. WING	OPEN SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  STHEALTH SERVICES  SOI EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904  SUMMARY STATEMENT OF DEFICIENCIES  TAG  (RACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)  PROVIDERS PLAN OF CORRECTI  (RACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)  PREFIX  TAG  PROVIDERS PLAN OF CORRECTI  (RACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)  PREFIX  TAG  PROVIDERS PLAN OF CORRECTIVE  (RACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)  PREFIX  TAG  PROVIDERS  (RACH CORRECTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)  PREFIX  TAG  PROVIDERS  PROVIDERS PLAN OF CORRECTIVE  (RACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)  PREFIX  TAG  PROVIDERS  (RACH CORRECTIVE ACTION  (RACH CORRECTIVE ACTION  (RACH CORRECTIVE ACTION  PREFIX  TAG  PROVIDERS  (RACH CORRECTIVE ACTION  (RACH CORRECTION  PREFIX  TAG  PROVIDERS  (RACH CORRECTIVE ACTION  (RACH CORRECTIVE	ODB SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  STHEALTH SERVICES  SOI EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904  SUMMARRY STATEMENT OF DEFICIENCIES  TAG  PROVIDERS PLAN OF CORRECTION  PROVID

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 9 of 12

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/	SUPPLIER/CLIA FION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED
712 . 271	0. 0020	.52		A. BUILDING	:		
	00953			B. WING		R-0 <b>05/0</b>	C <b>1/2018</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BOCHE	STER EAST HEALTH S	SEDVICES	501 EIGH	TH AVENUE	SOUTHEAST		
HOURES	DIEN EAST HEALTH	DENVICES	ROCHES	ΓER, MN 55	904		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
{21565}	Continued From page 9			{21565}			
(21303)	Nursing staff also nupdated.  Interview with R27 said things are bett medication for me troom."  Interview with admi a.m. said the facility can self-administer nebulizers, no oral self-administered.  During an observat a.m. there was a m sitting on her tray to this time. R27 was which included, one lactase, one tramace on 5/1/18, at 8:33 a registered nurse (R medications left on at 11:49 a.m.) RN-the medications age.  Interview on 5/1/18 Nursing (DON) registered for her to supervision. The Dosupervised during the nurse should stay with medications are taken to take later.  Policy titled-"Self-addated 12/16 reads in the said to the said the said to the said to the said the said to the said the sai	otified. Care pon 4/30/18, at er. Then said, o take and do nistrator on 4/3 only had five medications and of R27 on edication cupable. No staff vable to name to tablet iron, two dol and 1 potasta.m., during ar N)-A concernitray table yest A remembered ain for R27 to at 12:41 p.m. arding R27's notake independence on the taking of movith the residence and not left deministered medications.	8:50 a.m. who "They leave the not stay in  30/18, at 10:15 residents who ad it is only for re  4/30/18, at 11:49 with oral pills were present at the medications, to Tylenol, two ssium.  In interview with ng R27's rerday (4/30/18 d she had left take on her own.  with Director of nedications lently with no lys to be edications the nt until the t for the resident edications"		and identification of medications " R27 s Care Plan was reviewed updated on 5/7/2018 related to R1 findings of safe Self Administration Self Administration Assessment.  2. How will you identify other residential to be affected same deficient practice?  " Residents at Rochester East It Services who chose to self-adminimedication have the same potential affected by the same deficient pra."  An audit was conducted on 5/3 to assess Residents at Rochester Services East who chose to self-administer medications for sat Administration.  3. What measures will be put into or what systemic changes will you ensure that the deficient practice of recur?  " Nurses and TMAs were in-ser 5/7/18 or 5/8/18, related to the Mir Health Department findings of F-5 the Revisit Survey that ended on 5 This in-service included how to ma Residents who have been determined as to Self-Administer medication the Self-Administer Medication; with a on following MAR & TAR documer properly. Training was followed we post test.	s in per the sidents by the ster all to be ctice. 8/2018 Health fe Self oplace make to does not viced on inesota 54, from 6/1/18. anage ned is per int; have focus notation	
	supervision. The Do supervised during t nurse should stay v medications are tak to take later. Policy titled-"Self-ad	ON said if it sa he taking of m with the resider ken and not lef dministered mand Medications sh ess they are a	edications the the the the the the the resident edications" nould not be the the the the the the the the the th		Residents who have been determined safe to Self-Administer medication the Self-Administration Assessme a current Physician order to Self-Administer Medication; with a on following MAR & TAR document properly. Training was followed w	ned as per nt; have focus ntation ith a	

Minnesota Department of Health

STATE FORM 6899 VCL412 If continuation sheet 10 of 12

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
00953			B. WING		05/01/2018	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCHESTER FAST HEALTH SERVICES			TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	TE
{21565}	Continued From pa	ge 10	{21565}			
	from the residents rebedside will be decided DON. Under no cirkept at bedside.  This uncorrected or will be reviewed at the second process of the second p	room. Keeping medications at ded by the Administrator and cumstances will narcotics be der/s will remain in effect and the next onsite visit. Also will be reviewed for possible		Services will be assessed for Self-Administer Medications Quart Annual, with Significant Change of Condition, after Readmission, and for continued safety per the Self-Administration Assessment.  "Residents who choose to Self-Administer Medication at Roc East Health Services will perform a demonstration; and be able to vert education provide.  "IDT will review residents that heen screened for Self-Administra Medication to determine safety risk that the sense of the sensure the deficient provide of the sense of the sensure that the sense of the sensure that the sense of th	PRN hester a return palize have tion of K. ctive actice urance a Quality fervices who hister 3 times a week total of ursing or m audits	

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00953		A. BUILDING		R-C		
			B. WING			1/ <b>2018</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 55	SOUTHEAST 904			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{21565}	Continued From pa	ge 11	{21565}	based on results of the quality ass review.  " As part of the facility s on-goi Quality Assurance and Process Improvement (QAPI) program, fact policy and procedures are analyzed modified as necessary by the QAPI committee. All deficient practices with findings of investigations will be reviewed monthly in QAPI meeting three months to ensure compliance facility policy and state and federal regulations.  " The facility administrator and/ordesignee will monitor that the tools completed.	ng illity d and l along oe gs for e with		

6899

Minnesota Department of Health STATE FORM

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICALD CERTIFICATION AND TRANSMITTAL	
PART I. TO BE COMPLETED BY THE STATE SURVEY AGENCY	

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDE (L1) 245184 2.STATE VENDOR OR MEDICAID N (L2) 690925600	3. NAME AND ADDRESS OF FACILITY (L3) ROCHESTER EAST HEALTH SERV (L4) 501 EIGHTH AVENUE SOUTHEAST (L5) ROCHESTER, MN				•		
5. EFFECTIVE DATE CHANGE OF (19) 05/12/2006 6. DATE OF SURVEY 03/02	*		09 ESRD		7. On-Site Visit 9. Other  8. Full Survey After Complaint		
6. DATE OF SURVEY 03/02 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2018 (L34) (L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	IDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	116 (L18) 116 (L17)	Compliance1. A  X B. Not in Con	e guirements e Based On:	gram	And/Or Approved Waivers Of  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code  * Code: B*	6. Scope of 7. Medical	f Services Limit Director Room Size
14. LTC CERTIFIED BED BREAKDO  18 SNF 18/19 SNF  116  (L37) (L38)	WN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
. , , , , , , , , , , , , , , , , , , ,				DATE).			
16. STATE SURVEY AGENCY REM. See Attached Remarks	ARKS (IF APPLICE	ABLE SHOW LIC CA	INCELLATION	DAIE):			
17. SURVEYOR SIGNATURE Date :					18. STATE SURVEY AGENCY	APPROVAL	Date:
Jennifer Kolsrud, HFE NE	03/29/2018 (L19)			Debby Baker, Enforcement Specialist 04/06/2018 (L20)			
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY	
DETERMINATION OF ELIGIBIL      X     1. Facility is Eligible to P     2. Facility is not Eligible	20. COMPLIANCE WITH CIVIL RIGHTS ACT:			<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	:	(L30)
OF PARTICIPATION BEGINNING DATE 09/01/1972					VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination		to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions:  (L27) P. Respired Suspension Date:					04-Other Reason for Withdrawal  OTHER  07-Provider Status Change  00-Active		vider Status Change
B. Rescind Suspension Date: (L45)							
28. TERMINATION DATE:	20	9. INTERMEDIARY/			30. REMARKS		
03001							
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	DATE			
	(L32)	04/09/2018		(L33)	DETERMINATION APP	ROVAL	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART L. TO BE COMPLETED BY THE STATE SURVEY AGENCY

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

**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.



Protecting, Maintaining and Improving the Health of All Minnesotans

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:

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

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

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

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

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

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

#### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), 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; <u>OR</u>
- 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) <u>AND</u> 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.,

Rochester East Health Services March 16, 2018 Page 3 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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

### 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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,

Kumalu Fishe 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



Protecting, Maintaining and Improving the Health of All Minnesotans

## This letter will replace the letter sent to your facility on March 16, 2018.

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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

## **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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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

Kumalu Fishe Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

## This letter will replace the letter sent to your facility on March 22, 2018.

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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

## **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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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

Kumalu Fishe Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

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

cc: Licensing and Certification File

PRINTED: 03/29/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245184	B. WING_		03	C / <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		.02:20:0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted February 2018, during a rece is in compliance with Preparedness Requ		F 00	00		
	Focus Facility (SFF	ealth Services is a Special c) and received a Certification c 26, 27, 28, March 1 & 2,				
		complaint H5184097 were mplaint was substantiated and d at F689.				
	as your allegation of Department's accept	f correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.				
	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with the in Meds-Clinically Approp	F 58	54		3/30/18
ABODATOD	medications if the indefined by §483.21 this practice is clinic This REQUIREMENT by:	right to self-administer nterdisciplinary team, as (b)(2)(ii), has determined that cally appropriate. NT is not met as evidenced	NATI IRE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

03/28/2018

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING	/ING			) 2/2018
	PROVIDER OR SUPPLIER	SERVICES		5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST COCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 554	review, the facility faself-administration of place before leaving 1 resident (R27).  Findings include:  R27's admission for diabetes and deprediabetes and	r, observation and record ailed to verify a of medication order was in g medications in room for 1 of rm included a diagnosis of ssion.  imum Data set (MDS) an 12/22/17 as being cognitively terview of mental status of 15.  0 a.m. R27 voiced concern medications in her room while	F 5	554	F554: Resident Self-administered Medication-Clinically Appropriate SS: D  1. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice?  "R27 was assessed on 03/22/20 safe Self Administration of Medicati R27 same Medical Provider was not the findings that were obtained for Safe Self Administration Assessme 3/22/18; and a Physician sorder to self-administer medications with supervision was obtained.  "R27 same Responsible Party was notified of the findings that were obfrom the Safe Self Administration Assessment on 3/22/18 and that a Physician sorder to self-administer medication with supervision was obtained.  R27 same Self Administration Assessment on 3/22/18 and that a Physician of Self Administration was obtained on 03/22/2018 related to Findings of safe Self Administration Self Administration Assessment  2. How will you identify other residenting the potential to be affected to same deficient practice?  "Residents at Rochester East H Services who chose to self-administration have the same potential affected by the same deficient practice?  "Residents at Rochester East H Services who chose to self-administration have the same potential affected by the same deficient practice?  "An audit was conducted on 03/22/2018 to assess Residents at	to 18 for sons. otified rom the nt on otained. It ained and and and the ster the ster I to be	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	COMI	(X3) DATE SURVEY COMPLETED	
		245184	B. WING		C 03/02/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCHES	STER EAST HEALTH	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 554	Continued From paneeded.	nge 2	F 55	Rochester Health Services East v			
	R27 said on 3/1/18 practical nurse (LP tray table to self-ad On 3/1/18, at 8:34 how medication was morning. LPN-B satray table. LPN-B than order to self-ad LPN-B said, "To be and R27 requested later this a.m.  R27's care plan rev Self-medication ad 5% only.  R27's Medication self-ective date 7/26/can be self-administ Interview on 2/28/1 nurse consultant (Fhave a current order medications. The process of the self-administ interview on 2/28/1 nurse consultant (Fhave a current order medications. The process of the self-administ interview on 2/28/1 nurse consultant (Fhave a current order medications. The process of the self-administ interview on 2/28/1 nurse consultant (Fhave a current order medications. The process of the self-administration o	8, at 4:23 p.m. with registered RNC)-B verified R27 does not er to self-administer prior self-administration order		chose to self-administer medicatic safe Self Administration. (Exhibit safe Self Administration. (Exhibit safe Self Administration. (Exhibit safe Self Administration. (Exhibit safe Self Administration or what systemic changes will you to ensure that the deficient practic not recur?  "Nurses and TMAs were In-secon 3/13/18 or 3/14/18, (Exhibit #5 related to the Minnesota Health Department findings from the Anr Survey that ended on 3/2/18; and manage Residents who have been determined safe to Self-Administrations per the Self Administrations per the Self Administration Preparation of Medication Administration Preparation General Guidelines □ Self Administration for Medications; About not leaving medication in the Resident □ s root bedside; and the Responsibilities	ons for #554-B). to place a make be does rviced 54-C), and how to ner ration have a nducted elated to be by ation and estration m or at of		
	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.			Administering medication if reque perform a task outside of the app guidelines of medication administ and the need to Care Plan the sp directions when participating in se a Resident who is about to Self-Administer Medications as diby the Physician Sorder.  "Residents who reside and ch self-administer at Rochester East Services will be assessed for Self-Administer Medications Qual	roved ration; ecific etting up rected cose to Health		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(2) MULTIPLE CONSTRUCTION  BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING			03/02/2018		
NAME OF I	PROVIDER OR SUPPLIER	240104	1	STREET ADDRESS, CITY, STATE, ZIP CO			02/2016	
NAIVIL OI I	-NOVIDEN ON SUFFEIEN							
ROCHES	TER EAST HEALTH	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 554	Continued From pa	age 3	F 5	Annual, vaccondition for continual for continual for continual for continual for condition of Medical for condition of Medical for condition of Medical for continual for condition for medication for continual for	will you monitor the correct to ensure the deficient practur, i.e., what quality assured will be put into place?  facility has implemented a ce Program to ensure to sof Rochester Health Source monitoring Residents wen assessed to Self-Administration.	ose to nester sed on , of stration ctive actice urance Quality ervices who ister current eek; and or of med eduled		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245184	B. WING		03/0	C 02/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	1 00/0	,2,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 578 SS=D	Request/Refuse/Ds CFR(s): 483.10(c)(6) The rediscontinue treatment to participate in expformulate an advant §483.10(c)(8) Nothic construed as the right the provision of meservices deemed minappropriate.  §483.10(g)(12) The requirements specion subpart I (Advance (i) These requirements inform and provide residents concerning in the con	scntnue Trmnt; FormIte Adv Dir 6)(8)(g)(12)(i)-(v) right to request, refuse, and/or ent, to participate in or refuse perimental research, and to ace directive.  ing in this paragraph should be ght of the resident to receive dical treatment or medical nedically unnecessary or e facility must comply with the fied in 42 CFR part 489,	F 5	review.  " As part of the facility s on-going Quality Assurance and Process Improvement (QAPI) program, fact policy and procedures are analyzed modified as necessary by the QAPI committee. All deficient practices with findings of investigations will be reviewed monthly in QAPI meeting three months to ensure compliance facility policy and state and federal regulations.  " The facility administrator and/odesignee will monitor that the tools completed.	cility and and along oe gs for ee with I	3/30/18

PRINTED: 03/29/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING			00/6	
NAME OF I		243104	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	03/0	)2/2018
	PROVIDER OR SUPPLIER  STER EAST HEALTH	SERVICES		5	OT EIGHTH AVENUE SOUTHEAST COCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	resident's option, for (ii) This includes a facility's policies to and applicable State (iii) Facilities are presentities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission a information or articity has executed an admay give advance individual's resident with State Law. (v) The facility is not provide this information or she is able to refollow-up procedure the information to the appropriate time. This REQUIREMED by:  Based on interview	ormulate an advance directive. Written description of the implement advance directives e law.  From the description of the implement advance directives e law.  From the description but are still for ensuring that the section are met.  From the didual is incapacitated at the end is unable to receive for a compact of the divance directive, the facility directive information to the enteresentative in accordance of the relieved of its obligation to the individual once he delive such information.  From the must be in place to provide the individual directly at the entered of the review, the facility of and record review, the facility of and record review, the facility of the individual directly at the entered of the facility of the facility of the facility of the individual directly at the entered of the facility of the fac	F	578	F578: Request/Refuse/Discontinue		
	Care Directives for for advanced direct	identify preference for Health 1 of 1 resident (R8) reviewed ives.			Treatment; Formulate Advance Dire	ectives	
	according to the adobtained from the eincluding pneumon hyperosmolality and sodium and not endurinary tract infection	to the facility on 2/5/18, mission form, with diagnoses electronic health record (EHR) ia, encephalopathy, d hypernatremia (too much ough water in the body) and a on.			<ul> <li>1. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice?</li> <li>" On 3/24/18, R8 Advanced Heal Care Directives were reviewed and to be up.</li> <li>" On 3/24/18 R8 Second Medical Provinces and the current signed Advanced Health Care Directives</li> </ul>	th noted	

PRINTED: 03/29/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVE COMPLETED	
		245184	B. WING _			C <b>02/2018</b>
NAME OF F	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COD	•	02/2010
				501 EIGHTH AVENUE SOUTHEAST		
ROCHES	TER EAST HEALTH	SERVICES		ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 578	Continued From pa	age 6	F 57	8		
F 578	assessment dated brief interview for r 15, identifying R8 a R8's EHR was rev p.m., and identified not resuscitate (DI noted to be ordere acute care setting Review of R8's Ph Life-Sustaining Tre and dated 7/11/13, The care plan last as a full code. Nur dated 2/9/18, indic During an interview regarding code stat cannot tell you what During an interview on 2/28/18, at 10:0 code status is iden her care guide, dat to be a full code.  During an interview on 2/28/18, at 10:2 inconsistency betwand stated she would be a full code with an interview with 3/2/18, at 8:52 a.m.	11/21/17, indicated R8 had a mental status (BIMS) score of as having intact cognition.  iewed on 2/27/18, at 12:29 de that R8's code status as do NR). The code status was decomposed upon readmission from the on 2/5/18.  ysician Orders for reatment (POLST) on 2/27/18, indicated R8 to be a full code, revised on 1/8/18, indicated R8 sing home physician visit notes ated R8 as a full code.  y on 2/28/18, at 9:58 a.m., atus, R8 stated, "I honestly at I am, I just don't know."  y with nursing assistant (NA)-E, to a.m., related to resident attified, she stated she follows ted 2/17/18, which indicated R8	F 57	implemented and placed in he record.  " On 3/24/18 R8 s Responwas updated on the current sign Advanced Health Care Directi implemented and placed in he record.  " R8 s Care Plan was review updated on 03/24/2018 related Advanced Health Care Directi made by the Resident and Re Party.  2. How will you identify other having the potential to be affect same deficient practice?  " An audit was conducted on 03/21/2018 to assess Resider Rochester Health Services Ear Advanced Health Care Directi current and located in the Medand match the Physician sor Care Plan. (Exhibit #578-A).  3. What measures will be pure or what systemic changes will to ensure that the deficient pranot recur?  " Nursing Staff were In-serve 3/13/18 or 3/14/18, (Exhibit #578-A).  The partment findings from the Survey that ended on 3/2/18; a facility s process of managing facility s process of m	asible Party gned ves er medical ewed and do to ves Choices sponsible residents of the desired by the extending the foliation of the foliation	
		sed 4/13, titled "Advanced e changes or revocations of a		obtain the Medical Provider⊡s and this document will be stor Medical Record; and that Adva	ed on the	

Facility ID: 00953

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245184	B. WING			C <b>03/02/2018</b>	
	PROVIDER OR SUPPLIER	SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			1 00/0	7272010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		) BE	(X5) COMPLETION DATE
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 5	Hea a m with PR " 03/ Ser find the Ord dire Pro Dire nur the " Adr F57 Hea plac	Health Care Directives will be reviewed at a minimum of every Quarter, Annually, with Significant Change of Condition and PRN.		
				acti will pro " Ass Res Eas and ann	How will you monitor the correction(s) to ensure the deficient pranot recur, i.e., what quality assurance will be put into place?  The facility has implemented a surance Program to ensure sidents of Rochester Health Serst Advanced Directives are red current on Admission, quarterly hually, and PRN.  The Social Service Director an signee will complete a quality surance tool for Advance Directives.	actice urance Quality vices eviewed y,	

AND DUAN OF CODDECTION DENTIFICATION NUMBER.			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			X3) DATE SURVEY COMPLETED	
		245184	B. WING			03/0	) 2/2018
	PROVIDER OR SUPPLIER	SERVICES		50	TREET ADDRESS, CITY, STATE, ZIP CODE D1 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904	00/0	7272010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From pa	ge 8	F 5	578	(Exhibit #578-D) on three residents 3 times a week for one week; then 2 tim week for one week, and then weekly for two weeks.  " Additional training may be schedur based on results of the quality assurant review.  " As part of the facility□s on-going Quality Assurance and Process Improvement (QAPI) program, facility policy and procedures are analyzed at modified as necessary by the QAPI committee. All deficient practices alor 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 applicated."	ided nce nd ng or ith	
	CFR(s): 483.21(b)(1) §483.21(b) Compre §483.21(b)(1) The fimplement a compre care plan for each resident rights set for §483.10(c)(3), that objectives and time medical, nursing, an needs that are iden	chensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive comprehensive care plan must	F 6	356	completed.		3/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245184	B. WING			C <b>02/2018</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/2010	
ROCHES	STER EAST HEALTH	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 656	or maintain the resphysical, mental, a required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incommendations findings of the PAS rationale in the respective of the end	at are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not a resident's exercise of rights luding the right to refuse 483.10(c)(6). If services or specialized the set the nursing facility will of PASARR. If a facility disagrees with the 6ARR, it must indicate its ident's medical record. With the resident and the stative(s)-goals for admission and preference and potential for facilities must document and the sessed and any referrals to be sessed and any referral to the sessed and any referral	F6	F656: Develop/Implement Comprehensive Care Plans SS: D  1. Corrective action(s) will be accomplished for those resider			
	Findings Include:			accomplished for those resider have been affected by the defi			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING			03/0	) 2/2018	
NAME OF	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				50	01 EIGHTH AVENUE SOUTHEAST			
ROCHES	STER EAST HEALTH	SERVICES		R	OCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHO		BE	(X5) COMPLETION DATE	
F 656	During an interview member (FM)-A st brushing R67's tee orders to brush R6 the hospital dismist times he gets his there. FM-A stated liquids had a lot of have his teeth brustated she will set before she leaves and still sitting there. R67's hospital dismincluded, "ASPIRA oral care 3-5 times R67's physician order to day.  R67's care plan, no nursing assistant with direction to provide R67's care plan day. R67's nursing assistant with direction to provide oral care with R67's nursing assistant with direction to provide oral care with R67's nursing assistant with growing an interview nursing assistant (supposed to brush stated his wife wartimes a day. NA-C	or on 2/26/18, 12:29 p.m. family ated there was problems with eth. FM-A stated there were 67's teeth 3 to 5 times a day in isal summary and the only eeth brushed is when I am because the nectar thick sugar in them R67 was to shed 3 to 5 times a day. FM-A him up at night for dental cares and comes back the next day re untouched.	F 6	\$56	practice?  " R67 is no longer a resident at Rochester East Health Services.  2. How will you identify other residenting the potential to be affected be same deficient practice?  " Residents who are admitted to Rochester East Health Services has same potential to be affected by the deficient practice.  " An audit of resident's oral care conducted on 3/21/2018  3. What measures will be put into or what systemic changes will you reto ensure that the deficient practice not recur?  " Nursing Staff were In-serviced 3/13/18 or 3/14/18, (Exhibit #656-B related to the Minnesota Health Department findings from the Annu Survey that ended on 3/2/18; related the admission process, identifying and verifying them; and initiating ar completing the care plan process. (#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 Annu Survey that ended on 3/2/18  " Staff education will occur on 03 and 03/29/2018 related to the Minn Health Department findings from the Annu Survey that ended on will occur on 03 and 03/29/2018 related to the Minn Health Department findings from the Annu Survey that ended on the Minnesota Health Department findings from the Annu Survey that ended on 3/2/18	oy the every the		
	nursing assistant ( supposed to brush stated his wife war times a day. NA-C brush his own teet	NA)-C stated R67 was his teeth 5 times a day and nted his teeth brushed three stated R67 was capable to			Department findings from the Annu Survey that ended on 3/2/18  "Staff education will occur on 03 and 03/29/2018 related to the Minn	3/28/18 esota ie		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245184	B. WING _			02/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	his teeth and when and do it.  During an interview nursing assistant (I how often R67 was day. NA-A stated wand night we get reincluded oral cares and he was able to teeth) on his own a morning for oral care.  During an interview (NA)-B stated she bedtime. NA-B state was able to brush hwife was here I do believe she complethim.  During an interview registered nurse (Fitimes a day should and nursing assistated staff would not kno oral care with R67 evenings cares if it.  During an interview nurse consultant (Nexpected oral cares put in as an order a been completed per summary. NC-B states should have been a guide for R67. NC-	she is not here, we set him up  y on 3/1/18, at 1:33 p.m.  NA)-A stated she was not sure to have his teeth brushed a what I know is every morning esidents washed up (which ). NA-A stated we set R67 up take care of that (brushing and stated I set him up in the	F 65	Tag F656; and the importance of care.  4. How will you monitor the corraction(s) to ensure the deficient pwill not recur, i.e., what quality as program will be put into place?  "The facility has implemented Assurance Program to ensure Reof Rochester Health Services Eareceiving oral care during AM and cares  "The Director of Nursing and/designee will complete a quality assurance tool (Exhibit # 656-B) resident oral care during AM and or as otherwise specified by med provider; 3 times a week for one then 2 times a week for one weel then weekly for two weeks.  "Additional training may be so based on results of the quality as review.  "As part of the facility □s on-go Quality Assurance and Process Improvement (QAPI) program, fa policy and procedures are analyz modified as necessary by the QA committee. All deficient practices with findings of investigations will reviewed monthly in QAPI meeting three months to ensure compliant facility policy and state and federate gulations.	ective bractice surance a Quality esidents st sare d PM care ical week; x, and heduled surance bing cility ed and PI s along be ugs for ce with	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COMPLETED	
		245184	B. WING			l	C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		50	TREET ADDRESS, CITY, STATE, ZIP CODE  11 EIGHTH AVENUE SOUTHEAST  OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 12	F 6	556	" The facility administrator and/o designee will monitor that the tools completed.		3/30/18
	Activities Daily Livin CFR(s): 483.24(a)(	ng (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii)	F 6	76			
	assessment of a re resident's needs an provide the necessarensure that a reside daily living do not diof the individual's cl	on the comprehensive sident and consistent with the id choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances inical condition demonstrate in was unavoidable. This ensuring that:					
	treatment and servi or her ability to carr	ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)					
		ovide care and services in ragraph (a) for the following					
	§483.24(b)(1) Hygic grooming, and oral	ene -bathing, dressing, care,					
	§483.24(b)(2) Mobi including walking,	lity-transfer and ambulation,					
	§483.24(b)(3) Elimi	nation-toileting,					
	§483.24(b)(4) Dinin snacks,	g-eating, including meals and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245184	B. WING		C <b>03/02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION THE DATE
F 676	(i) Speech, (ii) Language, (iii) Other functional This REQUIREMED by: Based on interview failed to follow thromatic recommended wall resident (R67) reviolations.  Findings Include:  During an interview family member (FM were not walking R stated staff were to afternoon and ever walking to meals.  R67's Therapy Cor 2/22/18, indicated If front wheeled walk extremity motion as leg. Step by step in how to put strap on R67's nursing assis walking in the corriwas reviewed from revealed R67 had It 2/28/18 since the won 2/22/18.  R67's care plan da will ambulate with a stranger of the review of the wood of the review of the wood of the review of the wood of the revenue of the wood of the w	Inmunication, including Il communication systems. In is not met as evidenced If and record view, the facility It is not met as evidenced It is not met as ev	F 676	F676: Activities of Daily Living (ADL□s)/Maintain Abilities SS: D  1. Corrective action(s) will be accomplished for those residents fou have been affected by the deficient practice?  " Resident (R67) no longer resides Rochester East Health Services.  2. How will you identify other reside having the potential to be affected by same deficient practice?  " Residents at Rochester East Heast Services have the same potential to be affected by the same deficient practic." Therapy discharge recommenda as of 3/15/18 were implemented as indicated  3. What measures will be put into por what systemic changes will you mato ensure that the deficient practice donot recur?  " Nursing Staff were In-serviced or 3/13/18 or 3/14/18, (Exhibit #656-A), related to the Minnesota Health	nts the alth be ce ations

` '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245184	B. WING _			C 02/2018
NAME OF F	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP C		32/2010
				501 EIGHTH AVENUE SOUTHEAST		
ROCHES	STER EAST HEALTH	SERVICES		ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 676	strap is a brace.  R67's nursing ass 2/20/18, included wheeled walker 2-on right leg. Step closet door.  During an intervie assistant (NA)-C sto walk with him be she has not been comfortable to wahad weakness on (LEMA) to wear of NA-C stated she pademonstration of During an intervienursing assistant walked between the possible. NA-A stated sometimes things	istant care guide updated patient will ambulate with front 3 times a day with LEMA strap by step instruction taped on w on 2/28/18, 2:30 p.m. nursing stated she has not been trained y therapy. NA-C stated because trained, "I do not feel lk with him." NA-C stated R67 one side and there was a strap in his leg to help with walking. Danned to ask his therapist for of how to walk with him today.  W on 3/1/18, at 1:01 p.m. (NA)-A stated R67 was to be wo to three times a day if ated for me on my shift I am him two times. I walked him to oday and will walk back from d if there was one aide, happen and the walking is not d today I was lucky to get it	F 67	Survey that ended on 3/2/18 implement and follow through recommendations.; The new rounds and identify any potential of Daily Living care needs. If 676-B).  "CNA Staff were In-serving 3/20/18 or 3/21/18, (Exhibit related to the Minnesota Herman Department findings from the Survey that ended on 3/2/18 report any potential deficits Residents they care for relandativities of Daily Living.  "A second in-service will 3/28/18 and 3/29/18 related of F656; The importance of communication and follow the Therapy Recommendations utilize Tasks in PCC and Refunder Guides to communicate the interventions to prevent loss and the facility policy Follow Recommendations.  4. How will you monitor the action(s) to ensure the deficited for the second survey of the second surv	gh on Therapy ed to complete ential Activities Exhibit #  ced on #656-B), ealth ne Annual 3; the need to noted for the ted to  be held on to the findings  hru on s; The need to esident Care post Therapy s of function; ring Therapy e corrective	
	(walking) done. N. she did not have t working and state	A-A stated one half of the time ime to walk him when she was d she worked full times days.		will not recur, i.e., what qual program will be put into place	lity assurance ce?	
	the end of her shit next shift. NA-A st one to two aides of residents and dep stated like anybood staff on the unit. No criteria for staffing	e cares she could complete by ft, she passed that on to the sated the unit was staffed with depending on the needs of the rending on the census. NA-A ly I think we could use more IA-A stated there used to be on the unit. NA-A stated on the abilities of the residents		" The facility has implemed Assurance Program to ensure of Rochester Health Services to following therapy discharge recommendations.  " The Director of Nursing designee will complete a quassurance tool (Exhibit Tag	and/or	

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		PLETED
		245184	B. WING			03/0	) 2/2018
NAME OF PRO	OVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	72.2010
				5	01 EIGHTH AVENUE SOUTHEAST		
ROCHESTI	ER EAST HEALTH	SERVICES		F	ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF THE PROPORTION OF THE PROPOR	) BE	(X5) COMPLETION DATE
Entro section to secti	an go up and down ouring an interview oursing assistant (I to be walking R67 to tated staff documents are. NA-B stated initiative and he will com. NA-B stated noment, we are abstated normally whomat taking the initiative fier to walk him to com. NA-B stated work on first floor a desidents I might be ately most of the residents I might be ately most of the resident one like it should. Ouring an interview egistered nurse (R67 was on a walk nerapy communicated R67 was supported to make sure the stated the aides were computer to make one. RN-A verified andicated R67 had corridor on 2/28/18 and been implement.	at are currently on unit, which in and change continuously.  If on 3/1/18, at 4:08 p.m.  If which in corridor in point of it we get busy, R67 will take I wheel himself to the dining if we catch him at the right ole to walk to meals. NA-B en I am here his wife is here ative to help him. However, I do bring him down to the dining normally it is just me when I and it varies between 8 to 14 etaking care off. NA-B stated esident have been pretty bility to get cares done cannot's needs. NA-B Stated we try imes the walking does not get  If on 3/1/18, at 2:46 p.m.  If on 3/1/18, at 2:46 p.m.	F 6	576	related to follow through on Therap Recommendations on three reside times a week for one week; then 2 week, for one week, and then week two weeks.  " Additional training may be schebased on results of the quality assireview.  " As part of the facility on-goin Quality Assurance and Process Improvement (QAPI) program, facipolicy and procedures are analyzed modified as necessary by the QAP committee. All deficient practices with findings of investigations will be reviewed monthly in QAPI meeting three months to ensure compliance facility policy and state and federal regulations.  " The facility administrator and/odesignee will monitor that the tools completed.	nts; 3 times a kly for eduled urance ng lity d and I along se s for e with	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	(X3) DATE SURVEY COMPLETED C			
		245184	B. WING_		03/02/2018
NAME OF PROVIDER OR  ROCHESTER EAST I		SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
PREFIX (EACH [	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉTION
assistants the floor, would expendence to make time.  During an nurse consection of is wall therapy recommer provided.  A policy was recommer provided.  B 483.24(a out activities services to personal and This REQUID by:  B assed on review, the provided to reviewed for whom was provided to reviewed for whom was prindings in R12's Admadmission Alzheimer's would be a service of the following	g) was no need to why it was ect staff to compliant (National Provided 33.24(a)(a)(a)(b) A research of the complete of the com	ot being done they (nursing communicate to the nurse on so not completed. RN-A stated I to communicate if they did not ete the task.  You on 3/1/18, at 3:39 p.m. the NC)-B stated she expected gram to be followed per the dations and stated this should point of care.  Sted for following capy programs and was not I for Dependent Residents 2)  Sident who is unable to carry y living receives the necessary in good nutrition, grooming, and	F 67		s found to ctice?  oral care

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		LE CONSTRUCTION		PLETED
		245184	B. WING			03/0	) 2/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	72,2010
				5	01 EIGHTH AVENUE SOUTHEAST		
ROCHES	TER EAST HEALTH S	SERVICES		F	ROCHESTER, MN 55904		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE RIATE	COMPLETION DATE
F 677	· '	_	F6	677			
		imum Data Set (MDS) an			3/22/2018.		
		12/14/17, identified R12 to			" R5, R12, R53□s Responsible F		
		nitive deficit and required one			was notified of R1□s Nail and Oral	Needs	
	person extensive as	ssist with personal hygiene.			on 3/22/018.		
	D401	140/47/44 : 1	" R5, R12, R53□s Care Plan was				
		ted 10/17/11, identified R12 tof 1 to do grooming tasks.			reviewed and updated on 03/22/20 related to R1□s Nail and Oral.	18	
		ses to be washed up.				d a ust a	
	Doguested facility b	eath about for the last month			<ol><li>How will you identify other residential to be affected leading.</li></ol>		
		path sheets for the last month ormation, however a note was			same deficient practice?	by the	
		that stated, "Destroyed after			same dendent practice?		
	review."	that stated, Destroyed after			" Resident at Rochester East He	alth	
	TOVIOW.				Services have the same potential to		
	Facility document C	CNA (certified nursing			affected by the same deficient pract		
		des dated 2/13/18, identified			" An audit was conducted on		
		on Monday a.m., and 1 assist			03/21/2018 to assess Residents at		
	with all ADLs.				Rochester Health Services East to	assess	
					Nail and Oral needs (Exhibit Tag #	677-A).	
		ministration record dated					
		ntified weekly bathing every			<ol><li>What measures will be put into</li></ol>		
		am. 2/19/18 and 2/26/18 were			or what systemic changes will you	make	
		bath given. Document in			to	_	
	PCC progress note				ensure that the deficient praction not recur?		
		ogress notes identified on			" Nursing Staff were In-serviced		
		n., R12 had received her			3/13/18 or 3/14/18, (Exhibit #677-B	),	
		with no resistance. R12 did			related to the Minnesota Health		
	•	e at this time. No other			Department findings from the Annu		
		nd identified any nail care			Survey that ended on 3/2/18; and p		
	completed or docur	nented.			and timely nail and oral care; and the		
	During observation	on 2/26/19 of 7:42 a.m. D42			need to complete rounds on ADL c		
		on 2/26/18, at 7:43 a.m., R12 of her bed and noted to have			needs to maintain compliance with Resident ADL care needs.		
	soiled, long, untrim				" CNA Staff were In-serviced on		
	Jonea, long, untillill	nou illigerrialis.			3/20/18 or 3/22/18, (Exhibit #677-C	:)	
	During observation	on 2/27/18, at 5:47 p.m., R12			related to the Minnesota Health	<i>)</i> ,	
		able in the dining room in her			Department findings from the Annu	al	
		er supper independently and			Survey that ended on 3/2/18; and p		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING			03/0	) 2/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		1 00/1	7272010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ige 18	F 6	677			
	is noted to have lor brown-looking substant (NA)-l verlong, with a brown and stated her nail completed on Mondshe refuses. If it is she would docume During interview on licensed practical in fingernails are long underneath them.	and interview on 2/28/18, at sitting in her wheelchair in her window, wearing a gray holding a red heart shaped it is noted to have long, th brown substance er fingernails. R12 stated, "My			and timely nail and oral care; and to need to complete rounds on ADL coneeds to maintain compliance with Resident ADL care needs. (Exhibit 677-C).  "Oral Care will be provided daily AM and PM care and prn for deper residents.  "Nail Care will be provided weel shower/bathing care and prn for dependent residents.  "A second in-service will be held 3/28/2018 and 3/29/2018 related to findings of F677; The expectation of care being offered with bathing and The expectation of oral care being with am and pm cares and prn; and a Resident refuse that staff are to reattempt and document with the ebe focused on providing quality carneeded and to offer Residents perspreference; and the facility policy of Fingernails/Toenails.  4. How will you monitor the correction(s) to ensure the deficient prawill not recur, i.e., what quality assurance program will be put into	Tag #  / with ndent kly with  the of Nail ll prn; offered d that if ffort to e as sonal n Care  ctive actice	
	date of 5/10/17, and disease, aphasia (leexpress speech, can a cerebral infarction major depressive disease.	ecord identified an admission d a diagnoses of Alzheimer's oss of ability to understand or aused by brain damage), after n, type 2 diabetes mellitus, isorder, repeated falls, and			" The facility has implemented a Assurance Program to ensure Res of Rochester Health Services East receiving appropriate Nail and Oral for dependent residents.  " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit # 677-D) re	idents are care	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		E CONSTRUCTION	COMF	SURVEY PLETED
		245184	B. WING			03/0	) 2/2018
	PROVIDER OR SUPPLIER	SERVICES		5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	1/23/18, identified F deficit and requires with personal hygie Care plan dated 5/8 have a shower daily Requested facility band received a note review."  Facility document C 2/13/18, identified F a.m. and Friday a.m. R53's treatment ad 2/1/18-2/28/17, iden Monday and Friday not documented as reproach x 3 and donotes.  Review of R53's pro 1/22/17, at 1:49 p.n. bed bath with minin fingernail and toens scattered bruising c small scabs. No oth any nail care was containing room. Finger long with a brown so During observation is sitting up to the tay wheelchair eating here.	R53 to have a severe cognitive one person extensive assist ne.	F6	77	nail and oral for 3 residents care; 3 a week for one week; then 2 times for one week, and then weekly for weeks.  " Additional training may be schebased on results of the quality assureview.  " As part of the facility□s on-goin Quality Assurance and Process Improvement (QAPI) program, facipolicy and procedures are analyzed modified as necessary by the QAP committee. All deficient practices with findings of investigations will be reviewed monthly in QAPI meeting three months to ensure compliance facility policy and state and federal regulations.  " The facility administrator and/odesignee will monitor that the tools completed.	a week two eduled urance  ig d and I along ie s for e with	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING				C <b>02/2018</b>
	PROVIDER OR SUPPLIEF			501	EET ADDRESS, CITY, STATE, ZIP CODE EIGHTH AVENUE SOUTHEAST CHESTER, MN 55904	1 00.	<b></b>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 677	During interview of assistant (NA)-I Vowith brown debris "They should be conurse should have on Monday with his united by the progress notes of the progre	er his fingernails on both hands. In 2/28/18, at 1:43 p.m., nursing erified R53's fingernails are long underneath them and states, leaned out, he is diabetic, the excleaned and trimmed his nails is bath."  In 2/28/18, at 2:04 p.m., nurse (LPN)-C verified R53's title long, with a brown eath them. Further verified in Monday, nail care should have by the nurse at that time, and mented regarding nail care in its.  In the facility on 7/25/14, dimission record. R5's quarterly its (MDS) an assessment dated dr. R5 needed extensive assist of sonal hygiene needs. The briefical status (BIMS) assessment extended on 2/27/18, at 12:47 p.m., is wheelchair located in his fingernails on both hands and a	F 6	577			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING			C 03/02/2018	
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, S 501 EIGHTH AVENUE SC ROCHESTER, MN 559	STATE, ZIP CODE DUTHEAST	75/02/25 10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 677	Continued From pa	ge 21	F 6	77			
		with R5 on 2/28/18, at 9:33 his current nail status, and he his nails short.					
	on 2/28/18, at 9:52 preferred a bed bat Mondays. She verif and they "definitely	with nursing assistant (NA)-E a.m., NA-E stated the R5 h which he received on ied that R5's nails were long could use some attention." ould have been taken care of					
	it was verified that r days. Bath sheets a	with registered nurse (RN)-D, nail care is to be done on bath and progress notes reviewed nail care had been performed ruary 2018.					
F 684 SS=D	12/2016, indicated are to clean the nai prevent injuries and includes regular cle Unlicensed staff do residents or resider impairments. Notify refuses the care. Quality of Care	Of Fingernails/Toenails dated, the purpose of this procedure bed, keep nails trimmed, to infections. 1. Nail care aning and trimming. 3. not trim the nails of diabetic ats with circulatory of the supervisor if the resident	F 6	84		3/30/18	
	applies to all treatm facility residents. Ba assessment of a re that residents received	care fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE COMP	PLETED
		245184	B. WING			, 2/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 684	practice, the complete care plan, and the This REQUIREME by: Based on interview facility failed to impadministration of all medication for 1 of administered a PRI Findings Include: R67's Admission Radmitted to the factor of cerebral infarctic convulsions. R67's neurology visincluded, "We did to [family member (FI staring and unresponnepileptic in nature [electroencephalog of a seizure dischatthese are not going medications. Probachanges related to hemorrhage." R67's care plan indin Neurological States disorder. Interventimedication as order has ceased, monitor	rehensive person-centered residents' choices. NT is not met as evidenced and document review, the lement specific parameters for as needed (PRN) seizure 1 resident (R67) who was 1 seizure medication.  ecord identified R67 was lity on 1/26/18, with diagnoses on, and unspecified sit summary on 2/6/18, ell the patient [R67] and his M)-A] that his episodes of onsiveness appear to be are based on his previous EEG ram] that showed no evidence rege during these, and therefore it to be helped by antiepileptic ably these are due to cognitive	F 684	,	es at dents by the ester dal to be etice. place make does on ngs on	
	behavior changes, weakness/paralysis	confusion, poor coordination, s of body parts, sleep the resident to sleep after a		(Exhibit Tag # 684-A).  " A second in-service will be held 3/27/2018 and 3/28/2018 related to findings of F684. The monitoring of	d the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	СОМ	E SURVEY PLETED
		245184	B. WING _			C <b>02/2018</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	•	02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	R67's physician or Midazolam HCI So nostril as needed fover 3 minutes or Give 1 ml in each in R67's progress no administration reconstruction in R67's progress no administration Notes 5 MG/ML 2 ml in each nostri Prolonged seizures more than 3 seizur nostril."  R67's progress no regarding the as now was given, and revolution be a completed readministration of the facility attention the facility attention the facility had the progress note. The Entry: Note Text: L seizure at the table 1245p. [12:45 p.m. room and CNA [cereported to writer the Writer didn't witnessed in Resident's tears we stared up. When complete to turn his head [FM-A] witnessed in However, [FM-A] witnessed in	ders signed 2/27/18, included: lution 5 MG/ML 2 ml in each or seizures Prolonged seizures more than 3 seizures in 1 hour. nostril.  tes and medication ord revealed the following:  1:19 p.m.] Orders - e Text: Midazolam HCl Solution  I as needed for seizures sover 3 mins [minutes] or res in 1 hour. Give 1 ml in each research medication for seizures realed no documentation had agarding the need for the re PRN seizure medication. In a survey process, nurse add a late entry renote read, "2/24/18 Late ate Entry: Resident had a in dining room at around of the late of the resident had a seizure. The set of seizures resident had a seizure. The set of seizures resident had a seizure. The set of seizure resident had a seizure. The set of seizure resident had a seizure. The set of seizure resident had a seizure resident had a seizure. The set of seizure resident had a seizure resident had a seizure. The set of seizure resident had a seizure resident was and and respond to his name.	F 68	use of PRN medication parar Obtaining new or changed Pl Orders during the 24-hr. reported definition and care of a Seizur 4. How will you monitor the action(s) to ensure the deficit will not recur, i.e., what qualit program will be put into place.  "The facility has implement Assurance Program to ensur Residents of Rochester Heal East shedications are avait as per Physician so Order.  "The Director of Nursing and designee will complete a quatassurance tool (Exhibit Tag # three residents who receive from medications: 3 times a week week; then 2 times a week week; then 2 times a week week; then 2 times a week for and then weekly for two weel.  "Additional training may be based on results of the qualit review.  "As part of the facility so Quality Assurance and Proceed Improvement (QAPI) program policy and procedures are and modified as necessary by the committee. All deficient practice with findings of investigations reviewed monthly in QAPI methree months to ensure compliance.	hysician ort; The lire.  corrective ent practice by assurance erective ent practice by assurance erection and/or erection and/or erection and/or one week, which is a surance on going erections and erections and erections and erections and erections and erections are going erections and erections and erections and erections are going erections are g	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED	
		245184	B. WING _			C / <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP COI 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	continued eating luto monitor." However seizure R67 had an as needed medicate according to the not 2/6/18.  During an interview nurse consultant (Nourse to review the communicate on the care plan update. No expected the informat staff from the neuron episodes of staring appeared to be nor his previous EEG that seizure discharge of are not going to be medications. NC-Be expected the PRN when to administer symptoms. NC-Be sthing here is to educ constitutes a seizure have expected eduregarding R67's se on 2/6/18 and state completed with facinurse should have completed an obset the need for the PRR67's wife reported.	lam for resident. Resident nch after seizure. Will continue er, there was lack of type of nd if staring unresponsive the ion was not to be given tes from the neurologist dated on 3/1/18, at 12:15 p.m. IC)-B stated she expected the	F 68	" The facility administrator designee will monitor that the completed.		
F 688 SS=G		en administered in hindsight. Decrease in ROM/Mobility 1)-(3)	F 68	8		3/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVE COMPLETED		
		245184	B. WING _			) 02/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 688	resident who enters range of motion do range of motion un condition demonstro of motion is unavoid §483.25(c)(2) A resimption receives appropriate assistance to main the maximum practeduction in mobility. Based on observative, the facility frange of motion (Pubysician orders for reviewed who had sustained actual har range of motion (Refindings include:  LACK OF ROM SER23's Admission Radmission date of 2000 and a condition in the maximum practed actual har range of motion (Pubysician orders for reviewed who had sustained actual har range of motion (Refindings include:	facility must ensure that a set the facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range dable; and sident with limited range of propriate treatment and erange of motion and/or to rease in range of motion.  Sident with limited mobility the services, equipment, and tain or improve mobility with ticable independence unless and yis demonstrably unavoidable. Note is not met as evidenced failed to implement passive ROM) and a palm guard per resident (R23) contractures. As a result, R23 arm, a decline in functional OM) to the left wrist.	F 68	F-TAG 688: Increase/Prevent D in ROM/Mobility SSD: G  1. Corrective action(s) will be accomplished for those resident have been affected by the defic practice?  " R23 was assessed on 03/22 passive range of motion and adaequipment needs. " R23 s MD was notified of fi	s found to ient 2//2018 for aptive ndings of	
	hand contractures	(10/3/16), left ankle and foot 16), and right ankle and foot		passive range of motion and add equipment needs.  " A Restorative Program was implemented on 03/22/2018 to a	aptive	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING _			C 02/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		02/2010	
ROCHES	TER EAST HEALTH	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 688	Continued From pa	age 26	F 68	8			
	the Functional Lim 4/18/17, to have R (LUE) to have a 1 An occupational th the Functional Lim	erapy assessment identified in itation Assessment dated 23's left upper extremities percent (%)-19% impairment.  erapy assessment identified in itation Assessment dated 3's LUE to have 60% - 79%		R1□s Mobility and Tra " R23□s Responsible Pa notified of R1□s passive ra and adaptive equipment ne " R23□s Care Plan was updated on 03/22/2018 rela passive range of motion an equipment needs.	arty was nge of motion eds. reviewed and ated to R23□s		
	assessment dated severely cognitivel of motion (ROM) in extremities, contra ankle, and contract R23's physician Or an order initiated 7 range of motion PI (LUE), focusing or	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 olerance 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) poots 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.		2. How will you identify off having the potential to be a same deficient practice?  " Residents who reside a East Heath Services have t potential to be affected by t deficient practice. " An audit will be comple of Residents at Rochester I Services with those with co (Exhibit #688-A)	at Rochester the same he same ted by 4/1/18 East Health		
	Care Guides (contresidents assigned 2/13/18, identified boots to be applied extremities (LE) when up in chair. (PROM) for LUE of R23's Restorative reviewed from 5/1/documentation that completed as order			3. What measures will be or what systemic changes to ensure that the deficient not recur?  " Nursing Staff were In-s 3/13/18 or 3/14/18, (Exhibit related to the Minnesota He Department findings from the Survey that ended on 3/2/1."  CNA Staff were In-serv 3/20/18 or 3/22/18, (Exhibit related to the Minnesota He Department findings from the Survey that ended on 3/2/1.	will you make practice does erviced on #688-B), ealth he Annual 8. iced on #688-B), ealth he Annual		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. DOILD			(		
		245184	B. WING			03/02/2018		
	PROVIDER OR SUPPLIER STER EAST HEALTH	SERVICES		50	TREET ADDRESS, CITY, STATE, ZIP CODE  11 EIGHTH AVENUE SOUTHEAST  OCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	wheelchair with leg appeared to point of were resting in blue p.m. R23 was obserectining wheelchaithe right.  During observation R23 was observed with her legs extended with her resident was protectors.  During observation was seated in her resident covering her protector on both feodserved to be lying right knee bent.  During observation was observed in the wheelchair. She was protectors on both feodserved in the wheelchair. She was protectors on both from orthotics if patient a from orthotics if patient a from orthotics. Ple and after orthotics. Ple and after orthotic. Goals current level of phypossible. Additional	extenders. Both feet flownward and inward, and e heel protectors. At 12:59 erved to be seated in the r and leaning forward and to  on 2/27/18, at 12:19 p.m., sitting in a reclining wheelchair ded straight out. Both feet roint downward and inward, as wearing blue heel  on 2/28/18, at 9:51 a.m., R23 eclining wheelchair with a er lap, she had the blue heel eet. At 1:49 p.m. R23 was g on her back in bed with her  on 3/1/18 at 11:07 a.m., R23 e dining room seated in her as observed to have heel	F	688	# 688-C)  " Residents live at Rochester Ea Health Service will be assessed to any residents with contracture need those who are identified with needs care planned to meet those needs 4/1/18.  " A second in-service will be conon 3/28/18 and 3/29/2018 related to findings of F688; Passive Range of Motion and the use and expectation devices to prevent the development Contractures (i.e. palm guards, orthand etc.); the facility policy on Rest Nursing Care.  4. How will you monitor the correct action(s) to ensure the deficient prawill not recur, i.e., what quality assurprogram will be put into place?  " The facility has implemented a Assurance Program to ensure that Residents of Rochester Health Serestates Passive Range of motion program.  " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit #688-D) to compliance of Passive Range of M With the 3 residents who need passinge of motion; 3 times a week for one and then weekly for two weeks.  " Additional training may be schebased on results of the quality assurance."	dentify ds and will be by ducted of the n of t of notics, orative  ctive actice arance  Quality vices  monitor otion. sive one week,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING				C <b>02/2018</b>
	PROVIDER OR SUPPLIER			50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904	<u>,                                      </u>	<b>V</b> =/-2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 688	tolerance x 3 sets of Goal: decrease risi in order to provide to ensure skin interieritation.  During an interview nursing assistant (a restorative aide for NA-G stated when PROM, therapy we complete it, and state training. NA-G said in the communicate their assignments.  During an interview NA-H verified she'd morning, but had not stated, "It says on get range of motion.  During an interview licensed practical restoration and rare where the aides find restorative, I think plan sheets for the puring an interview trained medication aides are not responsible. The only person we gat different resident puring an interview and the puring an interview trained medication aides are not responsible.	of 10 reps for 15 minutes. It of further contractures in LUE comfort and reduce pain, and grity and reduce risk of skin  of on 2/28/18, at 10:13 a.m.  NA)-F stated they have not had for about a year. At 10:44 a.m., a resident is started on build demonstrate how to aff had to acknowledge the district this was usually documented in book where staff would find to do restorative nursing.  of on 3/1/18, at 11:12 a.m., digotten R23 out of bed that not completed PROM. NA-H my care plan that she does not in."  of on 3/1/18, at 10:53 a.m., hurse (LPN)-C stated, "We torative aide for about a year, grassistants to do it, like nige of motion. I am not sure and the information on who is on it is on their care sheets [care Na's]."  of on 3/1/18, at 11:16 a.m., aide (TMA)-B stated, "Our onsible for restorative nursing, e have on this unit for ROM is	F 6	888	review.  " As part of the facility□s on-goin Quality Assurance and Process Improvement (QAPI) program, faci policy and procedures are analyzed modified as necessary by the QAP committee. All deficient practices with findings of investigations will be reviewed monthly in QAPI meeting three months to ensure compliance facility policy and state and federal regulations.  " The facility administrator and/or designee will monitor that the tools completed.	lity d and l along e s for e with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245184	B. WING				C <b>02/2018</b>
	OVIDER OR SUPPLIER	SERVICES		50°	REET ADDRESS, CITY, STATE, ZIP CODE  1 EIGHTH AVENUE SOUTHEAST  OCHESTER, MN 55904	1 001	02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
Property of the control of the contr	ccupational therapy rogram on 4/18/17 ruring interview on erified R23 had not pril of 2017, becaute restorative, it was diministration reconnect. LPN-C state assive range of muring an interview 0:52 a.m., she said ROM program was contractures and to bobility of her left huring an interview hysical Therapy AT (physical ther	een discharged from by (OT) with a restorative 7.  1 3/2/18, at 10:01 a.m., LPN-C of been getting PROM since use although the order got put is not on the treatment ord (TAR) or on the CNA care ed, "My expectation is to have notion done daily as ordered."  1 with COTA-D on 3/2/18, at id that the purpose of R23's as to prevent worsening of prevent a decrease in the nand.  2 on 3/2/18, at 11:48 a.m. assistant (PTA)-A verified the by) Discharge Summary dated bilateral lower extremity (BLE) be limited, limiting patient's bility. PTA-A also verified there program put in place to remity range of motion.  2 on 3/2/18, at 12:08 p.m., nurse (LPN)-C stated R23 did a range of motion program in extremities.  Therapy (OT) Plan of Care ded for R23 "now presents with nal ROM of L [left] wrist, eal joints, proximal	F6	888			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		COM	E SURVEY PLETED
		245184	B. WING				C 0 <b>2/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZI 501 EIGHTH AVENUE SOUTHEA ROCHESTER, MN 55904		1 00/	02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 688	weeks ago, they als palm guard, which I patient now requirin assistance for hygic medical complexity OT to assess approprogram, educate of hygiene, wearing so LACK OF CONSIST LEFT PALM GUAR Doctors order dated left palm guard in the cares and hygiene; check for redness a hours off, for 4 hours guard, wear 4 hours A Therapy Commun 4/7/17, identified reresident to wear left off at night, to compromotion, and stretch taking palm guard of the 3rd West CNA Care Guides (contained and the contained and the contained are guides) as signed 2/13/18, identified For cloth in left hand, particular and observation buring an observation.  During an observation buring observation.	or report inconsistent use of has since resulted in the g significantly more ene and joint mobility. Due to this patient will require skilled priate and effective ROM haregiver on skin integrity, chedule of soft brace."  TENT USE OF ORDERED D: d 7/26/17, for R23 to wear a ne morning following morning Remove after 4 hours and and irritation; Replace after 2 as two times a day for palm as two times a day.  Inication note to nursing dated commendations for the total palm guard during the day, plete hygiene and range of ing fingers out straight when on and off.  (certified nursing assistant) in services/treatments for to the nursing assistant) dated R23's to need a rolled wash alm guard on right.  Ion in the dining room on and, R23 sat in a reclining alm protector in place on her on 2/27/18, at 12:19 p.m., sitting in a reclining wheelchair	F 6	<b>188</b>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245184	B. WING				02/2018
	PROVIDER OR SUPPLIER	SERVICES		501	REET ADDRESS, CITY, STATE, ZIP CODE I EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	During observation was seated in her rehand palm protecto was observed to be no palm guard on her palm guard on her palm guard on with wheelchair. She was palm guard on with When R23 was ask her left hand, R23 version and the relation of the contractures cloth rolled in left hand.  During an interview certified occupation verified R23 had be occupational therap program on 4/18/17 guard during the dated 3/2/18, identition left palm guard to	on 2/28/18, at 9:51 a.m., R23 eclining wheelchair with no left r in place. At 1:49 p.m. R23 elying on her back in bed with er left hand.  on 3/1/18, at 11:07 a.m., R23 elying room seated in her as observed to have the left her fingers curled around it. and whether she could open was unable to do so.  ised 4/3/17, identified a focus of hands, and need for wash and and palm protector in right on 3/1/18, at 2:02 p.m., all therapy aide (COTA)-Deen discharged from by (OT) with a restorative ry and to wear a left palm by and off at night.  Therapy (OT) Plan of Care fied R23 had a previous order or promote skin integrity and indicated R23 "The caregiver	F6	888	DEFICIENCY)		
	approximately two vinconsistent use of resulted in the patie more assistance for Due to medical conskilled OT to asses ROM program, edu	weeks ago, they also report palm guard, which has since ent now requiring significantly rhygiene and joint mobility. Inplexity, this patient will require appropriate and effective cate caregiver on skin rearing schedule of soft					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
		245184	B. WING _		C 03/02/2018
	PROVIDER OR SUPPLIER	SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		1 00/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE COMPLÉTION
F 688	dated 12/2016, inclis that which does a qualified profession care. Nursing person rehabilitative nursin active program of a developed and cool care plan. The fact program is designed achieve and maintal and independence, provided daily for the such a service. Profession of the such a service and maintal and independence.	Restorative Nursing Care uded: "restorative nursing care not require the use of a nal therapist to render such	F 6	38	
	exercises." Free of Accident HacFr(s): 483.25(d)( §483.25(d) Accident The facility must en §483.25(d)(1) The as free of accident  §483.25(d)(2)Each supervision and as accidents. This REQUIREMED by: Based on observareview, the facility fand/or revise intervals of 3 residents (Reaccidents. This res	azards/Supervision/Devices 1)(2) nts.	F 6	F689: Free of Accident Hazards/Supervision/Devices SS: G  1. Corrective action(s) will be accomplished for those residents	3/30/18 found to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING			03/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER EAST HEALTH	SERVICES			01 EIGHTH AVENUE SOUTHEAST COCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Findings include:  R54's admission M assessment indicate the facility 2/20/17, with injury sustaine addition, the MDS in including hypertens and recommendation of the room laying dor Resident was sase bruises. Wital signs	inimum Data Set (MDS) ted R54 had been admitted to from the hospital after a fall d in a different facility. In ndicated R54 had diagnoses sion and diabetes.  S assessment dated 11/21/17, experienced a fall with injury ive assistance of one staff obility, and extensive sfers with two staff. The indicated a Brief Interview for S) interview was attempted s unable to complete, so staff completed which identified short term memory loss.  Inange MDS assessment dated R54 had no previous falls and required extensive taff members for bed mobility  Tes were reviewed from and contained information in ound, assessment/appearance on (SBAR's) format of the  fall from bed with no injuries nt was found on the floor of wn on her side. no injuries. Inseed and no injuries found or checked and was within	F	689	have been affected by the deficient practice?  " R40 is not at the facility at this she will be reassessed upon return facility.  " R54 and R53 was assessed or 03/22/2018 related to his/her 03/22 and his/her care plan has been upowith Fall prevention intervention implemented at the time of the Fall R54 and R53 MD was notified findings of Fall history, risk, and cure Fall Care Plan Interventions.  " R54 and R53 Responsible Part notified of Fall history, risk, and cure Fall Care Plan Interventions.  " R54 and R53 S Care Plan was reviewed and updated on 03/22/20 related to Fall prevention intervent implemented at the time of the Fall.  2. How will you identify other resident of the Fall.  2. How will you identify other resident practice?  " Residents who reside at Roche East Health Services have the same deficient practice.  " An audit of Resident service.  " An audit of Resident service.	time. In to the In //2018 Idated I. of Irrent Ity was Irrent Is 18 Is ion I. dents Ity the In rester Ite	
	normal, denies pair	n. Recommendations: will morning nurse to monitor,			or what systemic changes will you to ensure that the deficient practice	make	

		(X2) MULTIPLE CONSTRUCTION A BUILDING			E SURVEY PLETED
		7. BOILDIN	<u> </u>		c
	245184	B. WING _			02/2018
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		02/2010
			501 EIGHTH AVENUE SOUTHEAST		
TER EAST HEALTH	SERVICES		ROCHESTER, MN 55904		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
Reminded resident get up by herself. In 11/17/17, R54 had room, close to her stated she was try room. Resident stated she was try room. Resident stated all day. Resident wo find family member patient. Recommendations this fall). Possible dated 11/21/17, Coreadings. Resident (hypertension) and Assessment (RN [LPN [licensed practiced for provident continuent readings on AM shad (highest reading). Metoprolol (to lowe this time, request for medication. Blooprinted for provident Recommendations 11/21/17, progress nurse practitioner plan to stop torsent blood pressure) ar pressure. The reposeen updated on F	to use the call light and don't amily notified.  been found on floor of her roommate's bed. Resident ing to close the door of her ated her right leg and head hurt. In the noticed on her coccyx. No at the coccyx is noticed on her coccyx. No at the floor. Director or continuous at the floor is noticed on her coccyx. No at the floor is noticed on her coccyx. No at the floor is noticed on her coccyx. No at the floor is noticed on her coccyx. No at the floor is noticed on her coccyx. No at the floor is noticed on her coccyx. No at the floor is noticed on the floor is noticed on the floor is noticed on the floor is noted in the floor is	F 68	not recur?  "Nursing Staff were In-se 3/13/18 or 3/14/18 (Exhibit # related to the Minnesota Head Department findings from the Survey that ended on 3/2/18 Fall prevention.  "CNA Staff were In-service 3/20/18 or 3/22/18 (Exhibit # related to the Minnesota Head Department findings from the Survey that ended on 3/2/18 Fall prevention.  "Risk Management tab in Care will be used to ensure tracking/investigation, document of the deciding of F689; Assessment Investigation, Immediate Interventions of F689; Assessme	689-B) alth e Annual ; Falls; and ced on 689-C) alth e Annual ; Falls; and i Point Click proper nentation, otification, eted. be conducted lated to the nt, ervention, and n and ne post fall process. e corrective ent practice ty assurance er? inted a Quality re Residents alth Care	
	ROVIDER OR SUPPLIER  TER EAST HEALTH  SUMMARY ST (EACH DEFICIENCE REGULATORY OR II  Continued From particles of Regulatory or II  11/17/17, R54 had room, close to her stated she was try room. Resident stated she was try room. Resident was other injuries noted all day. Resident wo finursing, nurse pand family member patient.  Recommendations this fall). Possible dated 11/21/17, Coreadings. Resident (RN [LPN [licensed praced dizziness with post Resident continued readings on AM she (highest reading). Metoprolo (to lowe this time, request for medication. Blooprinted for provide Recommendations 11/21/17, progress nurse practitioner of plan to stop torsen blood pressure) are pressure. The repost of related to the 11/11 of right hip and leg	TER EAST HEALTH SERVICES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	ROVIDER OR SUPPLIER  TER EAST HEALTH SERVICES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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]): 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	TER EAST HEALTH SERVICES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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 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 11/2/177, Continuous low blood pressure readings. Resident with history of HTN (hypertension) and CHF (congested heart failure). Assessment (RNI [registered nurse])/Appearance LDNI [licensed practical nurse]). Early licenses 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."  11/12/1/17, progress notes indicated the certified nurse practitioner (CNP) had visited R54 with a plan to stop torsemide (a diurretic 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 1/1/17/17, fall, resident complaining of right hip and leg pain, increased with weight	TER EAST HEALTH SERVICES  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION)  Continued From page 34  Reminded resident to use the call light and don't get up by herself. Family notified.  Continued From page 34  Reminded resident to use the call light and don't get up by herself. Family notified.  A small scrape was noticed on her coccyx. No other injuries noted. Resident has tated 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 has 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 outlines 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 CNP had been updated on RS4's prior falls. Possibly related to the H1/17/17, fall, resident complaining of right hip and leg pain, increased with weight in related to the H1/17/17, fall, resident complaining of right hip and leg pain, increased with weight in related to the H1/17/17, fall, resident complaining in representation and care are assessed post fall and a fall intervention is implemented and care in the resident of the control of the facilities policy Prevention and Management Guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245184	B. WING				C 02/2018
	PROVIDER OR SUPPLIER	SERVICES		50	TREET ADDRESS, CITY, STATE, ZIP CODE  101 EIGHTH AVENUE SOUTHEAST  OCHESTER, MN 55904	00/	,2,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	X-ray of right hip to fall. On 11/28/17, the g/hip pain and ord fracture. The limite included, X-ray rereport which reveal need a computerize confirm diagnosis chospital on 11/29/1 confirmed a right per A facility report inition 11/29/17, by the to the 11/17/17 incihip (11/29/17) to the (OHFC). The compute following inform "Description, A resifracture identified of attributes to a fall the The facility assessmand symptoms of permergency Room Results returned 11 fracture. Review of consultant pharmach changes at this time falls on 11/5/17. With while trying to self the slipped on the floor to the floor next to be reviewed falls agains she was trying to go posted outside her per her request at retreat as appropriate completed with addadded." Under descriptions.	rule out fracture from recent ne CNP visited R54 regarding dered X-ray to rule out ed evaluation clinical document sults noted an addendum to ed a possible fracture and will ed tomography (CT) scan to of pelvic fracture. Sent to 7, had CT scan and report ubic bone (hip) fracture.  ated (FRI) an incident reported director of nursing in regards dent with confirmed fracture of e Office of Facility Complaints plaint registration form included nation:  dent ([R54]) sustained a pelvic on 11/27/2017 that the facility mat occurred on 11/17/2017.  ment(s) did not identify the sign	F 6	689	" The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit Tag #689-D management of the Fall Prevention program 3 times a week for one we then 2 times a week for one week, a then weekly for two weeks.  " Additional training may be sche based on results of the quality assureview.  " As part of the facility□s on-goir Quality Assurance and Process Improvement (QAPI) program, facili policy and procedures are analyzed modified as necessary by the QAPI committee. All deficient practices a with findings of investigations will be reviewed monthly in QAPI meetings three months to ensure compliance facility policy and state and federal regulations.  " The facility administrator and/or designee will monitor that the tools completed.	ek; and duled rance ity and long e s for with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED	
		245184	B. WING_			C / <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP C 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		702/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	on 12/6/17, in rega 11/29/17. The infor "[R54] has been a r7/10/17. Her prima type II diabetes, rho atria fibrillation, milmetastatic breast of 10 on 10/9/17. Fall 0527 [5:27 a.m.] wi 2000 [8:00 p.m.] wi injury but then back checks. Resident preceives scheduled arthritis. On 11/27/in right hip, especial movement. SBAR nurse practitioner, recommended add diagnosis. On 11/2 POA [power of attoscan. Resident ser Room for outpatien 11/29/17 showing a medications compl No recommended Committee reviewed 11/3/17 resident fel out of bed but her fout of bed but her four four four four four four four fou	Investigation status to OHFC rds to the incident reported on mation contained the following: resident at the facility since ry diagnoses are: malaise, eumatoid arthritis, chromic d congestive impairment, and rancer. Last BIMS score was history includes: 11/3/17 @ reth no injury, and 11/17/17 @ reth pain in right hip at time of to baseline on subsequent reain is monitored daily and she diacetaminophen for pain from resident had increased pain ally with weight bearing or completed and reviewed by x-ray ordered. Results itional imaging for conclusive 8/17 approval obtained from rney] to send resident for CT reth to St. Mary's Emergency at CT scan. Results returned a pelvic fracture. Review of reted by consultant pharmacist. Changes at this time. Falls red falls on 11/5/17. With fall on all while trying to self transfer reet slipped on the floor. The added to the floor next to mittee reviewed falls again on said she was trying to get up red falls and treat as appropriate. The completed with addition of added." Under description of added." Under description of	F 68	39		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING				C <b>02/2018</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	OZ/ZO 10
ROCHES	TER EAST HEALTH S	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	_	F 6	89			
	harm it reads, "residence presumed from fall	dent with pelvic fracture 11/17/17."					
	SBAR format include room, pain all over and was admitted of the A facility reporting in Office of Health Coregarding the fall with 1/12/18. The descripport of the Armonian format to bed. Able to increased during nignesident sent to ER morning for further UTI [urinary tract in [abnormal brain fundiagnoses with left]	uded in the progress notes the ded: Fell to floor in resident sent in to emergency room lue to a hip fracture.  Incident was submitted to the implaint (OHFC) on 1/15/18, ith fracture incident on ption of incident read, if ferred from her bed saying 'I set name] snoring.' on floor implementation move all extremities. Pain ght while monitoring so [emergency room] Saturday evaluation. Diagnosed with fections] and encephalopathy inction] from the UTI. Now pelvic rami fracture. Car plan					
	management/pain resident was revenances, fall command 11/3/17, reside transfer out of bed Non-skid strips were her bed. Also review resident said she we door. No falls since plan completed, revenance plan completed.  Mayo Rochester Eredated 1/13/18, incluassessment: Extrements of the provided that is the same of the provided that is the provid	me of fall. Plan is conservative management." Also included viewed by pharmacist with no littee review fall on 11/5/17 nt fell while trying to self but her feet slipped on floor. e added to the floor next to wed all form 11/21/17 and as trying to get up to close her 11/21/17 until 1/12/18. Care view of room placement mergency Department record ided under nursing mity Lower, Patient had a fall vening unwitnessed at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED C	
		245184	B. WING _		03	/02/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP C 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	Rochester Health's facility (SNF), stated did hit her head. Utillness, it read, "[Rt 13 through January scan demonstrated pubic rami fracture inferior pubic rami vertebral body fraction pain management.  During observation 2/26/18, at 8:28 a.r. on 2/27/18, 4:08 p. strips on floor next read to keep door the fall intervention incident directed the Interview with registant 1:35 p.m. regard non-skid strips in fall on 11/17/17, Rt strips next to R54's the interview with FR54's floor. Mainter placed non-skid strips in fall on 1strips next to R54's the interview with FR54's floor. Mainter placed non-skid strips in fall on 1strips next to R54's the interview with FR54's floor. Mainter placed non-skid strips in falls r/t [relation of a control o	services East skilled nursing as she had her slippers on and order the History of present [54] was hospitalized January of 16, 2018 following a fall. CT of acute left superior and inferior s, subacute right superior an afractures, and the chronic L2 ture. She was admitted for"  It is of R54 in her room on m., 2/27/18, at 12:16 p.m. and m. there were no non-skid to her bed. The sign on door lopen at night even though of following the 11/27/17, we sign to say "closed."  Stered nurse (RN)-D on 3/1/18 alting the falls interventions of ront of R54's bed following the N-D observed no non-skid shed. At 1:45 p.m. following RN-D of no non-skid strips on nance-A was observed to have rips on the floor in front of the a focus of "Resident is at ted/to] History of falls, Pain."	F 68	9		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	_ (×	(3) DATE SURVEY COMPLETED
		245184	B. WING		_	C <b>03/02/2018</b>
	ROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, ST 501 EIGHTH AVENUE SOU ROCHESTER, MN 559	UTHEAST	00/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	
	strips "Zip/non-skip Record review and 3/1/18, at 4:23 p.m. (PTA)-G verified R5 2017, and none sind Interview on 3/1/18, assistance (NA)-D states they us gait belt. Clinical minterventions. On receives fall risk into NA-D states they us gait belt. Clinical minterventions. On receives fall risk into NA-D states they us gait belt. Clinical minterventions. On receives information specares/treatments) sand no other intervention would consition, call light in review care plan are electronic care plan always complete a survive manager and after fall. Neuros counwitnessed or whe LPN-A also added the assessment and the self-explanatory and facility started a revention of the self-explanatory and self-explan	or queried the use of safety strips on floor at bedside."  interview with therapy on physical therapy assistant of last evaluated in October of ce then.  at 3:57 p.m. with nursing stated R54 is a fall risk and erventions from the nurse. Se routine interventions like anager will update with new eview of the NA's care sheet ecific to resident howed only use of gait belt entions to prevent falls.  at 4:00 p.m. with licensed N)-A stated R54 is a fall risk, double check bed in low reach. LPN-A stated would not proceeded to check the for R54. LPN-A said nurses SBAR and notify family, CNP, I can put intervention in place completed on any fall en a resident hits their head. hey start a post fall	F6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG	CON	TE SURVEY MPLETED  C	
		245184	B. WING _			/ <b>02/2018</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	11/21/17. CNP-F's notes that there had provider to evaluate Interview on 3/1/18 consultants (RNC) were asked what the fall. This included indevelop intervention At 1:47 p.m. intervention after the falls. Administrator completed after regroom with diagnos 11/29/17 had not bor care sheets. Ad post falls intervention to been document assessment until sattention. Administrator now in place for	document dated 11/28/17, and not been a request for e.  8, at 1:40 p.m. registered nurse -B, H, & J and Administrator the policy/procedure following a nivestigation, assessment, ons following each fall for R54. The policy formation regarding R54's that post falls assessment atturn from hospital emergency is of hip fracture dated the een added to R54's care plan ministrator was not aware the fions to prevent further falls had atted at time of post fall surveyor brought it to his trator also said the safety strips or R54. Administrator verified procedure had not been	F 68	39		
	3:31 p.m. regardin regarding the falls	vs with RNC-B on 3/1/18, at g the requested information for the last four months. was no more information				
	facility continued to and was not able to paper work or add on R54 falls. R40's current diag Diagnosis Report, Parkinson's diseas	1 p.m. RNC-H verified the blook through charts and files o identify any of the facilities itional investigation paper work noses according to the dated 3/5/18, included se, cerebral infarction, muscle nal disorder, anxiety, and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		COM	E SURVEY IPLETED
		245184	B. WING				C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES			, CITY, STATE, ZIP CODE NUE SOUTHEAST MN 55904	1 00/	02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTI ORRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	major depressive d R40's annual Minimassessment dated cognitive impairment persons for transfer person for ambulating more falls since the During observation R40 is sitting in her out of the dining roof friend we have in Jet During observation R40 is sitting in her self-down the hall at R40's care plan, las R40 was at risk for falls. The goal listed safe and injuries frow through her next ret (1) attending staff if assist with transfer possible, (2) encourage reside area/recliner room (3) grab bar to be in bathroom in resider (4) offer to rest resinconsolable yelling demonstrate placing independently in ref (5) reinitiate 3 day is as/when indicated,	num Data Set (MDS) an 1/6/18, indicated severe nt, extensive assistance of two rs and extensive assist of 1 on and toileting, and two or prior assessment.  on 2/26/18, at 12:57 p.m., wheelchair and propelling selform while singing, "What a resus."  on 2/27/18, at 11:59 a.m., wheelchair, wheeling way from the secured exit.  St reviewed 1/2/18, indicated injury due to falls, history of dwas: resident will remain om falls will be minimized view. Approaches included: sten for R40 in the am and out of bed as soon as lent to rest in the dining mid-day, installed on wall next to nts room, dent in the recliner chair with a gitation. [R40] is able to g foot rest up and down cliner, powel and bladder diary	F6	89			
	toilet until after succ	resident after assisting onto cessful transfer off toilet, before meals and at bedtime.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		NSTRUCTION	COM	E SURVEY PLETED
		245184	B. WING				C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		501 EI	T ADDRESS, CITY, STATE, ZIP CODE  GHTH AVENUE SOUTHEAST  HESTER, MN 55904	1 001	02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	3/6/17: also toilet at (8) turn on Facility (1 listen to when more (9) when resident is encourage resident clothing rather than (10) PT to evaluate difficulties with bala A Fall Risk Assess and was not receive R40's Incident Repand Emergency Refrom 9/21/17 to 2/1/2 9/21/17, at 2:40 p.n and was found lying stated that her right injury. Predisposing transferring self, an Interventions to preto resident. Care pl Emergency departr 3:43 a.m., revealed standing. This occu 9/21/17. R40 denich hitting her right arm upper arm laceratic sutures. R40's CT 9th and 10th ribs. Enome. Nursing assefall 13 hours ago will bathroom herself. Is centimeter lacera Tenderness noted of	midnight, Channel music for resident to e anxious, e especially anxious, to wear sweaters/warmer blankets when in bed, and and treat per increased nce.  ment was requested for R40 ed.  orts, Post fall Assessments cord revealed the following 8/18, revealed the following: n., R40 was heard screaming g on the floor in her room, elbow hurt, no evidence of factors: impaired memory, houlating without assist. vent further falls: reeducation	F6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING			03	C 8 <b>/02/2018</b>
	PROVIDER OR SUPPLIE			501 EIGHTH	RESS, CITY, STATE, ZIP CO I AVENUE SOUTHEAST ER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORF ACH CORRECTIVE ACTION S SS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	11/13/18, 11/15/1¹ 1/21/18, 1/26/18, The falls were relatingled in blanket alone, left alone obed to her wheeld interventions deverally alone interventions deverally bear of the floor stated Runit on 1/17/17 aff several falls over completed a post. The floor staff show intervention after been doing that, always a new intervention in the emergence of the progress note analysis in the emergence of the progress note analysis in the interview on 3/2/1 nurse (RN)-E state followed, incident assessments are interventions are implemented. "M	7, 10/22/17, 11/8/17, 11/11/17, 7, 11/18/17, 11/24/17, 11/21/17, 1/29/18, 1/30/18, and 2/18/18. ated to toileting needs, getting is, attempting to get out of bed on toilet, and transferring from chair. Many falls lacked eloped after fall and the care in updated.  on 3/2/18, at 12:11 p.m., 40 was moved to this secured ter her last stroke and has had the last year. I have not always fall assessment after each fall. ould be identifying an immediate each fall and they have not Further stated there is not evention added to the care plan. Ovember, 2017, we had 48 falls init. I told the director of nursing "LPN-C verified R40's fall on properly assessed, and she did ergency room, ER 13 hours later to her right upper arm and 2 arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in second in the sutures arm were not documented in the sutures arm were not documented in the sutures are successed in the success are successed	F6	889			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED  C	
		245184	B. WING _		03	/ <b>02/2018</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	determine the causinterventions need and the falls need to determine their stated there should falls in the medical include monitoring appropriate delegal R53 was admitted according to the admedical record (El Alzheimer's diseas stroke, muscle we (balance), and republication of the elegal R53's quarterly Minassessment dated having severe cogextensive assist of unsteady only stable During an observation of R53's wheelchair wand R53 was walk holding the attaches lightly bent and hepresent or in view During an interview (LPN)-K on 3/1/18 falls from 10/2017 examples of revise included, keep in the encourage fluids, infection, alternate frequent toileting, interventions were	to be put in place immediately, to be reviewed at a later date effectiveness." RN-E further d be thorough documentation of record, with an injury to, treatment, and reporting to ations.  to the facility on 4/29/17 dmission form. The electronic MR) identified diagnoses of se, aphasia (unable to speak), akness, abnormal gait eated falls.  Inimum Data Set (MDS) an 1/28/18, identified R53 as nitive impairment, requiring one with walking, and solilizing with human assistance.  Ition on 3/2/18, at 12:42 p.m. was sitting empty in the hallway ing down the hall slowly, ed railing. His knees are e is unsteady. No staff was	F 68			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM		TE SURVEY MPLETED				
		245184	B. WING			C / <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIF 501 EIGHTH AVENUE SOUTHEAS ROCHESTER, MN 55904	CODE	702/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	LPN-K stated she usporadically when see A facility policy date Plans-Comprehens of residents is ongo as information about resident's condition. Facility policy, Fall I Guidelines, dated 2 maintain a fall prevent program. In as must facility, the facility we residents risk for fasincreased risk for fasiling. Pharmacy Srvcs/Pr CFR(s): 483.45(a)(s) \$483.45 Pharmacy The facility must prodrugs and biological them under an agres \$483.70(g). The fapersonnel to admin permits, but only una licensed nurse.	he revised interventions.  Ipdated care plans she can find the time.  Ind 12/16 "Care  Indicated that assessment or plans are revised at the resident and the change.  Prevention and Management (2017, indicated the facility will ention and management chas it is in the power of the will prevent and /or manage the lls. The elderly are at an alls related to several different or will implement a fall program nined to be at risk for falls in age these factors and prevent much as possible the resident sustaining injuries related to rocedures/Pharmacist/Records (b)(1)-(3)	F 6			3/30/18

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED C		
		245184	B. WING _			02/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	dispensing, and ad biologicals) to mee §483.45(b) Service must employ or obto pharmacist whospects of the provide facility.  §483.45(b)(1) Provide facility.  §483.45(b)(2) Estain receipt and disposition sufficient detail to expect the facility or and the facility of the facility failed to ensure a facility failed to ensure available to be admitted to the facility failed to the failed fai	ministering of all drugs and the needs of each resident.  Consultation. The facility tain the services of a licensed ides consultation on all rision of pharmacy services in blishes a system of records of tion of all controlled drugs in enable an accurate rmines that drug records are in account of all controlled drugs beriodically reconciled. NT is not met as evidenced and document review, the ure medications were ninistered as prescribed by the I resident (R67) who was ime sensitive medications.  ecord identified R67 was allity on 1/26/18, with diagnoses on, and unspecified ders signed 2/27/18, included: let 100 MG Give 2 capsule by	F 75	F755: Pharmacy Scvs/Procedures/Pharmacist/Re SS: D  1. Corrective action(s) will be accomplished for those resident have been affected by the defici practice?  " Resident (R67) no longer re Rochester East Health Services  2. How will you identify other re having the potential to be affected	es found to ent esides at esidents	
	mouth in the evening Capsule 100 MG G	ng for seizures, Zonisamide sive 1 capsule by mouth in the es and LamoTRIgine Tablet		same deficient practice?  " Residents who reside at Ro	·	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	COM	E SURVEY PLETED
		245184	B. WING			C 02/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP C 501 EIGHTH AVENUE SOUTHEAST		<i>5212</i>
KOOHEO	TER EAST HEALING	SERVICES .		ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 755		_	F 75		41	
	related to UNSPEC R67's progress not administration reco	rd revealed the following		East Health Services have a potential to be affected by the deficient practice.  " An audit was conducted 03/22/2018 to assess Residual Conduction of the deficient practice.	he same d on dents at	
	Administration Note Capsule 100 MG G	dication doses:  10:57 p.m.] Orders - e Note Text: Zonisamide Sive 2 capsule by mouth in the es run out of medication.		Rochester Health Service. have seizure Medications w monitored for availability. (I #755-A).	ill have them	
	Pharmacy called an "2/12/2018 09:28 [9 Administration Note	nd meds will be deliver tonight"		3. What measures will be or what systemic changes was to ensure that the deficient not recur?	will you make practice does	
	unavailable. Was n attempt to contact   were not answered manger] and he wil	•		" Licensed Nurses and T Assistants were In-serviced 3/14/18 (Exhibit #755-B) rel Minnesota Health Departme from the Annual Survey tha 3/2/18; Missed Medications	on 3/13/18 or lated to the ent findings t ended on ; and actions	
	Tablet 100 MG Given times a day related	e Note Text: LamoTRIgine e 1.5 tablet by mouth two to UNSPECIFIED 856] Pharmacy is delivering		required in the event a med available.  " Unit Managers will mak to identify any potentially monopolic.  " A second In-service will on 3/29/18 and 3/29/18 role.	e daily rounds edication	
	Tablet 100 MG Given morning related to	e Note Text: LamoTRIgine e 1.5 tablet by mouth in the		on 3/28/18 and 3/29/18 rela findings of F755; Missed Mactions required in the ever is not available.  4. How will you monitor th	edications; and It a medication	
	R67's progress not was no documenta	es were reviewed and there tion in regards to the physician d of the missed seizure		4. How will you monitor th action(s) to ensure the defic will not recur, i.e., what qua program will be put into place.	cient practice lity assurance	

AND DUAN OF CORRECTION TO IDENTIFICATION NUMBER:		` ′	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED C	
		245184	B. WING _			02/2018
NAME OF PROVIDER OF ROCHESTER EAST		SERVICES		STREET ADDRESS, CITY, STATE, ZIP OF SOIL EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	CODE	02/2010
PREFIX (EACH	<b>DEFICIENC</b>	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
done for I the misses R67's methe misses revealed complete medication R67's car in Neurold disorder. medication During and the nurses (District medication available DON states to be admissed pharmacy in the authentic in the facility pharmacy available was scheduled by the school of	on to receive the control of the receive the control of the receive the control of the receive the consultant to be administered of the control of the contr	ve direction on what should be onitoring or follow-up related to seizure medications.  error reports were requested for of seizure medications and n error reports had not been missed doses of seizure  eluded, Potential for Alteration tus related to: Has a seizure ons included: Administer	F 75	"The facility has implem Assurance Program to ens Residents of Rochester He East shedications are av Physician so Order."  "The Director of Nursing designee will complete a quassurance tool (Exhibit Tag Residents with prescription medication will be monitore medication availability; 3 tir one week; then 2 times a wweek, and then weekly for the shedical and the shedical training may based on results of the quareview.  "As part of the facility so Quality Assurance and Program of the facility shedical as necessary by the committee. All deficient program of the shedical program of the shedical training so investigation reviewed monthly in QAPI in three months to ensure confacility policy and state and regulations.  "The facility administrated designee will monitor that the completed.	ure alth Services ailable as per grand/or uality # 755-C). seizure ed for mes a week for yeek for one two weeks.  be scheduled ality assurance son-going cess am, facility analyzed and he QAPI actices along ns will be meetings for mpliance with federal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING		03	C 8/ <b>02/2018</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 501 EIGHTH AVENUE SC ROCHESTER, MN 559	STATE, ZIP CODE DUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 755	appropriate blood the DON and NC-seizure medication stated she was not doses of seizure medication error in The DON stated in have been completed the DON stated in medications and so note to have been During an intervier egistered nurse (medication is not pharmacy to see it dispensed and if the medication for chart to see if the order. RN-C state back and ask if the order. RN-C state back and ask if the order. RN-C state back and ask if the order. It would ask the gives us a four-hocritical medication from the cart would ask the gives us a four-hocritical medication. I would backup pharmacy medication that we the physician to let this medication ar like us to do. RN-c medications.	levels to prevent seizures. Both B verified the missed doses of as on the MAR. The DON at aware of R67 had missed nedication and stated eports were not turned into her. nedication error reports should sted for these missed doses. The physician should have been a missed doses of seizure stated she expected a progress completed by the nurse.  W on 2/28/18, at 12:31 p.m. RN)-C stated if I see the in the cart, I would call the fifthe medication was not there was an issue dispensing the ADU. I would review the medication was still a current of I would call the pharmacy e medication was from the ADU would ask them to dispense the medication was from the amount of the ADU or if it comes from the amount of the ADU or if it comes from the amount of the exit cation kit) to see if it is in there. I would look in the ekit cation kit) to see if it is in there. I would look in the ekit cation kit) to see if it is in there. I would look in the ekit cation kit) to see if it is in there. I would look in the ekit cation kit) to see if it is in the exit cation kit) to see if it is in the	F 7	755			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVE COMPLETED		
		245184	B. WING _		03	/02/2018	
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CO 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	seizures and if the medication there is have seizures.  During an interview registered nurse (Fithe e-kit and call of deliver the medicar RN-B stated I wou and see if I could go a different pharma sure if the facility his stated she would obackup pharmacy RN-B stated I wou medication so it would not able to get it (the medication error. Fith Fither RN-B stated call to get direction solution.  During an interview registered nurse (Fither any pharmacy in to During an interview receive his seizure risk of having a seiunaware of R67's medication and state aware of this made aware of this seizure of this seizure of this medication and state aware of this seizure of t	y do not receive that at the possibility the resident will be a von 2/28/18, at 3:23 p.m. RN)-B stated she would check for pharmacy and have them tion if it was not available. It talk to my clinical manager get that medication in town from cy. RN-B stated she was not ad a backup pharmacy. RN-B sheck to see if the facility had a land would let this writer know. It try all options to get the buld be available and if I was ne medication) it would be RN-B stated it was really eizure medications on time as ave a seizure if they did not get	F 75	55			
	medication error, a	and notified them of the as they (the missed doses) e side effects, the provider					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	COM	MPLETED
		245184	B. WING_			C / <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	would keep closer up on the resident's  The Unavailable M included, "The fato ensure that med the needs of each of the needs of each of the Medication Errundated, included, drug reactions must Director of Nursing pharmacist."  Resident Records CFR(s): 483.20(f)(s)  §483.20(f)(5) Resid (i) A facility may no resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of except to the extent to do so.  §483.70(i) Medical §483.70(i)(1) In according the most maintain meditat are- (i) Complete; (ii) Accurately docut (iii) Readily access (iv) Systematically §483.70(i)(2) The face of the resident of the complete; (iii) Readily access (iv) Systematically §483.70(i)(2) The face of the resident of the resid	eye on the patient and follow is condition.  edications policy dated 6/15, acility must make every effort ications are available to meet resident"  For and Drug Reactions policy "All medication errors and is to be promptly reported to the attending physician and the length of the length of the length of the public.  I dentifiable Information that is to the public.  I release information that is to an agent only in contract under which the agent of disclose the information at the facility itself is permitted records.  Cordance with accepted and and practices, the facility lical records on each resident attending and	F 7			3/30/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245184	B. WING			C / <b>02/2018</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 842	regardless of the frecords, except who (i) To the individual representative who (ii) Required by La (iii) For treatment, operations, as perwith 45 CFR 164.5 (iv) For public head neglect, or domesticativities, judicial allow enforcement purposes, research medical examiners a serious threat to by and in compliant §483.70(i)(3) The record information unauthorized use. §483.70(i)(4) Med for- (i) The period of time (ii) Five years from there is no require (iii) For a minor, 3 legal age under Standard standa	orm or storage method of the nen release is- I, or their resident ere permitted by applicable law; w; payment, or health care mitted by and in compliance 506; Ith activities, reporting of abuse, tic violence, health oversight and administrative proceedings, purposes, organ donation h purposes, or to coroners, s, funeral directors, and to avert health or safety as permitted nee with 45 CFR 164.512.  facility must safeguard medical against loss, destruction, or ithe date of discharge when ment in State law; or years after a resident reaches ate law.  medical record must containation to identify the resident; resident's assessments; nsive plan of care and services any preadmission screening	F8	42		

PRINTED: 03/29/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION (2	COMF	SURVEY
		245184	B. WING			03/0	) 2/2018
	PROVIDER OR SUPPLIER	SERVICES		50	TREET ADDRESS, CITY, STATE, ZIP CODE 11 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904	00/0	272010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 842	services reports as This REQUIREMEI by: Based on interview failed to maintain a include an admission plan of care for 1 or discharge. Findings include: R96's Admission R 10/27/17, identified with diagnoses of a systolic and diastol malignant neoplasmand muscle weakned on asking for R96's was learned that the completed following provided to the sundischarge date was progress notes. Review of R96's proof 10/27/17 to 12/4, admission note registrate need to comprehensive assistant as care plan is completed 12/4/17, identified to be an admination of the state there to be an admination of the sundischarge dates of the sundischarge date was progress to the sundischarge date was progress notes of the sundischarge date was pr	ress notes; and iology and other diagnostic required under §483.50. NT is not met as evidenced and record review, the facility complete medical record to on note and a comprehensive f 1 resident (R96) reviewed for ecord document dated an admit date of 10/27/17, ioute on chronic combined ic heart failure, edema, m of the bone, lung and breast, ess. Is comprehensive care plan it ere had not been one g admission and the one weyor was dated 3/1/18. R96's is 12/4/18, according to ogress notes from admission arding resident needs and	F 8	42	F842: Resident Records □ Identifiate Information SS: D  1. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice?  " R96 no longer resides at Rochest East Health Services  2. How will you identify other reside having the potential to be affected by same deficient practice?  " Residents who reside at Rochest 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 been admitted in the last 7 days to conduct admission note and initial care within 48 hours. (Exhibit Tag # 842-A)  3. What measures will be put into por what systemic changes will you me to ensure that the deficient practice cont recur?	und to ster ents / the ter have urrent plan )	

Facility ID: 00953

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG	COM	E SURVEY PLETED
		245184	B. WING _			C 0 <b>2/2018</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				501 EIGHTH AVENUE SOUTHEAST		
ROCHES	STER EAST HEALTH S	SERVICES		ROCHESTER, MN 55904		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		I SHOULD BE	COMPLETION DATE
F 842	Continued From pa	nge 54	F 84	12		
. 0.2			1 0-		f the endurate state	
	potential, incontinence, falls, and pressure ulcers RN-E stated, "Based on the information in the			ensure all the completion of checklist which now contain		
		ecord I do not have a clear		admission note and initial ca		
	picture of why [R96			" Licensed Nurses and T		
		ssion Notes, dated 12/2016,		Assistants were In-serviced		
		sident is admitted to the		3/14/18 related to the Minne		
		mitting nurse must document		Department findings from the		
		nation (as each may apply) in		Survey that ended on 3/2/18		
		admission form, or other		842-B); and actions require		
	appropriate place, a	as designated by facility		completion of the admissior	٦.	
	protocol: a. the date	e and the time of the residents		" A second in-service will	be conducted	
	admission, b. the re	esidents sex, age, race and		on 03/28/18 and 3/29/2018	related to the	
		om where the resident was		findings of F842; completion		
		for the admission, e. the		admission note and compre		
		, f. the general condition of the		plan; the revised Admission		
		ssion: head to toe assessment				
		nent, g. the time the attending		4. How will you monitor the		
		ied of the residents admission,		action(s) to ensure the defic		
		sicians orders were received cription of any lab work		will not recur, i.e., what qual		
				program will be put into place	Je :	
		me the specimens were sent sence of catheters, dressings		" The facility has impleme	ented a Ouality	
		e dietary department was		Assurance Program to ensu		
		order, I. the time the		of Rochester Health Service		
		ordered from the pharmacy, m.		on Admission, implementing		
		of any disabilities (i.e. blind,		Care Plan followed by comp		
		peech impairment, paralysis,		Comprehensive Care Plan.		
		y known allergies, o.				
		(glasses, dentures, hearing		" The Director of Nursing	and/or	
		, eye etc.), p. the height and		designee will complete a qu		
		sident, q. a statement		assurance tool (Exhibit # 84		
		nursing history and preliminary		Admission/Readmissions 3		
		pleted and has been started,		for one week; then 2 times		
		gns or symptoms of an		week, and then weekly for t		
		unicable disease, s. notation		" Additional training may		
		t advance directives apply, t.		based on results of the qua	lity assurance	
	signature and title o	of the person recording the		review.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	` ´COM	E SURVEY PLETED
		245184	B. WING			l	C 02/2018
	PROVIDER OR SUPPLIER	SERVICES		5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	1 00/	02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880 SS=F	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the follows \$483.80(a)(1) A systematical environment of the systematical	a & Control 1)(2)(4)(e)(f)  control tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions.  a prevention and control tablish an infection prevention and (IPCP) that must include, at	F8		" As part of the facility□s on-goir Quality Assurance and Process Improvement (QAPI) program, faci policy and procedures are analyzed modified as necessary by the QAPI committee. All deficient practices a with findings of investigations will b reviewed monthly in QAPI meetings three months to ensure compliance facility policy and state and federal regulations.  compliance with facility policy and sand federal regulations.  The facility administrator and/o designee will monitor that the tools completed.	lity I and I along e s for e with	3/30/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	` '	SURVEY PLETED
			7 t. BOILB			(	
		245184	B. WING			03/0	02/2018
	PROVIDER OR SUPPLIER	SERVICES		5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF THE PROPORTION OF THE PROPOR	BE	(X5) COMPLETION DATE
F 880	conducted accordinaccepted national signs accepted national signs signs accepted national signs accepted national signs accepted national signs accepted national signs accepted signs acc	under a contractual dupon the facility assessment of the system of the s	F 8	380			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245184	B. WING		03/02/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 880	Personnel must hat transport linens so infection.  §483.80(f) Annual The facility will con IPCP and update to This REQUIREMED by: Based on interview facility failed to est control program, we surveillance of resignally possible	review. Iduct an annual review of its heir program, as necessary. INT is not met as evidenced w and document review, the ablish an on-going infection which included comprehensive ident infections to identify and atterns of infection in the igns/symptoms of infections to it of communicable disease and ion, the facility failed to esting to reduce the risk of a erium) in the facility water cases and outbreaks of ase (a serious type of deficient practice had the all 91 residents who resided in	F 880	F880: Infection Prevention & Contr SS: F  1. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice?  "The facilities Infection Control I have been returned to current status 3/1/18.  "The facilities H2O testing programing beginniaires programs was completed of 3/26/2018  2. How will you identify other resident having the potential to be affected became 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 Leg program will be compled in two ween serious program will serious program will be compled in two ween serious program will be compled in two ween serious program will be compled in two ween serious programs will be completed in two ween serious programs will be serious programs will be completed in two ween serious programs will be completed in two w	ound to t  Logs Is as of Is am for eted as  Idents	
	or tracking tools fo was unable to prov	r infections in the facility and vide documentation that they ons for January 2018 or		3. What measures will be put into or what systemic changes will you it.	place	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	
		245184	B. WING			ے 02/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 880	February 2018.  During an interview director of nursing unable to print the computer for the m February 2018 as a her computer. Sunt to print the infection for review, that the computer screen. Unable to get into the even pull them up to buring an interview nurse consultant (It been unable to locate and the policy infections since present the Don's computer screen infections since present facility employments and the policy titled Surevised December Control Officer or Esurveillance for He and other epidemic that have substant outcomes and that based precautions interventions.  LACK OF IMPLEM	age 58  on 2/28/18, at 9:33 a.m. the (DON) stated she had been infection control logs from her norths January 2018 and she was having problems with reyor stated she did not have in control logs off her computer by could be viewed from her The DON then stated she was the infection control files to for surveyor review.  on 3/1/18, at 7:06 a.m. the NC)-B stated the facility had atterned any documentation control for the months of early of 2018. NC-B stated there any, trending or analysis of evious infection control nursement in December 2018. The stated they had looked through the information that this had been arrestless and stated they were information that this had been althoughed in the conduct ongoing although although the infections of the conduct on the preventable.  ENTING WATER TESTING TOP I FOLING TOP I FOLING I A	F 880	to ensure that the deficient pract not recur?  "Licensed Nurses and Traine Assistants were In-serviced on 3 3/14/18 related to the Minnesota Department findings from the An Survey that ended on 3/2/18; Info Control logs and H2O testing Legionnaires Program. (Exhibit # "CNA Staff were In-serviced of 3/20/18 or 3/21/18 related to the Minnesota Health Department fir from the Annual Survey that end 3/2/18; Infection Control and H20 Legionnaires Program. (Exhibit # "A second staff training will be 3/28/18 and 3/29/2018 related to findings of F880; Infection Control Legionnaires Program; and the findings of Surveillance of Infection "Infection Control Program hadesignated Infection Control Prehas been assigned to manage the program.  "The Legionnaires program hadesignated to be managed Mainted With samples of the water obtain 3/26.208 with a two week turn are the test results with NalcoWater.  4. How will you monitor the coraction(s) to ensure the deficient will not recur, i.e., what quality as program will be put into place?	d Medical /13/18 or Health nual ection £ 880-C). on edings ed on D testing £ 880-C). e held on the ol and acility ns. es a ventionist recas been nance. ed ound on	

	OF DEFICIENCIES OF CORRECTION			СОМІ	E SURVEY PLETED		
		245184	B. WING				C 02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/0	32/2010
ROCHES	TER EAST HEALTH	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	senior executive dir completed the asse prevention, but hav testing. The senior facility would be wo Testing Laboratorie testing and stated v	_	F 8	880	" The facility has implemented a Assurance Program to ensure the Infection Control Program in being monitored as evidence by current Infection Control Logs.  " The facility has implemented a Assurance Program to ensure the I testing program for Legionnaires in monitored as evidence by current H testing Logs.  " The Director of Nursing and/or designee will complete a quality assurance tool (Exhibit #880-E) Wi monitor updating of infection control surveillance log; weekly times 4 we  " The Maintenance Director and/designee will manage the ongoing compliance of the Legionnaires prowith testing per company policy.  " Additional training may be schebased on results of the quality assurance and Process Improvement (QAPI) program, facil policy and procedures are analyzed modified as necessary by the QAPI committee. All deficient practices a with findings of investigations will b reviewed monthly in QAPI meetings three months to ensure compliance facility policy and state and federal regulations.	Quality H2O being H2O ill bl eeks. /or ogram eduled urance ilty d and I along e s for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245184	B. WING _			C <b>02/2018</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		02/2010	
ROCHES	TER EAST HEALTH	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ge 60	F 88	" The facility administrate designee will monitor that the completed.	or and/or ne tools are		

F5184027

PRINTED: 03/26/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245184 B. WING 02/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST ROCHESTER EAST HEALTH SERVICES** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		II	TIPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>		COMPLETED	
		245184	B. WING		02/	27/2018
	PROVIDER OR SUPPLIER	SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian.Whitney@s Angela.Kappenmar	tate.mn.us, and	Κ0	00		
		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:				
	1. A description of to correct the defici	what has been, or will be, done ency.				
	2. The actual, or pr	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency.				
	building with a full b	alth Services is a 3-story pasement. The building was and was determined to be of ruction.				
	facility has a fire ala smoke detection ar	fully sprinkler system The arm system with full corridor and spaces open to the onitored for automatic fire stion.				
	The facility has a cocensus of 91 at the	apacity of 116 beds and had a time of the survey.				
	The requirement at NOT MET as evide	: 42 CFR, Subpart 483.70(a) is enced by:				

PRINTED: 03/26/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245184 B. WING 02/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST **ROCHESTER EAST HEALTH SERVICES** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 291 | Continued From page 2 K 291 K 291 Emergency Lighting K 291 3/26/18 SS=D 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 Based on documentation review and staff A description of what has been, or will be interview, the facility emergency lighting done to correct the deficiency. documentation did not provide all of the required information in accordance with 7.9, 18.2.9.1, All emergency lighting was labeled based 19.2.9.1 off location in the building as either stairwell landings hallway, and floor level. Findings Include: The emergency lighting units are marked in visible permeant sharple writing On facility tour between 09:00 AM and 12:30 PM identifying their location. 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 What measures will be put into place or who performed the tests. what systemic changes will you make to ensure that the deficient practice does not This deficient practice was confirmed by the recur. Facility Maintenance Director at the time of discovery. 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.

AND DIAM OF CORDECTION   IDENTIFICATION AND DED						SURVEY PLETED	
		245184	B. WING	B. WING			27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
D001150				50	01 EIGHTH AVENUE SOUTHEAST		
ROCHESTER EAST HEALTH SERVICES				R	OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa		K 2	91	Director of Maintenance, David We will bring audit results to safety committee, which will report up into for the next three months.	egman	×



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Rochester East Health Services March 16, 2018 Page 2

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

Licensing and Certification Program Minnesota Department of Health

Kamala Fiske Downing

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

PRINTED: 03/29/2018 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			71. BOILBING.			С	
		00953		B. WING			2/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES		TH AVENUE FER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION O	RDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of	ction order has be y. If, upon reinspoiency or deficienci ected, a fine for ease be assessed in actines promulgated artment of Health. The there a violation le rule provided at the number indicatins several items, the items will be considered.	ten issued ection, it is ies cited ach violation ecordance by rule of thas been ll the tag ted below. failure to onsidered				
	lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	ny item of multi-pa ment of a fine eve	art rule will en if the item				
	You may request a that may result from orders provided that the Department with notice of assessme	n non-compliance t a written reques hin 15 days of rec	with these t is made to eipt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm The State delineated on the a	participate in the nsure orders cons artment of Health in 14-01, available tate.mn.us/divs/fp e licensing orders	sistent with e at c/profinfo/inf are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 03/28/18

TITLE

STATE FORM 6899 If continuation sheet 1 of 53 VCL411

PRINTED: 03/29/2018 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING:				
		00953		B. WING		0:	C <b>3/02/2018</b>	
NAME OF PROVIDER OR	SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ROCHESTER EAST H	IEALTH :	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904			
PREFIX (EACH D	EFICIENC'	ATEMENT OF DE Y MUST BE PREC SC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
you electronic is necessal enter the watext. You may state licent completion corrected particles above provorders are electronic previewed that they will be a signed to hursing House The assigned to hursing House The assign column enter the state of th	ont of Head inically. The sure properties of this Departm of the sure properties of this Departm of the sure properties. The sure properties of the sure propert	alth orders be Although no ate Statutes/Frected" in the indicate in the cess, under the date your collectronically sheet of Health 7, 28, March epartment's shall the following Please indictorrection that lers, and identified.  The following Please indictorrection that lers, and identified ag numbers had state stated.  The compliance is compliance is compliance is column alin violation of the column alin violation alin violation alin violation alin	he heading orders will be submitting to the grorrection at ein your tryou have suiffy the date when is documenting orders using have been tutes/rules for the state listed in the so includes the state statute in the state statute in the submitted in the state statute in the state statute in the submitted in the submitted in the submitted in the state statute in the state statute in the submitted in the state statute in the submitted in the submitted in the submitted in the state statute in the submitted in t	2 000				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 2 of 53

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00050	B. WING		00/0	
		00953	I.		03/0	2/2018
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE SOUTHEAST		
ROCHES	STER EAST HEALTH S	SERVICES	TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
	H5184097 was com licensing survey. Th	n order was issued at MN				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			3/30/18
	comprehensive pland objectives and time long- and short-term and mental and psylidentified in the condusted assessment. The compassion of the condust include the incompassion of the compassion	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, ychosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on interview facility failed to deve	and document review, the elop and implement a care based on physician orders nissal summary for 1 of 1 ewed for dental.		completed		
	Findings Include:					
	member (FM)-A sta	on 2/26/18, 12:29 p.m. family ted there was problems with h. FM-A stated there were				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 3 of 53

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00953	B. WING			C <b>02/2018</b>
	OVIDER OR SUPPLIER ER EAST HEALTH S	SERVICES 501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
titithii hsba Fii o Fad Fnd Fp F2tt Ensstibyha	the hospital dismiss imes he gets his tenere. FM-A stated by increasing a lot of stated she will set hospital dismission at the perior of the period of the perior of the perior of the perior of the period of the period of the	7's teeth 3 to 5 times a day in sal summary and the only eth brushed is when I am because the nectar thick sugar in them R67 was to hed 3 to 5 times a day. FM-A him up at night for dental cares and comes back the next day e untouched.  issal summary dated 1/26/18, TON PRECAUTION: Good				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 4 of 53

PRINTED: 03/29/2018 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING			C <b>02/2018</b>
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	STATE, ZIP CODE	·	
ROCHES	STER EAST HEALTH S	SERVICES	IGHTH AVENUE IESTER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	nursing assistant (N how often R67 was day. NA-A stated w and night we get re included oral cares and he was able to teeth) on his own a morning for oral care. During an interview (NA)-B stated she hedtime. NA-B state was able to brush hwife was here I do believe she comple him.  During an interview registered nurse (R times a day should and nursing assistate staff would not know oral care with R67 revenings cares if it.  During an interview nurse consultant (Nexpected oral cares put in as an order abeen completed pesummary. NC-B state should have been a guide for R67. NC-I care provided as redismissal summary.	NA)-A stated she was not so to have his teeth brushed a hat I know is every morning sidents washed up (which). NA-A stated we set R67 take care of that (brushing and stated I set him up in the res.  I on 3/1/18, at 4:06 a.m. and R67 brush his teeth at led she set him up and R67 his own teeth. NA-B said if he hat be set him up and R67 his own teeth. NA-B said if he hat set his evenings cares with a stated oral care 3-5 have been on the care plane and the care guides. RN-A verification with morning and was not care planned.  I on 3/1/18, at 3:43 p.m. the lC)-B stated she would have a safety of the hospital dismissal atted oral cares 3-5 times a dadded to care plan and care added to care plan and care and stated R67 should have commended in the hospital dismissal atted R67 should have commended in the hospital	a la			
	The director of nurs	sing or designee could direct are plan to include appropridentified care needs. A				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 5 of 53

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
ANDFLAN	OF CONNECTION	IDENTIFICA	ATION NOMBER.	A. BUILDING:		COIVII	LLILD
		00953		B. WING			C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID	SUMMARY STA	ATEMENT OF DEF		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PREC	EDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	COMPLETE DATE
2 560	Continued From pa	ige 5		2 560			
	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.						
2 625	MN Rule 4658.045 Contents; In Gener		Clinical Record	2 625			3/30/18
	admission; B. temperature pressure, according subpart 2, item C. the resident according to part 4 D. the resident and attitudes; E. observation interventions providing subpart 2.	ursing notes, n of the reside e, pulse, respig to part 4658 l; l's height and 658.0520, su's general cors, assessmended by all discorresident, with unications with nnel; bservations on, adjustmenijudgment, or quantity of doctration of all me f the nurse or instered the me a tuberculin terito admission 10;	must include: ent at the time of ration, and blood 3.0520, weight, abpart 2, item J; adition, actions, ats, and ciplines the exception of an, for example, at to the amoods; sage, and anedications, and anedications, and anedication; est within the an, as described				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING			C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES 50	REET ADDRESS, CITY  11 EIGHTH AVENUE  12 OCHESTER, MN 5	E SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 625	J. dates and tirdressings; K. dates and tirhealth care practition. L. visits to clinion M. any orders comprehensive plands N. any change habits or appetite; O. pertinent farresident's general of P. results of the resident assessme	mes of all treatments and mes of visits by all licensoners; cs or hospitals; or instructions relative to an of care; in the resident's sleepin ctors regarding changes	ed the g in the			
	by: Based on interview failed to maintain a include an admissic plan of care for 1 o discharge.  Findings include:  R96's Admission R 10/27/17, identified with diagnoses of a systolic and diastol malignant neoplasr and muscle weakney On asking for R96's	ent is not met as evident and record review, the factomplete medical record on note and a comprehe factor of 1 resident (R96) review acute on chronic combined in the acute on chronic combined in the bone, lung and less.	facility d to ensive ved for  17, ed breast,	completed		
	completed following provided to the sur	ere had not been one g admission and the one veyor was dated 3/1/18. s 12/4/18, according to				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 7 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/	/SUPPLIER/CLIA TION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
,	0. 002011011	.52.***		A. BUILDING:			
		00953		B. WING			C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
POCHE	STER EAST HEALTH S	SEDVICES	501 EIGH	TH AVENUE	SOUTHEAST		
KOCHE	DIER EAST HEALTH	SERVICES	ROCHES	ΓER, MN 55	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 625	Continued From pa	ge 7		2 625			
	progress notes.						
	Review of R96's prof 10/27/17 to 12/4/admission note reg cares that need to I comprehensive assocare plan is compledated 12/4/17, idenback to home. Interview on 3/1/18 nurse (RN)-E stated there to be an adminad not been an adcontain why R96 was progress notes of his verified R96 should care plan develope potential, incontined RN-E stated, "Based chart and medical repicture of why [R96 Facility policy Admirevealed when a renursing unit, the addithe following information the nurse's notes, a appropriate place, a protocol: a. the data admission, b. the remarital status, c. from admitting diagnosis resident upon adminant a skin assessing physician was notified, i. descompleted or the tire to the lab, j. the presentations.	A17 had not incarding residence met before bessments and beted. R96's protified R96 was at 12:06 p.m. d. "I would have ission note," a limission note has in the facilitate medical received have had a cold to address funce, falls, and ad on the information (as each admission formation (as each admission formation), f. the general soin the admission: head to be a for the admission formation of the residence of the speciment, g. the time the speciment of any the the speciment of the speciment	cluded an at needs and the d comprehensive ogress note a discharged and verified there which should by based on cord. Further omprehensive unctional rehab pressure ulcers. In the shave a clear lated 12/2016, tted to the must document an may apply) in an, or other by facility of the residents age, race and resident was usion, e. the all condition of the to toe assessment a the attending dents admission, were received lab work arens were sent				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 8 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00953	B. WING			C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES 501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 625	etc, k. the time the notified of the diet of medications were of a brief description of deaf, hemiplegia, symbility etc.), n. any prosthesis required aide, artificial limbs the weight of the reindicating that the massessment is common r. notation of any significations or common as to whether or no signature and title of data.  SUGGESTED MET DON and/or design staff the facility's poreview of resident of ensure necessary in admission note and care is included in the education was provided in the discontinuous director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recommon director of nursing of licensed staff and president clinical recomment director director director director director director direct	ge 8 e dietary department was order, I. the time the ordered from the pharmacy, m. of any disabilities (i.e. blind, peech impairment, paralysis, y known allergies, o. (glasses, dentures, hearing, eye etc.), p. the height and sident, q. a statement pursing history and preliminary pleted and has been started, gns or symptoms of an unicable disease, s. notation t advance directives apply, t. of the person recording the THOD OF CORRECTION: The ee could review with licensed blicy and procedure regarding slinical record documents, to information including an a comprehensive plan of the medical record, and rided to licensed staff. The or designee could train perform audits to ensure each ord is complete to include and a comprehensive plan of	2 625			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			3/30/18
		general. A resident must e and treatment, personal and				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 9 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE	
		00953	B. WING		03/0	; 2/2018
			<u> </u>		03/0	2/2010
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the iin in bed or the resident	2 830			
	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.			completed		
	admitted to the faci of cerebral infarctio convulsions.  R67's neurology visincluded, "We did to [family member (FN staring and unrespondence of a seizure discharation of a seizure discharation of cerebral of convenience of a seizure discharation of cerebral	ecord identified R67 was lity on 1/26/18, with diagnoses n, and unspecified sit summary on 2/6/18, ell the patient [R67] and his M)-A] that his episodes of onsiveness appear to be are based on his previous EEG ram] that showed no evidence rege during these, and therefore to be helped by antiepileptic				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 10 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00953	B. WING			C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES 501 EIGH	DRESS, CITY, ST	SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	medications. Probachanges related to hemorrhage."  R67's care plan incin Neurological Stat disorder. Intervention medication as order has ceased, monitogag reflex, headach behavior changes, weakness/paralysis disturbance. Allow seizure and reorient R67's physician ord Midazolam HCI Sol nostril as needed for over 3 minutes or min	luded, Potential for Alteration tus related to: Has a seizure ons included: Administer red. After the seizure activity or/document/report: decreased ne, incontinence, injury, confusion, poor coordination, s of body parts, sleep the resident to sleep after a t upon awakening.  ders signed 2/27/18, included: ution 5 MG/ML 2 ml in each or seizures Prolonged seizures nore than 3 seizures in 1 hour. nostril.	2 830			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 11 of 53

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			:
		00953	B. WING		1	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	TER EAST HEALTH S	SERVICES		SOUTHEAST		
		ROCHEST	ER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
2 830	Entry: Note Text: La seizure at the table 1245p. [12:45 p.m.] room and CNA [cer reported to writer th Writer didn't witnes Resident's tears we stared up. When ca able to turn his hea [FM-A] witnessed th However, [FM-A] was eizure lasted. She medication Midazol continued eating lut to monitor." Howeve seizure R67 had an as needed medicat according to the no 2/6/18.  During an interview nurse consultant (Nonurse to review the communicate on the care plan update. Nexpected the inform staff from the neuron episodes of staring appeared to be nor his previous EEG the seizure discharge of are not going to be medications. NC-B expected the PRN when to administer symptoms. NC-B sthing here is to edu	note read, "2/24/18 Late ate Entry: Resident had in dining room at around Writer was in medication tified nursing assistant] at resident had a seizure. So the process of seizure. For falling down when he alling his name, resident was down and respond to his name. The whole process as not able to tell how long the also requested PRN seizure am for resident. Resident anch after seizure. Will continue for the the was lack of type of the different seizure was not to be given the serion the neurologist dated on 3/1/18, at 12:15 p.m. IC)-B stated she expected the	2 830			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 12 of 53

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  501 EIGHTH AVENUE SOUTHEAST		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
501 FIGHTH AVENUE SOUTHEAST			00953	B. WING		l l	_
501 EIGHTH AVENUE SOUTHEAST	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
ROCHESTER EAST HEALTH SERVICES ROCHESTER, MN 55904	ROCHES	STER EAST HEALTH S	SERVICES				
	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETE DATE
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 midzaolam 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 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.	2 830	regarding R67's sei on 2/6/18 and state completed with faci nurse should have completed an obse the need for the PR R67's wife reported the dining room. No should not have been R54's admission Mi assessment indicate the facility 2/20/17, with injury sustained addition, the MDS in including hypertens R54's quarterly MD indicated R54 had and needed extens member for bed modes assistance for transquarterly MDS also Mental Status (BIM but the resident was interview had been R54 had long and service where the coding) assistance of two seand transfers.  R54's progress note 11/20/17 to 2/28/18, a situation, background recommendation and service when the commendation of the commendation of the service with factors.	izures after the neurology visited education was not deducation was not deducation was not defermine the information and revation of R67 to determine the was having a seizure in C-B stated the PRN midazolamen administered in hindsight.  Inimum Data Set (MDS) ded R54 had been admitted to from the hospital after a fall doin a different facility. In addicated R54 had diagnoses diston and diabetes.  Source assessment dated 11/21/17, experienced a fall with injury ive assistance of one staff obility, and extensive afters with two staff. The indicated a Brief Interview for Source interview was attempted sounds unable to complete, so staff completed which identified short term memory loss.  In ange MDS assessment dated R54 had no previous falls and required extensive taff members for bed mobility des were reviewed from and contained information in bound, assessment/appearance	2 830			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00953	B. WING		l l	C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	11/3/17, R54 had a or bruises. Resider her room laying down Resident was assest bruises. Vital signs normal, denies pair communicate with remainded resident get up by herself. For 11/17/17, R54 had be room, close to her restated she was trying room. Resident stated and scrape was other injuries noted all day. Resident was of nursing, nurse president. Recommendations: this fall). Possible of dated 11/21/17, Correadings. Resident (hypertension) and Assessment (RN [recommendations: Resident continues readings on AM shi (highest reading) of Metoprolol (to lower this time, request for medication. Blooprinted for provider Recommendations: 11/21/17, progress	fall from bed with no injuries not was found on the floor of who on her side. no injuries. It was found on injuries found or checked and was within in. Recommendations: will morning nurse to monitor, to use the call light and don't amily notified.  I been found on floor of her roommate's bed. Residenting to close the door of her ted her right leg and head hurt. It is noticed on her coccyx. No is Resident had been confused as helped off the floor. Director fractitioner, clinical manager, were notified. Educated  I (none were documented for contributing factor for falls intinuous low blood pressure with history of HTN CHF (congested heart failure) egistered nurse])/Appearance tical nurse]): Lethargic, ion changes. Assessment: to have blood pressure ft ranging from systolic of 90 to 110. Response: It blood pressure and pulse readings review.  I see above."				
		CNP) had visited R54 with a ide (a diuretic used to lower				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 14 of 53

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
711012711	OF CONTRACTION	IDENTIFICATION NOMBER.	A. BUILDING:			LETED
		00953	B. WING			C <b>)2/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DOCUE	TED FACT HEALTH	501 EIGH	TH AVENUE	SOUTHEAST		
ROUHES	STER EAST HEALTH S	ROCHEST	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	pressure. The repo been updated on R related to the 11/17 of right hip and leg bearing. Recomme X-ray of right hip to fall. On 11/28/17, the leg/hip pain and ord fracture. The limite included, X-ray rereport which reveal need a computerize confirm diagnosis of hospital on 11/29/11 confirmed a right property of the property of the report which reveals a computerized and the results of the results of the report which reveals a computerized and the results of the results of the report which reveals a computerized and the results of the results of the report which reports of the report which reports of the reports of	d for staff to monitor blood rt also indicated the CNP had 54's prior falls. Possibly /17, fall, resident complaining pain, increased with weight ndations: Request for in house rule out fracture from recent the CNP visited R54 regarding dered X-ray to rule out devaluation clinical document sults noted an addendum to led a possible fracture and will led tomography (CT) scan to of pelvic fracture. Sent to 7, had CT scan and report lubic bone (hip) fracture.				
	on 11/29/17, by the to the 11/17/17 incichip (11/29/17) to the (OHFC). The comp the following inform "Description, A resignature identified of attributes to a fall that The facility assess and symptoms of p "Emergency Room Results returned 11 fracture. Review of consultant pharmach changes at this time falls on 11/5/17. Wi while trying to self the slipped on the floor to the floor next to be reviewed falls again	dent ([R54]) sustained a pelvic n 11/27/2017 that the facility nat occurred on 11/17/2017. nent(s) did not identify the sign				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 15 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA :ATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
AND FLAIN	OF CORRECTION	IDENTIFIC	ATION NUMBER.	A. BUILDING:		COIVII	PLETED
							С
		00953		B. WING		03/	02/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DOOUE	TED EAST HEALTH	05D\#050	501 EIGH	TH AVENUE	SOUTHEAST		
ROCHES	STER EAST HEALTH	SERVICES	ROCHEST	TER, MN 559	904		
(X4) ID	SUMMARY STA	ATEMENT OF DE	FICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PRÉFIX	(EACH DEFICIENC)			PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETE DATE
TAG	REGULATORY OR L	.SC IDENTIFTING	INFORMATION)	TAG	DEFICIENCY)	FROFRIATE	DAIL
	0 " 1 =			0.000			
2 830	Continued From pa	ige 15		2 830			
	per her request at r	night. PT/OT	to evaluate and				
	treat as appropriate						
	completed with add						
	added." Under des						
	"resident with pelvi-	c fracture pre	sumed from fall				
	11/17/17."						
	The facility contan	las cantination	atatus to OUEC				
	The facility sent an on 12/6/17, in rega						
	11/29/17. The infor						
	"[R54] has been a						
	7/10/17. Her primary diagnoses are: malaise, type II diabetes, rheumatoid arthritis, chromic						
	atria fibrillation, mile						
	metastatic breast c						
	10 on 10/9/17. Fall						
	0527 [5:27 a.m.] wi						
	2000 [8:00 p.m.] wi						
	injury but then back						
	checks. Resident p						
	receives scheduled						
	arthritis. On 11/27/ in right hip, especia						
	movement. SBAR						
	nurse practitioner,						
	recommended add						
	diagnosis. On 11/2						
	POA [power of atto						
	scan. Resident sen						
	Room for outpatien						
	11/29/17 showing a						
	medications compl	•	•				
	No recommended						
	Committee reviewe						
	11/3/17 resident fel						
	out of bed but her f						
	Non-skid strips wer her bed. Falls com						
	11/21/17 - resident						
	to close her door. S						

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 16 of 53

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00953	B. WING		03/0	; 2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	PT/OT to evaluate a Review of care plar the above changes harm it reads, "resigner presumed from fall 1/12/18, R54 sustait documentation inclusions. SBAR format inclusions, pain all over and was admitted of A facility reporting in Office of Health Coregarding the fall w 1/12/18. The descripion of Health Coregarding the fall w 1/12/18. The descripion in the increased during ninext to bed. Able to increased during ninesident sent to ER morning for further UTI [urinary tract in [abnormal brain fundiagnoses with left being followed at time management/pain in the incident was rechanges, fall command 11/3/17, reside transfer out of bed Non-skid strips were her bed. Also review resident said she widoor. No falls since	sed per her request at night. and treat as appropriate. and completed with addition of added." Under description of dent with pelvic fracture 11/17/17."	2 830	DEFICIENCY		
	Mayo Rochester Er	mergency Department record				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 17 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA TION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BUILDING:			c
		00953		B. WING		l l	)2/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		TH AVENUE FER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>*</sup> REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From particles and the season and the sea	uded under numity Lower, Parvening unwith services East is she had here ander the Histor (4) was hospital (7) 16, 2018 following the services, and ture. She was hospital (7) 18, at most of R54 in hem, 2/27/18, at most of R54 in hem, 2/27/18, at most of R54's bear to her bed. The control of R54's bear to here and the sign to say "tered nurse (Fing the falls in font of R54's bear to here and the control of R54's bear to here.	atient had a fall essed at skilled nursing slippers on and ry of present alized January owing a fall. CT perior and inferior ght superior and the chronic L2 admitted for room on 12:16 p.m. and no non-skid he sign on door even though 11/27/17, closed."  RN)-D on 3/1/18 terventions of hed following the no non-skid p.m. following the no non-skid p.m. following heskid strips on observed to have or in front of Resident is at of falls, Pain." deed heet the Resident to light in reach." cooped side)."	2 830			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 18 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILDING:			_
		00953	B. WING		<b>I</b>	C )2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHESTER EAST HEALTH SERVICES  501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	determine cause of minimize injuries." 3/1/18 after surveyor strips "Zip/non-skip" Record review and 3/1/18, at 4:23 p.m (PTA)-G verified Rs 2017, and none sin Interview on 3/1/18 assistance (NA)-D receives fall risk int NA-D states they urgait belt. Clinical minterventions. On receives fall risk int NA-D states they urgait belt. Clinical minterventions. On receives fall risk int NA-D states they urgait belt. Clinical minterventions. On receives fall risk int NA-D states they urgait belt. Clinical minterventions. On receives fall risk intervention specares/treatments) sand no other intervention would position, call light in review care plan and electronic care pl	if falls for prevention and to Also added to care plan on or queried the use of safety strips on floor at bedside."  interview with therapy on physical therapy assistant of last evaluated in October of ce then.  , at 3:57 p.m. with nursing stated R54 is a fall risk and reventions from the nurse. See routine interventions like manager will update with new eview of the NA's care sheet recific to resident showed only use of gait belt rentions to prevent falls.  , at 4:00 p.m. with licensed N)-A stated R54 is a fall risk, double check bed in low in reach. LPN-A stated would and proceeded to check the infor R54. LPN-A said nurses SBAR and notify family, CNP, discan put intervention in place ompleted on any fall en a resident hits their head. they start a post fall	2 830			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 19 of 53

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING		1	2/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	11/21/17. CNP-F's notes that there had provider to evaluate Interview on 3/1/18	, at 1:40 p.m. registered nurse				
	were asked what the fall. This included in develop intervention At 1:47 p.m. interview regarding further in falls. Administrator completed after return room with diagnosis 11/29/17 had not be or care sheets. Administration to been document assessment until sufficiency attention. Administrate now in place for	B, H, & J and Administrator are policy/procedure following a nevestigation, assessment, as following each fall for R54. The work with administrator formation regarding R54's had post falls assessment are from hospital emergency of hip fracture dated the en added to R54's care plant in the post of prevent further falls had the dat time of post fall arreyor brought it to his eator also said the safety strips or R54. Administrator verified procedure had not been R54's falls.				
	3:31 p.m. regarding regarding the falls f	s with RNC-B on 3/1/18, at y the requested information for the last four months. was no more information				
	facility continued to and was not able to	p.m. RNC-H verified the look through charts and files identify any of the facilities ional investigation paper work				
	Diagnosis Report, o	noses according to the dated 3/5/18, included e, cerebral infarction, muscle				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00953	B. WING			C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		501 FIGH		SOUTHEAST		
ROCHES	STER EAST HEALTH S	ROCHES	TER, MN 559	004		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
	weakness, delusior major depressive d R40's annual Minim	nal disorder, anxiety, and isorder.				
	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."					
	R40 is sitting in her	on 2/27/18, at 11:59 a.m., wheelchair, wheeling way 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 residence area/recliner room (3) grab bar to be in bathroom in resider (4) offer to rest resinconsolable yelling demonstrate placing independently in residence (5) reinitiate 3 day be	nstalled on wall next to ts room, dent in the recliner chair with l, agitation. [R40] is able to g foot rest up and down				
	toilet until after succ	resident after assisting onto cessful transfer off toilet, before meals and at bedtime.				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 21 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00953		B. WING			C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES	501 EIGH	TH AVENUE	STATE, ZIP CODE SOUTHEAST		
	0.11.41.45.7.4.074	TEMENT OF BEE10151		TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN  MUST BE PRECEDEL  SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 21		2 830			
	3/6/17: also toilet at (8) turn on Facility (listen to when more (9) when resident is encourage resident clothing rather than (10) PT to evaluate difficulties with bala A Fall Risk Assessr and was not receive R40's Incident Repand Emergency Refrom 9/21/17 to 2/18 9/21/17, at 2:40 p.n and was found lying stated that her right injury. Predisposing transferring self, an Interventions to preto resident. Care pl	Channel music for anxious, a especially anxious, to wear sweaters blankets when ir and treat per inconce.  The ment was requested.  The proof of the second revealed revealed the second revealed revealed the second revealed revealed the second revealed reve	us, s/warmer in bed, and reased sed for R40 dessments e following e following: a screaming er room, vidence of dimemory, assist.				
	Emergency departr 3:43 a.m., revealed standing. This occu 9/21/17. R40 denie hitting her right arm upper arm laceratic sutures. R40's CT 9th and 10th ribs. Dhome. Nursing assefall 13 hours ago wibathroom herself. It is centimeter lacera Tenderness noted of There were falls rec 10/21/17, 10/21/17,	nent record dated, R40 presents a pred earlier in the search and traun with the fall. R4 on that will require scan showed fractions and the sament indicated in the trying to get up to the scan to right upper over the ribs on the corded on 10/10/10/10/10/10/10/10/10/10/10/10/10/1	fter a fall from e evening of na but reports 0 has a right e repair with cture of the o the nursing d, R40 had a up to the uising and a r arm. he right side.				

Minnesota Department of Health STATE FORM

STATE FORM 6899 VCL411 If continuation sheet 22 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.	<del></del>		С
		00953		B. WING			02/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHE	STER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From part 11/13/18, 11/15/17, 1/21/18, 1/26/18, 1. The falls were related tangled in blankets alone, left alone on bed to her wheelch interventions developlan had not been of the completed a post farther floor staff shown intervention after expected been doing that. Falways a new intervention after expected unit that I was behind." 9/21/17, was not prend up in the emerwith a laceration to fractured ribs. The on her right upper at the progress notes analysis in the interventions, but the interventions are not implemented. "My occurs, an assessments are not implemented." "My occurs, an assessment interventions need interventions need."	11/18/17, 11, /29/18, 1/30/18 ed to toileting, attempting to toilet, and trair. Many falls oped after fall updated.  13/2/18, at 12/0 was moved or her last strong last year. It all assessmental be identify ach fall and though the fall and the fall system to the fall system to the fall system of the fall, as of the fall as of the	18, and 2/18/18. If needs, getting of get out of bed ansferring from solacked I and the care  2:11 p.m., to this secured oke and has had I have not always not after each fall, ing an immediate ney have not there is not I to the care plan. If we had 48 falls irector of nursing led R40's fall on sed, and she did ER 13 hours later er arm and 2 so and the sutures documented in a root cause leam, (IDT) were not always  1., registered lem has not been lost fall ling filled out, and in place or being so that when a fall line done timely to appropriate	2 830			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 23 of 53

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED					
		00953	B. WING		03/0	) 2/2018				
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE						
ROCHES	ROCHESTER EAST HEALTH SERVICES  501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904									
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	COMPLETE DATE				
2 830	Continued From pa	ge 23	2 830							
	to determine their e stated there should falls in the medical	o be reviewed at a later date ffectiveness." RN-E further be thorough documentation of record, with an injury to treatment, and reporting to ions.								
	according to the ad medical record (EM Alzheimer's disease	o the facility on 4/29/17 mission form. The electronic IR) identified diagnoses of e, aphasia (unable to speak), kness, abnormal gait eated 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.									
	R53's wheelchair w and R53 was walkir holding the attached	ion on 3/2/18, at 12:42 p.m. as sitting empty in the hallway ng down the hall slowly, d railing. His knees are is unsteady. No staff was if R53.								
	(LPN)-K on 3/1/18 a falls from 10/2017 t examples of revised included, keep in the encourage fluids, minfection, alternate of frequent toileting. Linterventions were cassistant (NA) care not know to follow the LPN-K stated she up to 10/2017 to 10/2018 t	with licence practical nurse at 2:10 p.m., regarding R53's o 2/2018, LPN-K reviewed d fall interventions in place and e dining room during meals, nonitor for urinary tract choices for snacks, and more LPN-K verified that none of the on the care plan or the nursing sheet and that the staff would he revised interventions. updated care plans she can find the time.								

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 24 of 53

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			,
		00953	B. WING			2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES	TH AVENUE TER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 24	2 830			
	of residents is ongo as information about resident's condition.  Facility policy, Fall I Guidelines, dated 2 maintain a fall preve program. In as mutacility, the facility we residents risk for fatincreased risk fatincr	ive" identified that assessment bing and care plans are revised ut the resident and the				
	The DON and/or de the facility's policy a review of resident vinecessary informat provided to facility a provide education to cares/treatments to assess falls and de director of nursing and perform audits receiving appropriatinformation in physical contents.	CHOD FOR CORRECTION: esignee could review with staff and procedure regarding risit summaries to ensure ion and education was staff from physician visits. Also to staff responsible for resident to follow the care plan and evelop falls interventions. The for designee could train staff to ensure each resident is te nursing care based on ician visit summaries.				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00953	B. WING		<b>I</b>	C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES		SOUTHEAST		
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	STER, MN 55	PROVIDER'S PLAN OF CORRE	CTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 25	2 860			
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet		2 860			3/30/18
	proper care. The c adequate and prope E. per care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and				
	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.			completed		
	Findings include:					
	admission date of 5 Alzheimer's disease	ecord identified an original 5/28/10, and a diagnoses of e, major depressive disorder, tract infections, and				
	assessment dated have a severe cogr	imum Data Set (MDS) an 12/14/17, identified R12 to nitive deficit and required one ssist with personal hygiene.				
	requires staff assist	red 10/17/11, identified R12 to f 1 to do grooming tasks. ses to be washed up.				
	regarding R12's info	oath sheets for the last month ormation, however a note was that stated, "Destroyed after				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BUILDING.			C
		00953		B. WING			02/2018
NAME OF	PROVIDER OR SUPPLIER	STR	REET ADD	RESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		H AVENUE ER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 860	Continued From pa	nge 26		2 860			
	assistant) Care Gu R12 will get a bath with all ADLs. R12's treatment ad 2/1/18-2/28/17, ide Monday during the not documented as PCC progress note		ery Were				
	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.						
		on 2/26/18, at 7:43 a.m., e of her bed and noted to med fingernails.					
	is sitting up to the to wheelchair eating h is noted to have lor	on 2/27/18, at 5:47 p.m., able in the dining room in her supper independently ng, untrimmed fingernails stance under her fingerna	her and with				
	10:02 a.m., R12 is room in front of her velour sweat outfit, pillow in her lap, an untrimmed nails wit underneath all of he fingernails need to	and interview on 2/28/18 sitting in her wheelchair in window, wearing a gray holding a red heart shaped is noted to have long, the brown substance er fingernails. R12 stated be clipped."	n her ed d, "My				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 27 of 53

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI		l ` ′	E CONSTRUCTION		SURVEY PLETED	
				A. BUILDING:				
		00953		B. WING			C <b>02/2018</b>	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ROCHES	TER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 860	long, with a brown and stated her nail completed on Mond she refuses. If it is she would docume  During interview on licensed practical infingernails are long underneath them. was on Monday and completed.  R53's Admission R date of 5/10/17, and disease, aphasia (lexpress speech, care a cerebral infarction major depressive disease, and weakness.  R53's quarterly MD 1/23/18, identified F deficit and requires with personal hygie.  Care plan dated 5/5 have a shower daily Requested facility to and received a note review."	rified R12's fingernal substance undernead care should have be day on her bath day, refused we tell the int the refusal in the	ath them een , unless nurse and chart.  m., ed R12's tance 's bath ave been  admission cheimer's erstand or age), after ellitus, lls, and  ated e cognitive ve assist  prefers to  ast month d after  ated	2 860				
		R12 will get a bath o n., and 1 assist with						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X3) DATE SURVEY COMPLETED				
00953	B. WING	C 03/02/2018				
NAME OF PROVIDER OR SUPPLIER  ROCHESTER EAST HEALTH SERVICES  STREET ADDRESS, CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN ( PREFIX (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE				
R53's treatment administration record dated 2/1/18-2/28/17, identified weekly bathing eve Monday and Friday during the a.m. On 2/16/not documented as bath given. If refused reproach x 3 and document in computer pronotes.  Review of R53's progress notes identified on 1/22/17, at 1:49 p.m., R53 received his schebed bath with minimal resistance. R53 has fingernail and toenail care. R53 has some scattered bruising on upper extremities and small scabs. No other progress notes identifiany nail care was completed or documented.  During observation on 2/26/18, at 8:08 a.m., had been seated in his wheelchair located in dining room. Fingernails were observed to be long with a brown substance underneath the During observation on 2/27/18, at 5:49 p.m., is sitting up to the table in the dining room in wheelchair eating her supper independently is noted to have long, untrimmed fingernails brown debris under his fingernails on both h.  During interview on 2/28/18, at 1:43 p.m., not assistant (NA)-I Verified R53's fingernails are with brown debris underneath them and stat "They should be cleaned out, he is diabetic, nurse should have cleaned and trimmed his on Monday with his bath."  During interview on 2/28/18, at 2:04 p.m., licensed practical nurse (LPN)-C verified R5 fingernails are a little long, with a brown substance underneath them. Further verified R53's bath was on Monday, nail care should been completed by the nurse at that time, are	gress  n duled  a few ied  .  R53 the be im all.  R53 his and with ands.  Irsing e long es, the nails  3's  I have					

Minnesota Department of Health STATE FORM

ORM 6899 VCL411 If continuation sheet 29 of 53

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		c	
		00953	B. WING		1	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	according to his ad Minimum Data Set 11/17/18, indicated one staff with perso interview for menta resulted in a score cognitively intact.  R5 had been obser while seated in his room. Noted long fibrown substance u  On 2/28/28, at 9:33 sitting in his wheeld to have long nails withem.  R5's care plan, revirequired assist of or During an interview a.m., in regards to stated he preferred  During an interview on 2/28/18, at 9:52 preferred a bed bat Mondays. She verified and they "definitely She stated they sho on Monday.  During an interview on Monday.	the facility on 7/25/14, mission record. R5's quarterly (MDS) an assessment dated R5 needed extensive assist of onal hygiene needs. The brief I status (BIMS) assessment of 13 indicating R5 was ved on 2/27/18, at 12:47 p.m., wheelchair located in his ngernails on both hands and a nder them.  a. m., R5 was observed thair in his room, he continued with a brown substance under sed 4/3/17, indicated R5 ne staff for personal hygiene.  with R5 on 2/28/18, at 9:33 his current nail status, and he his nails short.  with nursing assistant (NA)-E a.m., NA-E stated the R5 h which he received on fied that R5's nails were long could use some attention." ould have been taken care of	2 860			
	it was verified that r days. Bath sheets a	nail care is to be done on bath and progress notes reviewed nail care had been performed				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 30 of 53

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00953	B. WING			C 02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	in the month of Feb Facility policy, Care 12/2016, indicated, are to clean the nai prevent injuries and includes regular cle Unlicensed staff do residents or resider impairments. Notify refuses the care.  SUGGESTED MET The director of nurs review and revise p to ensuring nail care is followed. The dir could develop a sys develop a monitorin providing care as di care.	ruary 2018.  Of Fingernails/Toenails dated, the purpose of this procedure bed, keep nails trimmed, to infections. 1. Nail care aning and trimming. 3. not trim the nails of diabetic	2 860			
2 895	Motion  Subp. 2. Range of that is directed towa through positioning implemented and motion comprehensive resident of a nursing services development of a nursing services.  B. a resident with the subprovides that:	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which the a limited range of motion to treatment and services to	2 895			3/30/18

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		E SURVEY PLETED
		00953	B. WING			C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES 501 EIG	HTH AVENUE	SOUTHEAST		
- KOOIILO	TER EAST HEALTH	ROCHE	STER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 31	2 895			
	increase range of n decrease in range of	notion and to prevent further of motion.				
	by: Based on observati review, the facility for range of motion (PF) physician orders for reviewed who had of sustained actual had	ent is not met as evidenced on, interview and record ailed to implement passive ROM) and a palm guard per r 1 of 1 resident (R23) contractures. As a result, R23 irm, a decline in functional OM) to the left wrist.		completed		
	Findings include:					
	LACK OF ROM SE	RVICES AS ORDERED:				
	admission date of 2 hand contractures (	ecord document identified an 2/20/12, and diagnoses of left (10/3/16), left ankle and foot 16), and right ankle and foot 16).				
	the Functional Limit 4/18/17, to have R2	erapy assessment identified in tation Assessment dated 23's left upper extremities percent (%)-19% impairment.	1			
	the Functional Limit	erapy assessment identified ir tation Assessment dated b's LUE to have 60% - 79%	1			
	severely cognitively of motion (ROM) in extremities, contract	m Data Set (MDS) 12/14/17, identified R23 to be impaired, with limited range bilateral upper and lower stures of the left hand and ures of the right ankle.				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 32 of 53

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDING.			C
		00953	B. WING			02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES	GHTH AVENUE ESTER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	age 32	2 895			
	an order initiated 7, range of motion PF	der Review Report, identified /27/16, included to do passiv ROM to left upper extremity wrist and fingers, per patien ay.	е			
	Care Guides (conta residents assigned 2/13/18, identified I boots to be applied extremities (LE) wh	(certified nursing assistant) ain services/treatments for to the nursing assistant) dat R23's Prevalon (heel protect) bilaterally to both lower nen in bed, and ortho booties There was no mention of n the care guide.	or)			
	reviewed from 5/1/	Administrative Record (RAR) 17, to 2/28/18, did not have t LUE PROM had been red.	,			
	2/26/18, at 8:20 a.r wheelchair with leg appeared to point of were resting in blue p.m. R23 was obse	tion in the dining room on m., R23 sat in a reclining extenders. Both feet downward and inward, and heel protectors. At 12:59 erved to be seated in the ir and leaning forward and to				
	R23 was observed with her legs exten were observed to p	on 2/27/18, at 12:19 p.m., sitting in a reclining wheelch ded straight out. Both feet point downward and inward, as wearing blue heel	air			
	was seated in her r	on 2/28/18, at 9:51 a.m., R2 reclining wheelchair with a er lap, she had the blue heel	3			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 33 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
			A. BUILDING.			c
		00953	B. WING			02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES	HTH AVENUE STER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	age 33	2 895			
		eet. At 1:49 p.m. R23 was g on her back in bed with her				
	was observed in th	on 3/1/18 at 11:07 a.m., R23 e dining room seated in her as observed to have heel feet.				
	use BLE [Bilateral I ankles every day a orthotics if patient a from orthotics. Ple and after orthotics Perform light ROM to ensure proper pl Achilles and back of the orthotic." Goals current level of phy possible. Additiona to LUE focusing on tolerance x 3 sets of Goal: decrease risk in order to provide	vised 4/3/17, read, "Patient to Lower Extremity] orthotics for s tolerated and to remove appears to be in distress/pain ase check skin integrity befor are donned/doffed [on/off]. to each ankle before donning accement of the device so the of calf are all the way back in s included: I will maintain my visical functioning as long as I interventions included: PRO a wrists and fingers, per patier of 10 reps for 15 minutes. It is to further contractures in LU comfort and reduce pain, and grity and reduce risk of skin	M ut			
	nursing assistant (I a restorative aide for NA-G stated when PROM, therapy wo complete it, and state training. NA-G said in the communicati	on 2/28/18, at 10:13 a.m. NA)-F stated they have not hat or about a year. At 10:44 a.m. a resident is started on audd demonstrate how to aff had to acknowledge the this was usually documented on book where staff would fing to do restorative nursing.	.,			
		on 3/1/18, at 11:12 a.m., I gotten R23 out of bed that				

Minnesota Department of Health STATE FORM

STATE FORM VCL411 If continuation sheet 34 of 53

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		03/0	) 2/2018
NAME OF	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	1 00/0	2/2010
		501 FIGH		SOUTHEAST		
ROCHES	STER EAST HEALTH S	SERVICES	TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 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."					
	licensed practical n have not had a rest we train our nursing ambulation and ran where the aides find	on 3/1/18, at 10:53 a.m., urse (LPN)-C stated, "We orative aide for about a year, assistants to do it, like ge of motion. I am not sure the information on who is on is on their care sheets [care 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]."					
	certified occupation verified R23 had be	on 3/1/18, at 2:02 p.m., al therapy aide (COTA)-D en discharged from by (OT) with a restorative				
	verified R23 had no April of 2017, becau in restorative, it was administration reco sheet. LPN-C state	3/2/18, at 10:01 a.m., LPN-C it been getting PROM since use although the order got put is not on the treatment rd (TAR) or on the CNA care ed, "My expectation is to have otion done daily as ordered."				
	10:52 a.m., she said PROM program wa contractures and to mobility of her left h					
	שuring an interview	on 3/2/18, at 11:48 a.m.				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER	/SUPPLIER/CLIA TION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BUILDING.			C
		00953		B. WING			)2/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 895	Physical Therapy A PT (physical therapy 9/21/16, identified to participation in mot was no restorative maintain lower extremaintain lower extremaintaintain lower extremaintaintaintaintaintaintaintaintaintaint	ussistant (PTA) by) Discharge sollateral lower be limited, limi bility. PTA-A a program put in emity range of on 3/2/18, at nurse (LPN)-Co a range of mon extremities.  Therapy (OT) I ded for R23 "n nal ROM of L   eal joints, provints and the dis ints. The careg e in ROM appr so report incor has since result g significantly ene and joint r or, this patient w priate and eff caregiver on sl chedule of sof  TENT USE OF the morning fol Remove after and irritation; F rs two times a s two times a s two times a nication note t	Summary dated extremity (BLE) iting patient's lso verified there in place to f motion.  12:08 p.m., is stated R23 did tion program in  Plan of Care ow presents with [left] wrist, kimal itel iver started roximately two insistent use of culted in the remobility. Due to will require skilled fective ROM kin integrity, it brace."  F ORDERED  R23 to wear a llowing morning r 4 hours and Replace after 2 in day for palm day.	2 895			

	NT OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA ATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			С
		00953		B. WING			02/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>N</sup> REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	resident to wear lef off at night, to composition, and stretch taking palm guard of the 3rd West CNA Care Guides (contained residents assigned 2/13/18, identified Folloth in left hand, puring an observat 2/26/18, at 8:20 a.r wheelchair with a pleft hand.	plete hygiene ling fingers out on and off.  (certified nurse in services/truto the nursing R23's to need alm guard on the dininn, R23 sat in	and range of at straight when sing assistant) eatments for assistant) dated a rolled wash right.				
	During observation R23 was observed with no palm protect During observation was seated in her rhand palm protects was observed to be no palm guard on houring observation was observed in the	sitting in a rector in her left on 2/28/18, a reclining whee or in place. At elying on her her left hand. on 3/1/18, at e dining room	clining wheelchair hand.  t 9:51 a.m., R23 lchair with no left 1:49 p.m. R23 back in bed with  11:07 a.m., R23 seated in her				
	wheelchair. She was palm guard on with When R23 was ask her left hand, R23 was ask her left hand, R23 was area of contracture cloth rolled in left hand.  During an interview certified occupation	as observed to her fingers co ked whether s was unable to vised 4/3/17, io s of hands, ar and and palm	o have the left urled around it. he could open do so. dentified a focus and need for wash protector in right 2:02 p.m.,				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 37 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BUILDING:			С
		00953		B. WING			02/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 895	Continued From participation of the Occupational The Plan is started noticing a diapproximately two inconsistent use of resulted in the patient of the Occupational The Plan is started noticing a diapproximately two inconsistent use of resulted in the patient of the Occupation of the Occupation of the Occupation of Plan Incomparation of the Occupation of Plan Incomparation of the Occupation of Plan Incomparation of the Occupation of the Occupation of Plan Incomparation of the Occupation of the Occupation of Plan Incomparation of the Occupation of Plan Incomparation of Plan Incompa	een discharge by (OT) with a 7, and to wear ay and off at n 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	restorative r a left palm hight.  Plan of Care a previous order in integrity and "The caregiver OM hey also report which has since ring significantly d joint mobility. Doatient will require and effective er on skin dule of soft  Nursing Care ative nursing care e use of a or render such hed in acility has an rsing which is ugh the resident's even nursing care ach resident to I level of self-care nursing is s who require s assisting er of motion	2 895			
	director of nursing a responsible staff to	and/or design	ee could educate				

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
7.110 1 27.11	or correction.	ISERTIN IO/RITORRICANISER.	A. BUILDING:	:		
		00953	B. WING		03/0	) 2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ROCHES	TER EAST HEALTH	SERVICES	HTH AVENUE STER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 895 2 915	dependant on facilit decrease in range of comprehensively as designee could con residents with limite mobility needs are in TIME PERIOD FOR (21) days.  MN Rule 4658.0528	d splint programs to residents' ty staff to prevent further of motion, based on residents' ssessed needs. The DON or nduct audits of dependent ed mobility to ensure their met consistently.  R CORRECTION: Twenty-one 5 Subp. 6 A Rehab - ADLs				3/30/18
	comprehensive reshome must ensure A. a resident is treatments and sensibilities in activities deterioration is a not the resident's condipart, activities of daresident's ability to: (1) bathe, dres(2) transfer an(3) use the toil (4) eat; and (5) use speed functional commun	s given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the ss, and groom; and ambulate;		Completed		
	failed to follow throu			Completed		

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00953	B. WING			C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 39	2 915			
	resident (R67) reviewed for activities of daily living.					
	Findings Include:					
	family member (FM were not walking Rostated staff were to	on 2/26/18, at 12:29 p.m. l)-A stated the facility staff 67 like they should. FM-A be walking resident in the ings. I think they want him				
	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.					
	walking in the corric was reviewed from revealed R67 had b	stant documentation for dor in electronic point of care 2/22/18 to 2/28/18, and seen walked two times on ralking had been implemented				
	will ambulate with a times a day with LE	ed 2/27/18; included resident front wheeled walker, 2-3 MA strap on right leg. Step by bed on closet door. LEMA				
	2/20/18, included pa wheeled walker 2-3	stant care guide updated atient will ambulate with front times a day with LEMA strap y step instruction taped on				
		on 2/28/18, 2:30 p.m. nursing ated she has not been trained				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00953	B. WING		03/0	) 2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 915	to walk with him by she has not been to comfortable to walk had weakness on content (LEMA) to wear on NA-C stated she plus a demonstration of During an interview nursing assistant (Now walked between two possible. NA-A stated supposed to walk had the dining room too lunch. NA-A stated sometimes things had done. NA-A stated (walking) done. NA she did not have tirk working and stated NA-A if there were the end of her shift, next shift. NA-A stated one to two aides do residents and depensated like anybody staff on the unit. Nacriteria for staffing changed or and care needs the can go up and dow During an interview nursing assistant (Not to be walking R67 to stated staff document care. NA-B stated initiative and he will room. NA-B stated initiative and he will room. NA-B stated	therapy. NA-C stated because rained, "I do not feel with him." NA-C stated R67 one side and there was a strap his leg to help with walking. anned to ask his therapist for how to walk with him today.  I on 3/1/18, at 1:01 p.m.  NA)-A stated R67 was to be to three times a day if ed for me on my shift I amount im two times. I walked him to lay and will walk back from if there was one aide, happen and the walking is not today I was lucky to get it.  A stated one half of the time me to walk him when she was she worked full times days. Cares she could complete by a she passed that on to the ted the unit was staffed with expending on the needs of the nding on the census. NA-A of I think we could use more that the abilities of the residents at are currently on unit, which in and change continuously.  I on 3/1/18, at 4:08 p.m.  NA)-B stated we are supposed on and from meals. NA-B ent walk in corridor in point of the get busy, R67 will take wheel himself to the dining if we catch him at the right of the walk to meals. NA-B	2 915			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 41 of 53

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  **SOTHEAST**  **ROCHESTER EAST HEALTH SERVICES**  **SOTHEAST**  **ROCHESTER, MN 55904**    CACH OF PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OGNE ACTION SHOULD BE (EACH OGNE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DATE    CACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG**    CACH OGNE CITY ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DATE    CACH OGNE CITY ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DATE    2 915	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  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 (DENTIFYING INFORMATION)  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							
ROCHESTER EAST HEALTH SERVICES  501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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			00953	B. WING		03/0	2/2018
CAU   ID   REFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE    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	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	ROCHES	STER FAST HEALTH S	SERVICES				
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  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			ROCHEST	ER, MN 559	904		
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
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	2 915	Continued From pa	ge 41	2 915			
is to make sure the staff were walking him. RN-A	2 313	stated normally who and taking the initial offer to walk him to room. NA-B stated work on first floor a residents I might be lately most of the reindependent, but all depend the residen our best but sometid done like it should.  During an interview registered nurse (RR67 was on a walkitherapy communical stated R67 was supof times a day. RN-	en I am here his wife is here tive to help him. However, I do bring him down to the dining normally it is just me when I and it varies between 8 to 14 to taking care off. NA-B stated esident have been pretty bility to get cares done can t's needs. NA-B Stated we try mes the walking does not get  on 3/1/18, at 2:46 p.m.  N)-A stated he was aware ng program and had seen the ation to nursing form. RN-A oposed to be walked a couple A stated the nurse on the floor	2 3 1 3			

6899

Minnesota Department of Health STATE FORM

VCL411 If continuation sheet 42 of 53

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		03/0	) 2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES		SOUTHEAST		
			TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 42	2 915			
	A policy was request recommended there provided.	sted for following apy programs and was not				
	The director of nurs could review or revi for staff regarding r The Quality Assess	HOD OF CORRECTION: sing (DON) and/or designee se policies, provide education esident ambulation services. ment and Assurance (QAA) o random audits to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			3/30/18
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on interview facility failed to esta control program, wh surveillance of resid analyze possible pafacility, including sig prevent the spread infections. In additional implement water tealing to be be be be system to prevent to be be be be a system to prevent to be be be a system to prevent to be be be a system to prevent to be be be be a system to prevent to be be be a system to prevent to be be be a system to prevent to be be be be a system to prevent to be be be a system to prevent to be be a system to prevent to be be a system to prevent to be a system to	and document review, the ablish an on-going infection nich included comprehensive dent infections to identify and atterns of infection in the gns/symptoms of infections to of communicable disease and on, the facility failed to sting to reduce the risk of a rium) in the facility water cases and outbreaks of se (a serious type of eficient practice had the		Completed		

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00953	B. WING			C <b>02/2018</b>
	PROVIDER OR SUPPLIER	SERVICES 501 EIGH		STATE, ZIP CODE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	potential to affect a the facility, staff and facility, staff and Findings Include:  Review of the mont and trending from 4 revealed the facility they had analyzed determine correctiv of the infections for 2018.  The facility was una or tracking tools for was unable to provinad tracked infection February 2018.  During an interview director of nursing (unable to print the incomputer for the mercomputer for the mercomputer. Survito print the infection for review, that they computer screen. The unable to get into the even pull them up for the pull them	Il 91 residents who resided in divisitors.  The provided any further logs and a for January 2018 or February  The provided any further logs and a for January 2018 or February  The provided any further logs and a for January 2018 or February  The provided any further logs and a for January 2018 or February  The provided any further logs and a for January 2018 or February  The provided any further logs and a for January 2018 or February  The provided any further logs and a for January 2018 or February  The provided any further logs and a for January 2018 and a for Janua	21375			

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 44 of 53

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953			03/0	2/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 44	21375			
		er files and stated they were information that this had been				
	revised December Control Officer or D surveillance for Hea and other epidemio that have substantioutcomes and that	rveillance for Infections 2012, indicated the Infection resignee will conduct ongoing althcare-Associated Infections logical significant infections al impact on potential resident may require transmission- and other preventable				
	LACK OF IMPLEMENTING WATER TESTING AS A COMPONENT OF LEGIONELLA INFECTIONS PREVENTION:					
	senior executive dir completed the asse prevention, but hav testing. The senior facility would be wo Testing Laboratorie testing and stated v	on 2/27/18, at 3:07 p.m. the rector stated the facility had essment for Legionella e not completed the water executive director stated the rking with Minnesota Valley s for completion of water we will have a contract with e program for the facility.				
	The director of nurs in-service the infect to track and trend in senior executive dir	HOD OF CORRECTION: sing or designee could tion control nurse on the need affections. In addition the rector could in-service a water testing for legionaries.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				

6899

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	UPPLIER/CLIA ION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00953		B. WING			C <b>02/2018</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	501 EIGH	TH AVENUE	SOUTHEAST		
- NOOHE	TER EAST HEALING	JERVIOLO	ROCHES	TER, MN 55	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 45		21550			
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv.		21550			3/30/18	
	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			Completed			
	prescribed critical ti	me sensitive m	edications.				
	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 ord Zonisamide Capsul mouth in the evenir Capsule 100 MG G morning for seizure 100 MG Give 1.5 ta related to UNSPEC	le 100 MG Give ng for seizures, ive 1 capsule b s and LamoTR ablet by mouth t	2 capsule by Zonisamide y mouth in the Igine Tablet wo times a day				
	R67's progress note administration recomissed seizure med	rd revealed the	following				
	"2/11/2018 22:57 [1 Administration Note Capsule 100 MG G evening for seizure	Note Text: Zoi ive 2 capsule b	nisamide y mouth in the				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 46 of 53

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.	<del></del>		
		00953	B. WING			2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21550	Pharmacy called ar "2/12/2018 09:28 [9 Administration Note Capsule 100 MG Grown morning for seizure unavailable. Was nattempt to contact pwere not answered manger] and he wil "2/14/2018 18:28 [6 Administration Note Tablet 100 MG Give times a day related CONVULSIONS [R this medication late "2/22/2018 08:53 [8 Administration Note Tablet 100 MG Give morning related to CONVULSIONS (R reordered today."  R67's progress not was no documental having been notified medication to receid done for R67 for medication to receid to the missed critical stream of the missed doses or revealed medication to medication.	nd meds will be deliver tonight"  2:28 a.m.] Orders - e Note Text: Zonisamide live 1 capsule by mouth in the es. This medication is ot sent from pharmacy. Did charmacy, but phone calls . Spoke with CM [clinical I call pharmacy"  3:28 p.m.] Orders - e Note Text: LamoTRIgine e 1.5 tablet by mouth two to UNSPECIFIED 1:56] Pharmacy is delivering or during the night."  3:53 a.m.] Orders - e Note Text: LamoTRIgine e 1.5 tablet by mouth in the	21550			
		luded, Potential for Alteration tus related to: Has a seizure				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 47 of 53

Willing 30ta D	Ainnesota Department of Health						
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	o.	PLE CONSTRUCTION  G:		SURVEY PLETED	
		00953	B. WING _			C <b>02/2018</b>	
		00333			03/	02/2010	
NAME OF PROV	IDER OR SUPPLIER	STF	REET ADDRESS, CITY	, STATE, ZIP CODE			
ROCHESTER	EAST HEALTH S	SERVICES	1 EIGHTH AVENU CHESTER, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21550 Cor	ntinued From pa	ge 47	21550				
	disorder. Interventions included: Administer medication as ordered.						
the nur me ava DO to be phate in the phate ava was not reather was the produced shows seized appetite seize state dose me The have The seize appetite the seize state dose me the produced shows the seize appetite seize state dose me the produced shows the seize state dose me the seize state shows the seize shows the sei	nurse consultant ses (DON), the I dications that are dilable to be administered, armacy to determine automated distribution and to be in son cannot be dilable in the ADU secheduled for a planned to be in son cannot be dilable in the ADU secheduled for a planned to be in son cannot be dilable in the ADU secheduled for a planned to be in son cannot be dilable and for directly did not have a poole and for directly did not have been dication secheduled do. The DOI zure medication are poole and NC-Bizure medication secheduled secheduled medication error reperies and se	on 2/28/18, at 11:56 AM at (NC)-B and director of DON stated she expecte e ordered to be here and inistered to the residents a medication was not availine if it (the medication) spensing unit (ADU) made it is there, we have the at lift the medication was not availine if it (the medication was not it it is the medication was not it is they would notify a not it is they would not	d d d s. The hilable was chine not hen it n was use on that and a not d ve the he . Both hes of d o her. hould hes. heen				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

OTATEMENT OF REFINENCES AND PROVIDED OUR DEPOSITE OF A		ı	(VO) MILITIDI	E CONOTRUCTION	(VO) DATE	OLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	LETED
			A. BUILDING:	<del></del>		
					C	
		00953	B. WING	<del></del>	03/0	2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE		
		501 FIGH		SOUTHEAST		
ROCHES	STER EAST HEALTH S	SERVICES	ΓER, MN 559			
040.15	CUMMA DV CTA					()(5)
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	<b>`</b>	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
				DEFICIENCY)		
21550	Continued From pa	ae 48	21550			
	-					
	During an interview on 2/28/18, at 12:31 p.m. registered nurse (RN)-C stated if I see the					
		the cart, I would call the the medication was not				
		ere was an issue dispensing				
	_	he ADU. I would review the				
		nedication was still a current				
		I would call the pharmacy				
		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 then	n to stat the medication, which				
	gives us a four-hou	r window. RN-C stated if it a				
		would look in the ekit				
		ation kit) to see if it is in there.				
		nedication like a seizure				
		ask the pharmacy to have a				
		send it to us. If we have a				
		s not available, I would contact				
		them know they have missed				
		ask them what they would				
		stated she would fill out a				
		port on a critical medication medications were critical				
		stated if a resident had a				
		on that was given to prevent				
		do not receive that				
		the possibility the resident will				
	have seizures.	are peccionity are recident will				
	During an interview	on 2/28/18, at 3:23 p.m.				
		N)-B stated she would check				
	,	r pharmacy and have them				
	deliver the medicati	ion if it was not available.				
	RN-B stated I would	d talk to my clinical manager				
		et that medication in town from				
		y. RN-B stated she was not				
		ad a backup pharmacy. RN-B				
		neck to see if the facility had a				
	backup pharmacy a	and would let this writer know.				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 49 of 53

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
							С
		00953		B. WING		03/	02/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>*</sup> REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21550	Continued From particles of the Medication error, a could have adverse would keep closer up on the resident's  The Unavailable Mincluded, drug reactions mus Director of Nursing pharmacist."	d try all option all de medications. N-B stated it eizure medications we could call to see if they on 2/28/18, at N)-B stated who as our back of a dose they and notified to see if they are they are side effects, eye on the passions are a cresident"	ble and if I was ) it would be was really ations on time as if they did not get the doctor on have another  at 4:27 p.m. we are able to use ckup pharmacy.  at 12:41 p.m. if R67 did not s ordered he is at ated she was of seizure Id have been I as soon as they y should have hem of the issed doses) the provider itient and follow  licy dated 6/15, ake every effort available to meet  Reactions policy on errors and reported to the	21550			
	SUGGESTED MET	HOD FOR C	ORRECTION:				

Minnesota Department of Health

STATE FORM 6899 VCL411 If continuation sheet 50 of 53

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		03/0	2/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 50	21550			
	the facility's policy a ordering of medicat period. A member of randomly review mo- rooms to ensure all received in a timely	esignee could review with staff and procedure regarding the ions within a specified time of the nursing staff could edication carts and medication medications have been and manner.  R CORRECTION: Fourteen				
21565	MN Rule 4658.1329 Medications Self Ac	5 Subp. 4 Administration of Imin	21565			3/30/18
	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 Requirements	ent is not met as evidenced				
	Based on interview review, the facility faself-administration of	, observation and record ailed to verify a of medication order was in g medications in room for 1 of		Completed		
	Findings include:					
	R27's admission for diabetes and depre	rm included a diagnosis of ssion.				
	assessment dated	imum Data set (MDS) an 12/22/17 as being cognitively terview of mental status of 15.				
	On 2/26/18, at 11:2	0 a.m. R27 voiced concern				

6899

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDING.			C
		00953	B. WING		1	)2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21565	some nurses leave others tell her they Observation on 2/2 medication cup sitti R27 said it containe pain), baclofen (used for lactose in Medications were it present. R27 took Interview on 2/28/1 medication aide (TI R27 to take on her self-administration own after set up. Interview on 2/28/1 nurse (RN)-D said never was put back Had been discontin said there was no condition so another needed. R27 said on 3/1/18 practical nurse (LPI tray table to self-add On 3/1/18, at 8:34 a how medication was morning. LPN-B said tray table. LPN-B tran order to self-add LPN-B said, "To be and R27 requested later this a.m.	medications in her room while	21565			
		ministration: lidocaine ointment				

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERA	SUPPLIER/CLIA TION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
				A. BUILDING:			c
		00953		B. WING			02/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
21565	Continued From pa	nge 52		21565			
	5% only.						
	R27's Medication's effective date 7/26/can be self-administrations. The phad been discontinuous review titled Administration-Prej Guidelines-Self-Addated 6/15 reads: Felf-administer, the the resident ability for the self-administration of the self-administer, the self-administer, the self-administer ability for the self-administer ability for the self-administer and self-administer.	17, identified "stered.  8, at 4:23 p.m. RNC)-B verifieder to self-admination and Generation and Generation of for those residents.	all medications"  with registered d R27 does not nister nistration order 3.  General Medications lent who ary team verifies				
	by mean of a skill a (quarterly) basis or change in condition	ssessment co when there is	nducted on a				
	SUGGESTED MET The director of nurs on the required ass for self administrati self administered s ongoing compliance	sing could in-s sessment and on before med afely. Also to r	ervice all staff physician order dications can be				
	TIME PERIOD FOR (21) days.	R CORRECTION	ON: Twenty-one				

6899

Minnesota Department of Health STATE FORM