DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2020

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

RE: CCN: 245626
Survey Start Date: May 5, 2020

Dear Administrator:

On June 20, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 20, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
May 13, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245626
Cycle Start Date: May 5, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 5, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Rochester Rehabilitation And Living Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 5, 2020 survey. Rochester Rehabilitation And Living Center may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The

provider will have ten days from the date the suspensions are lifted to submit an ePOC. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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

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

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:

Jennifer Kolsrud Brown, Unit Supervisor
Fax: (507) 206-2711
Email: jennifer.kolsrud@state.mn.us

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 5, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Jennifer Kolsrud Brown, Unit Supervisor
Fax: (507) 206-2711
Email: jennifer.kolsrud@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Rochester Rehabilitation And Living Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 05/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 5/04/2020 and 5/05/2020 at your facility by the Minnesota Department of health to determine compliance with Emergency Preparedness regulations [§] 483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 5/04/2020 and 5/05/2020 at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/23/20

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

Electronically Signed | 05/20/2020

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

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F 880	Continued From page 1 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 2 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review the facility failed to use proper infection control practices for hand hygiene and transmission based precautions to prevent or mitigate the risk of COVID-19 outbreak. In addition, the facility failed to ensure all staff completed mandatory infection control education. The facility's deficient practices had the potential to effect all residents and staff. Findings include During the entrance conference on 5/4/2020, at 9:00 a.m. with the director of nursing (DON) stated the facility did not have any residents positive with COVID-19 and had adequate supplies for daily use and in the event of an outbreak. DON stated the facility designated Rehab 2 for hospital admissions; residents were admitted to a private room, quarantined for 14	F 880	F483.80 Infection Prevention and Control It is the policy of Rochester Rehab and Living Center has an established infection prevention and control program which includes a system for preventing, identifying, reporting, investigations, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to accepted national standards. This policy includes CMS & CDC guidance for infection prevention and control to prevent and/or mitigate the risk of a COVID-19 outbreak. Transmission-Based Precautions are in place as per CDC guidelines. To date, RRLC continues to	

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F 880	Continued From page 3 days, monitored at least twice a day for the onset of symptoms, and were on droplet precautions. DON stated since the facility did not have a shortage of personal protective equipment (PPE), she expected staff to put on all required PPE (gloves, mask, eye protection, and gown) before entering the rooms. REHAB 2 On Rehab 2, carts that contained PPE were located outside of the resident rooms in addition to droplet precaution signs posted on the outside of resident's rooms. During an observation and interview on 5/4/2020, at 9:44 a.m. Speech therapist (ST)-A stood outside a resident's room with a cloth face mask and face shield on. ST-A put on a gown and gloves outside the resident's room, and then entered. ST-A exited room wearing cloth mask and shield. ST-A stated the face shield would be disinfected back in therapy room. During an observation and interview on 5/4/2020, at 09:50 a.m., licensed practical nurse (LPN)-A was observed wearing cloth mask with a face shield. LPN-A stated the homemade mask had a filter inside. LPN-A stated she would disinfect shield as needed. LPN-A entered a resident's room after she donned gown and gloves and exited without changing mask or disinfecting shield. During an observation on 5/4/2020, at 10:28 a.m., nurse aide (NA)-A exited resident room on precautions wearing mask and shield, carrying water pitcher to kitchen area to refill and returned to resident room. No change of mask or	F 880	have no COVID-19 resident cases. The policy on transmission based precautions was reviewed on 5/5/20 and will be revised as CMS/CDC provides future guidance. Mandatory education and training was provided on transmission based precautions for COVID-19 and departmental specifics (Rehab, Dietary, Housekeeping/Environmental Services, Social Services, and Nursing) starting on 5/5/20 and additional dates: Additional staff education and training was held on Mary 5th, 6th, 7th, 9th, 9th, and 11th and will continue training through May 22nd, 2020 on PPE, Handwashing, Droplet Isolation Precautions. Education will continue as identified by the infection preventionist. To ensure on-going compliance to achieve and sustain compliance, the facility imitated 2x daily departmental audits starting 5/5/20 and will continue for 3 weeks, 1x daily for 2 weeks, then the PPE Compliance Audits will continue 3x/week rotating location, departments, and time of day will continue for 3 months, then as directed by the Medical Director and Infection Preventionist. Audits are reviewed by the infection preventionist and outcomes shares with the QAPI and Medical Director. Any items requiring refinement or correction are acted upon as close to the time of the	

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F 880	Continued From page 4 disinfecting of shield observed. During an observation and interview on 5/4/2020, at 10:31 a.m., social worker (SW)-A entered resident room on precautions wearing surgical mask and shield delivering weekly COVID print out to resident. No hand hygiene observed before or after going into resident rooms. SW-A stated she tried to get in and out of rooms quickly to set down the newsletter on the table or would ask other staff who were going into the room to deliver it. SW-A stated she had received education on PPE and hand hygiene in and out of resident rooms. During an observation and interview on 5/4/2020, at 10:39 a.m., housekeeper (HSKP)-A was wearing cloth mask, gown, and gloves but no shield prior to entering resident room on precautions. HSKP-A exited resident room and walked to her cart; with the same gloves on she discarded the cleaning cloth, removed keys to the cart from her pocket, unlocked the cart, and put the cleaning solution away. HSKP-A then with the same gloves on re-entered room with a roll of toilet paper, she then exited again with a trash bag which she placed in the larger trash bag on her cart. HSKP-A wearing same gloves obtained new cleaning cloth and disinfectant, she wiped down sink area, door knob, and knobs of drawers. HSKP-A then exited, discarded the cleaning cloth and re-entered with swifter floor cleaner. After cleaning the floors, HSKP-A exited the room, removed gloves, and performed hand hygiene. HSKP-A did not remove gown and continued to wear. During an observation and interview on 5/4/2020,	F 880	audit as possible. Audits will continue at frequencies directed by the infection preventionists and/or designee. The Executive Director or designee will be responsible to ensure compliance.	

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F 880	Continued From page 5	F 880		

at 10:52 a.m., NA-A was wearing same surgical mask and shield entering and exiting rooms of residents on droplet precautions. NA-A stated the shields are washed at end of shift but if COVID symptoms then would be wiped down each time leaving resident room.

During an observation on 5/4/2020, at 10:55 a.m., HSKP-A entered resident room wearing same cloth mask and gown from previous room.

During an observation and interview on 5/4/2020, at 11:10 a.m., HSKP-A exited resident room and stated she wears the same gown into all resident rooms and was not told to change in between. HSKP-A also stated she was not told she had to wear a shield. HSKP-A stated she would use what was available on the precaution cart or if she was told.

KITCHEN

During an observation on 5/4/2020, at 10:00 a.m., dietary aide (DA)-A had cloth face mask dangling from one ear with mask hanging down on left side of face. DA-A was sitting adjacent to unidentified dietary staff at table in dining area outside of kitchen doing paperwork. The unidentified dietary staff cloth mask was observed to be sitting below the nose. LPN-A approached DA-A and asked her to wear mask appropriately. DA-A responded abruptly stating, "I know but I am talking now."

During an observation on 5/4/2020, at 11:09 a.m. DA-A had a cloth facemask around her chin leaving her mouth and nose uncovered, upon seeing the surveyor DA-A pulled the mask into the proper position and without first performing hand hygiene picked up clean silverware that was

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F 880	Continued From page 6	F 880		

on the table. DA-A then touched the front of her mask, did not perform hand hygiene and continued to complete tasks in the kitchen area.

-At 11:10 a.m. DA-A stood in the kitchen with a surgical mask on below nose, touched the front of the mask, then picked up a serving tray and dumped the tray in the garbage, DA-A was not observed to perform hand hygiene after touching the mask.

During an observation and interview on 5/4/2020, at 11:15 a.m., DA-B was observed in the kitchen wearing face mask that draped down to near chin area, DA-B pulled up the mask over mouth and nose upon seeing surveyors. A short time later, DA-B then again was observed wearing mask below nose. DA-B pulled mask down below his mouth to answer the surveyor's questions. DA-B did not pull the face mask back over his mouth and nose until the surveyor requested. Even though the surveyor had also requested DA-B perform hand hygiene after touching the mask, DA-B continued to take items out of the refrigerator placing them on a nearby cart. DA-B then pushed the cart into another dining area where another refrigerator was and continued to take items out of refrigerator wearing mask below the nose. DA-B stated he had not received education on hand hygiene since orientation and had not received education on mask hygiene practices.

During an interview on 5/4/2020, at 11:16 a.m. certified dietary manager (CDM) stated she had only been at the facility for a couple of days. CDM stated an expectation that dietary assistants wear masks at all times in the correct position and if staff touch their mask they have to do hand

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F 880	Continued From page 7	F 880		

hygiene. CDM was not aware if any hand hygiene or PPE education had been provided prior to her employment.

During an interview on 5/4/2020, at 11:22 a.m. DA-A indicated she had a habit of removing her mask to talk, DA-A verified she did not perform hand hygiene after touching her mask and should have.

According to the facility's education records DA-A has not completed any education pertaining to infection control practices.

PRAIRIE UNIT
During an interview on 5/4/2020, at 10:10 a.m. registered nurse (RN)-A stated R1 was readmitted to the facility from the hospital last week. RN-A stated because R1 was quarantined for 14 days, was being monitored for the onset of symptoms of COVID-19, and was on droplet precautions.

During an observation on 5/4/2020, at 10:30 a.m. HSKP-B sanitized hands and put on gloves prior to entering a resident's room. After a short time HSKP-B came out of the room, went to cart, and with the same gloves on opened the top of the cart, put items inside, and took cleaning supplies back into the room. HSKP-B came back out of the room with a bag of garbage, placed it in the larger bag on her cart, and removed gloves. HSKP-B did not perform hand hygiene after removing her gloves. HSKP-B then took the dust mop into the resident's room and cleaned the floor, then returned the dust mop to the cart. HSKP-B then donned gloves without first doing hand hygiene and walked into the nurses station where she removed garbage bags. HSKP-B went

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back and forth from the housekeeping cart several times for supplies, she then removed her gloves and pushed cart down the hallway without performing hand hygiene. HSKP-B then walked into R1's room where there was a posted sign that indicated R1 was on droplet precautions; HSKP-B had on a facemask and gloves, however, no gown or eye protection. HSKP-B walked over to R1 who was lying in bed and conversed. HSKP-B came out of the room, opened the top of the cart with gloves on removed cleaning supplies and reentered R1's room. After several trips into the room with the same gloves on, HSKP-B removed gloves and without performing hand hygiene took broom and dust pan into the room. After sweeping HSKP-B returned to cart, donned gloves without performing hand hygiene, went back into R1's room grabbed a cup off bedside table and through it away, HSKP-B then exited room, closed the door, and removed gloves. Without first performing hand hygiene HSKP-B pushed cart down the hallway and pushed the fire doors open to exit the unit.

-At 10:45 a.m. HSKP-B verified she had not performed hygiene at all while cleaning the nurses station and resident rooms. HSKP-B stated she should have done hand hygiene after she removed her gloves, indicated she had been in a rush, and forgot. HSKP-B stated since she was not providing direct care she did not have to where one of the reusable polyester gowns. HSKP-B then stated she was informed she did not have to wear eye protection on because she wore glasses and stated an unawareness that glasses were not considered adequate PPE.

During an interview on 5/4/2020, DON stated if

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 staff go into a resident's room that was on droplet precautions she expected staff to have on gloves, gown, surgical mask, and eye protection. DON indicated cloth masks or surgical masks must be worn appropriately so that the mask covers the mouth and nose, if staff touched the mask then they were to do hand hygiene immediately. DON also stated that she expected all staff to perform hand hygiene after removing gloves, touching face masks, touching contaminated surfaces. Centers for Disease Control (CDC) signage How To Safely Remove Personal Protective Equipment (PPE) provided by the facility included, Remove all PPE before exiting the patient room except respirator... The sign directed to remove gloves first, then eye protection- if reusable place in designated area for reprocessing (disinfection), then remove gown, followed by mask or respirator. Wash hands or use alcohol based hand sanitizer immediately after removing all PPE. A hand-washing policy and droplet precautions policies were not provided.	F 880		