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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z76Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29822

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/02/2022** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Karen Aldinger, Unit Supervisor — 03/22/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 03/22/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/04/2022
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 22, 2022

CMS Certification Number (CCN): 245626

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

Dear Administrator:

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 February 14, 2022 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 22, 2022

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

RE: CCN: 245626
Cycle Start Date: January 21, 2022

Dear Administrator:

On January 31, 2022, we notified you a remedy was imposed. On March 2, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 14, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 17, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 31, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 17, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 14, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z76Y

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(L5) **ROCHESTER, MN** (L6) **55901**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/21/2022** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 02/16/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 03/03/2022 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
January 31, 2022

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

RE: CCN: 245626
Cycle Start Date: January 21, 2022

Dear Administrator:

On January 21, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 17, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 17, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 17, 2022.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 17, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester Rehabilitation And Living Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 17, 2022. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 21, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at

https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 01/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/18/21 through 1/21/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007		2/14/22

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

Electronically Signed | 02/07/2022

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	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 01/21/2022

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 007	Continued From page 1 *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address their resident population including the persons at risk in their emergency preparedness plan (EPP). This had the potential to affect all 48 residents residing at the facility. Findings include: Review of the facilities EPP plan on 1/21/22 revealed the facility failed to address their resident population including the persons at risk in their EPP. During interview on 1/21/22, at 9:20 a.m. the assistant administrator verified the facility EPP did not address the population of persons served.	E 007	Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for all alleged deficiencies. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident population served procedure was updated and placed in Emergency	

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 01/21/2022

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 007	Continued From page 2	E 007	Preparedness Manual. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Resident Population Served requirement for the EPP was reviewed and updated to be in compliance with the regulation. Staff was educated on the addition of resident populations served to the EPP. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Patient population served will continue to be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 015		2/14/22

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	245626	A. BUILDING _____ B. WING _____	C 01/21/2022

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E 015	Continued From page 3	E 015		

plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and

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E 015	Continued From page 4 safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include in their emergency preparedness plan (EPP) how to how to maintain sewage and waste disposal during an emergency. This had the potential to affect 48 residents at the facility. Findings include: Review of the facilities EPP plan on 1/21/22 revealed the facility failed to address how they would maintain sewage and waste disposal during an emergency. During interview on 1/21/22, at 9:30 a.m. the assistant administrator verified the facility EPP did not address sewage and waste disposal during an emergency.	E 015	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Sewer and Waste Management Policy was added into the Emergency Preparedness Manual to address the management of sewage and waste disposal during an emergency. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Subsistence Needs for Staff and Patients requirement for the EPP was reviewed and updated to be in compliance with the regulation. Staff was educated on the addition of Subsistence Needs for Staff and Patients to the EPP. How the facility will monitor its corrective actions to ensure that the deficient	

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E 015	Continued From page 5	E 015	practice is being corrected and will not recur. Subsistence Needs for Staff and Patients will continue to be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	E 041		2/14/22

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E 041	Continued From page 6 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park,	E 041		

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E 041	Continued From page 7 Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4, 5.6.4.5.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 1/20/22 between 9:45 AM to 11:45 AM, it was	E 041	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Interstate power systems replaced generator batteries on 1/27/22. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice.	

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E 041	Continued From page 8 revealed by a review of available documentation that documentation presented for review revealed that the batteries for the emergency power supply system were the last replaced in March 2019. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Emergency Preparedness Plan for facility was updated with battery replacement date. Preventative maintenance program (TELS)was updated to include future battery replacement task. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. TELS system updates will be reviewed by the QAPI committee and committee's recommendations for further action will be followed.	
F 000	INITIAL COMMENTS On 1/18/22 through 1/21/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5626005C/MN57764 H5626007C/MN56353 H5626008C/MN56353 H5626010C/MN48938 H5626043C/MN69791	F 000		

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F 000	Continued From page 9 H5626044C/MN69731 H5626045C/MN72885 H5626046C/MN62271 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		2/14/22

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F 561	Continued From page 10 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor resident choices for bathing preferences for 1 of 3 residents (R203) reviewed for choices. Findings include: R203's entry tracking Minimum Data Set identified an admission date of 1/13/22, no admission MDS had been completed yet. When interviewed on 1/18/22, at 3:38 p.m. R203 stated she wanted a shower this morning, but no one followed up with her, she had told several staff. R203 told them she would generally like a shower in the evenings. R203's order summary report dated 1/13/22, included a physician order for, "Shower daily using a mild liquid soap, every shift." The order summary report identified R203 had been discharged from the hospital after cardiovascular surgery and had surgical wounds on chest and abdomen. R203's CNA (certified nursing assistant) Admission Checklist, undated, identified bathing preference of 3 times per week.	F 561	F000 Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for all alleged deficiencies. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 203□'s care plan was updated to reflect her bathing/showering preference. Resident received a shower on 1/17/22, 1/20/22, and 1/24/2022. Resident 203 discharged on 1/25/22. How the facility will identify other residents having the potential to be affected by the	

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F 561	Continued From page 11 R203's Nursing Data Collection-Admission/Readmission Day 1 dated 1/13/22, identified R1 required one assistance with bathing. R203's care plan dated 1/13/22, identified, "I trigger for ADL's (activities of daily living) because I have preferences and other items of need listed in my interventions." Staff were directed to, "I need one person assist for bathing." The facility's Rehab 2 Bath Schedule identified R203 was to receive a shower on Wednesday's during the day shift. R203's point of care documentation did not show R203 had received any baths from 1/13/22 through 1/21/22. When interviewed on 1/19/22, at 2:05 p.m. registered nurse (RN)-A stated, when he used to be a nurse a manager, he was assigned to schedule bathes, however, since no longer the manager, he felt no one was really assigned to do that work any longer. If a resident asks for a bath and it is not scheduled, staff should honor that wish and provide the bath. When interviewed on 1/19/22, at 2:30 p.m. licensed practical nurse (LPN)-B stated, residents should get a bath if they request it, even if it is not their day to get one. However, baths are, "tough to get done," due to staffing. When interviewed on 1/20/22, at 10:36 a.m. R203 stated, staff are not cleansing her surgical incision correctly, they are only painting it with a swab and not washing with a mild soap and water	F 561	same deficient practice. All newly admitted residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Audit of bathing preferences was completed for all residents. Bathing policy was reviewed and found to be in compliance with the regulation. Education was provided to nursing staff on collecting resident□s' bathing preference. Audits of Bathing Preferences for new admissions will be completed by DON or designee weekly x1 month and continue on-going audits as warranted with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Bathing Preference audit will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	

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F 561	Continued From page 12	F 561		

as her surgeon had directed. R203 stated she had been telling staff every day since admission. R203 stated she keeps asking for a bath and has told them multiple times, but has only gotten one since admission.

When interviewed on 1/20/22, at 10:50 a.m. licensed practical nurse (LPN)-D stated, she would have to ask an aide when R203 was due for a bath, she doesn't have anything to do with them. LPN-D did state if a resident wanted a bath staff should assist them with a bath.

When interviewed on 1/21/22, at 8:50 a.m. the health unit coordinator, LPN-G stated, the nurse aides fill out a worksheet with bathing preference on it on the day of admission and the worksheet goes in a pile in the charting room. Every resident should be set up for a weekly bath.

When interviewed on 1/21/22, at 8:58 a.m. the admissions nurse, RN-H stated she does not know how residents preferences about bathing are gathered.

When interviewed on 1/21/22, at 9:02 a.m. nurse supervisor, RN-F, stated, nurse aides fill out a worksheet on the day of admissions and this has the resident bathing preference on it. The aide gives the worksheet to the nurse working and if they do not have time to schedule baths, then they notify the nurse manager to schedule. The nurse working the day R203 was admitted was not available for interview.

A facility policy titled, Tub Baths/Showers and Bed Baths, dated March 2012, identified, "Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices,

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F 561	Continued From page 13 the facility must provide the necessary care and services." The policy did not identify how a resident's choice in bathing would be accomplished.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	F 565		2/14/22

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F 565	Continued From page 14 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, review of facility documents, and policy review, the facility failed to ensure resolution was provided to the members of the resident council when concerns were identified related to cold food. During the council meeting seven residents (R10, R5, R25, R38, R348, R12, and R6) had complaints of cold food. This had the potential to affect care and services to 48 residents who currently reside in the facility. Findings include: The Resident Council Minutes," dated 10/19/21, indicated the council members voiced concerns of food being served cold. There was no indication how the complaint was going to be addressed to the council members. The RRLC (Rochester Rehabilitation and Living Center) Resident Council, dated 11/16/21, indicated the council members voiced the food was good, but there was no indication how the facility addressed the previous month's concern from the resident council members that addressed cold food. There was no indication in the resident council meeting minutes how resolution was achieved or the rationale for not addressing the previous complaints of cold food. The RRLC Resident Council notes dated 12/21/21, indicated, once again, from the council members that the food was cold. There was no indication how this issue was previously addressed or how the staff member in attendance	F 565	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident Council meeting concerns for 1/18/22 were addressed by the designated department via the Council Action form. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents that express concerns at resident council have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Resident Council policy was reviewed and found to be in compliance with the regulation. Education was provided to Social Service and Life Enrichment staff on utilization of Council Action Form to address Resident Council concerns. Audits of Resident Council concerns will be completed by ED or designee monthly x3 months and continue on-going audits as warranted with follow-up and re-education provided as indicated.	

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	245626	A. BUILDING _____ B. WING _____	C 01/21/2022

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F 565	Continued From page 15 would resolve this issue. During an interview on 01/18/22, at 4:26 p.m. the dietary manager (DM) stated she has not been invited to the resident council meetings to discuss the complaints of cold food, nor made aware of the concern. During an interview on 01/19/22, at 2:33 p.m. the interim social worker (SW) stated she was familiar with long-term care and has worked with the resident council members in her past. The SW stated in her experience she has invited department heads to attend resident council meetings to address resident complaints. During an interview on 01/19/22, at 5:09 p.m. the activity assistant (AA)-A, stated she shared the concerns of cold food with the registered dietician (RD) and the general manager (GM). AA-A stated there had been changes to the role of social services and stated she has been the one assigned to support the resident council meetings. AA-A confirmed there was no documentation to show resolution of the cold food complaints from the council members. AA-A confirmed there was no feedback provided to the council members on the cold food issue. A facility policy titled Resident Council, dated November 2016, identified social services would be responsible for responding to concerns discussed at the council meetings and taking action on those concerns. The policy also identified the facility would act upon grievances and recommendations promptly and would be documented and reported on at following council meetings.	F 565	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Resident Council concern audits will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	

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F 645	Continued From page 16	F 645		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide	F 645		2/14/22

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F 645	Continued From page 17 for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level 1 had been completed for 1 of 12 residents (R11) reviewed for PASRR. Findings include:	F 645	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. PASARR for R11 was obtained and scanned to resident's medical record.	

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F 645	Continued From page 18 R11's Admission Record indicated an admission date of 1/1/21 with a readmission on 9/30/21, and diagnoses including bi-polar disorder and generalized anxiety disorder. Review of a document provided by the facility titled, Senior 'LinkAge' Line, dated 1/7/21, indicated they did not conduct the PASRR review for R11 and made a referral to the resident's managed care organization to process. The letter indicated a copy of the PASRR was included the pre-admission screening with this letter. Review of the EMR and hard chart for R11 was reviewed and there was no evidence of the PASRR assessment. R11's significant change Minimum Data Set (MDS) dated 10/6/21, identified she had not been assessed by a level II PASRR and determined to have a serious mental illness. The MDS identified she was cognitively intact and had diagnoses including bi-polar disorder and generalized anxiety disorder. R11 triggered to complete a Care Area Assessment (CAA) for psycho-social well-being. R11's care plan dated 2/17/22, indicated a diagnoses of anxiety and bi-polar disorder and took psychotropic medications on a regular basis to manage her symptoms. The care plan also indicated the resident would participate in psychotherapy during the quarter. During an interview on 1/19/22 at 2:37 p.m. the interim social worker (SW) stated, she would verify if there was a completed PASRR Level I completed for R11. During a subsequent interview on 1/19/22 at 3:07	F 645	How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents with MI and ID have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Preadmission Screening for Nursing Facility Admission policy and procedure was reviewed and the policy utilized to be in compliance with the regulation. Audit of PASARR□s was completed for all residents. Education was provided to Social Services and Admissions staff on assuring all residents have a finalized PASSAR. Audits of new admission PASARR□s will be completed by the Social Services Director or designee to assure completed PASARR is received and scanned to resident record weekly x 4 weeks and continue on-going audits as warranted with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of PASARR audits will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	

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F 645	Continued From page 19 p.m. the SW stated the facility did not have a completed Level I PASRR for R11. During an interview on 1/20/22 at 8:19 a.m. the director of nursing (DON) stated it was her expectation that there was a completed PASRR on each resident when they were admitted. At 1:58 p.m. the DON presented a completed PASRR for R11 dated 1/7/21 and confirmed the document titled Screening for Developmental Disabilities or Mental Illness, was not in R11's clinical record and the document was obtained on the date of this interview. Review of the policy provided by the facility titled, Preadmission Screening for Nursing Facility Admission Policies and Procedures, dated 1/6/22, indicated, "State and federal law requires preadmission screening before all admissions to Medical Assistance-certified nursing facilities. Screen people for serious mental illness or developmental disabilities based on the requirements in the Omnibus Budget Reconciliation Act (OBRA) of 1987, also referred to as OBRA Level 1 screening. This screening is completed to identify and refer people to other professionals to evaluate the need for specialized mental health or developmental disability services as required under federal law. These additional activities are referred to as OBRA Level II evaluation activities."	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		2/14/22

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F 677	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assist 1 of 3 residents (R18) reviewed who was dependent upon staff for bathing, with bathing according to their physician orders and care plan. Findings include: R18's annual Minimum Data Set (MDS) dated 12/8/21, identified cognitively intact, with diagnosis including Multiple Sclerosis. R18 required total staff assistance with bathing and did not reject cares. R18's care plan dated 12/12/21, included, an alteration in functional status and directed staff to bathe between breakfast and lunch using a reclining shower chair. R18's physician orders dated 9/1/21, included to use house dandruff shampoo one time a day on Tuesdays, Thursdays and Saturdays with bathing. R18's Treatment Administration Record (TAR) for 1/1/22-1/31/22, revealed R18 was not bathed on 1/1/22, 1/6/22, 1/8/22, and 1/13/22 but should have been according to physician order dated 9/1/21. R18's Census report located in EMR, revealed resident was located on unit Rehab 1 from 2/3/21 through 1/16/22, and then moved to Prairie on 1/17/22. The Prairie Bath Schedule printed 1/19/22, revealed R18 was to be bathed 1/22/22.	F 677	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 18 care plan was updated to reflect her bathing/showering preference. Review of documents provided to survey team reflect resident did receive a shower on 1/6/22, 1/8/22, 1/11/22, 1/13/22, but did not receive a shower on 1/18/22 due to bath schedule not updated from resident transfer on 1/17/22 to a different unit. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents that are transferred between units have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Audit of bathing preferences was completed for all residents. ADL policy was reviewed and found to be in compliance with the regulation. Education was provided to nurse managers on updating bath schedules when residents transfer units. Audits of Bathing Preferences for residents transferred between units will be completed by DON or designee weekly x1 month and continue on-going audits as warranted	

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F 677	Continued From page 21 During an interview conducted on 1/19/22, at 1:56 p.m. the director of nursing (DON) stated, R18 should be bathed on Tuesday, Thursday and Saturday per physician order dated 9/1/21. DON confirmed R18 did not receive a bath on 1/1/22, 1/6/22, 1/8/22, and 1/13/22 but should have been according to physician order dated 9/1/21. During an interview on 1/19/22, 1:35 p.m. R18 stated, she required full staff assistance with bathing, but had no had a bath in several days. During an interview on 1/19/22, at 1:47 p.m. nursing assistant (NA)-F stated R18 had just moved to the Prairie unit and was scheduled for a bath 1/22/22. During an interview on 1/19/22, at 2:20 p.m. the MDS coordinator and DON confirmed R18 should have a bath/shower with medicated shampoo three times a week per physician's order and TAR. DON confirmed care plans are revised as deemed necessary upon change of orders or with updated information provided during Interdisciplinary Team meetings. DON stated resident was receiving showers three time a week while on Rehab 1, and moved from Rehab to the on Prairie unit on 1/17/22. DON stated, "it appears her shower schedule fell through the cracks when she moved rooms". Review of the facility's policy titled, Activities of Daily Living (ADL) (Daily Life Functions), revised October 2021, included, "Facility ensures a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene."	F 677	with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Bathing Preference for residents transferred between units audit will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	

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F 677	Continued From page 22 Review of the facility's policy titled, Tub baths/showers & bed baths, revised date November 2021, included, "Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and service to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individuals clinical condition demonstrate that such a diminution was unavoidable. This includes ensuring that the facility provides care and services for the following activities of daily living: 1. Hygiene-Bathing."	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		2/14/22

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F 755	Continued From page 23 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and policy review, the facility failed to maintain accurate narcotic count for 1 of 9 residents (R16) reviewed for controlled substance accuracy. Findings include: R16's quarterly Minimum Data Set (MDS) dated 12/1/21, identified moderate cognitive impairment with diagnoses including dementia and heart failure. R16 had pain and received an opioid pain medicaion 4 times during the assessment week. R16's physician orders dated 12/6/21, included an order for dilaudid liquid (a narcotic pain medication), 1 milligram (mg) per milliliter (ml). During observation of narcotic reconciliation on 1/20/22, at 7:51 a.m. licensed practical nurse (LPN)-F and registered nurse (RN)-C noted the Individual Narcotic Record for R16's dilaudid liquid identified 3 ml. RN-C visualized the dilaudid and stated it appeared to be less than 3 ml. LPN-F and RN-C continued to count the rest of the narcotics on the cart without reconciling the dilaudid. When requested RN-C drew up the dilaudid liquid into a syringe and noted a quantity	F 755	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 16'□s narcotic reconciliation was completed. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents that are on liquid controlled medications have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Audit of controlled liquids medications reconciliation was completed for all residents. Inventory of Controlled Substance policy was reviewed and found to be in compliance with the regulation. Education was provided to nurses on controlled liquid medication reconciliation.	

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F 755	Continued From page 24 of 0.5 ml remaining only. LPN-F and RN-C indicated they do would not worry about a discrepancy in liquid narcotics, "unless it is empty." Review of the facility's policy titled, Routine Reconciliation of Controlled Substances, dated 1/1/22, indicated, "This policy sets forth the procedures for Routine Reconciliation of Controlled Substances. 5. To conduct a routine reconciliation of controlled substances, the Facility Staff should compare: 5.1 The total number of doses originally dispensed by the pharmacy to 5.2 The number of doses remaining to 5.3 The number of doses recorded as remaining on the medication-specific declining inventory sheet to 54 The number of doses administration record. 6.8 Both nurses should sign the reconciliation worksheet. 6.10 If unable to reconcile any quantities of controlled substances, notify the Director of Nursing or designee immediately." Review of the facility's policy titled, Inventory Control of Controlled Substances, dated 01/01/22, included, "1.3 Facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on a "Controlled Substance Count Verification/Shift Count Sheet. Facility should, 1.3.2 Reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift Count Sheet."	F 755	Audits of Reconciliation of Liquid controlled medication will be completed by DON or designee weekly x1 month and continue on-going audits as warranted with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Reconciliation of Liquid controlled medication audit will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		2/14/22

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F 803	Continued From page 25 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the menus were followed (portion size) for 34 residents, who selected beef and tomato casserole and mixed vegetable on 1/18/22 for dinner. Unplanned menu changes potentially could result in unintentional weight loss for those residents who were nutritionally at risk without providing the appropriate meal portions.	F 803	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents served incorrect portion of beef and tomato casserole and mixed vegetables were interviewed by RD and reviewed for weight loss. No residents that received the incorrect portion had	

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F 803	Continued From page 26 Findings include: Review of a document provided by the facility titled, Data Spread Sheet, dated 1/18/22 indicated the dinner menu, for the residents, revealed eight ounces of beef and tomato casserole was the serving size for a regular meal and one-half cup of mixed vegetables. During an observation on 1/18/22 at 4:26 p.m. (Cook)-A was observed to use one four-ounce scoop to serve multiple residents the beef and tomato casserole. In addition, Cook A was observed to served mixed vegetables with a three-ounce spoodle. At 4:56 p.m. the dietary manager (DM) confirmed Cook-A used a four-ounce scoop for the beef and tomato casserole and a three-ounce spoodle for the mixed vegetables. During an interview on 1/19/22 at 5:47 p.m. the Registered Dietician stated there were no residents with a significant weight loss who were served one half of the portion of beef and tomato casserole. During an interview on 1/20/22 at 12:10 p.m. Cook-A confirmed he typically follows the menus for the residents' meals. When asked how he determines portion size Cook-A stated when chicken or beef was served it was four-ounce serving and assumed this was the same for the beef and tomato casserole. Cook-A stated he only had access to the four-ounce scoop and the portion size seemed to be too large for the residents. During an interview on 1/20/22 at 12:33 p.m. the Regional Wellness Dietitian stated, she has gone	F 803	experienced sustained significant weight loss. Cook A was educated on scoop and spoodle sizes and reading the menu for portion sizes. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Audit of diet extensions in regard to portions sizes was completed by in-house RD and CURA RD. Resident Menu policy was reviewed and found to be in compliance with the regulation. Education was provided to cooks regarding scoop and spoodle sizes and reading the menu for portion sizes. Audits of Portion Sizes will be completed by RD or designee weekly x1 month and continue on-going audits as warranted with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Portion Sizes audit will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	

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F 803	Continued From page 27 to the kitchen to watch meals be served but has not done this for the past eight months. During an interview on 1/20/22 at 12:17 p.m. when the DM was asked how the facility ensures menus were followed, the DM stated she was the one who typically pulls the components of the menu out for the cook. Review of a policy provided by the facility titled, Resident Menus, dated September 202, included, "The menu incorporates principles of the Liberalized Diet approach as detailed in the Nutrition Care Manual." "The menu is planned in conjunction with the RD who reviews and revises the diet spreadsheet."	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide palatable meals for 4 of 12 residents (R297, R6, R26 and R12) reviewed for food palatability. Findings include: Review of the resident council meeting minutes	F 804	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Council Action form regarding cold food was addressed by Dietary Manager. R297 had gravy added to his menus. R6	2/14/22

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F 804	Continued From page 28 from 10/19/21 and 12/21/21 indicated the residents who participated in the council meeting complained of cold food. Review of a document provided by the facility titled Policy & Procedure Manual Food Satisfaction Questionnaire Form, dated 11/9/21, indicated most meals were cold, which was voiced from the residents who participated in the food committee. During an interview on 1/18/22 at 12:08 p.m. R297 stated, the "pork and chicken are sometimes dry." During an interview conducted on 1/18/22 at 12:30 p.m. R6 stated, the food was typically not hot, but cold and did not like it. During an interview on 1/18/22, at 12:35 p.m. R26 stated, at "breakfast sometimes the eggs aren't warm enough, they are cold." During an interview conducted on 1/18/22, at 2:58 p.m. R12 stated the vegetables and eggs were cold. During a dinner meal observation on 1/18/22, at 4:26 p.m. Cook-A began to serve residents the main meal of beef and tomato casserole and mixed vegetables. During a continuous observation of the tray line between 4:26 p.m. and 5:14 p.m. the request was made at the end of the service for a test tray to be placed on the service cart for the surveyor to sample. During the continued meal observation, reviewed a posted document, to the left side of the steam table, titled, Hot Food Production & Cooling	F 804	was interviewed by RD regarding food temperatures. R26 was interviewed by RD and normally eats in dining room with no food temperature issues. R12 was interviewed by RD regarding food temperatures. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Holding TCS (TCS foods or Time/Temperature Control for Safety Foods) Food policy was reviewed and found to be in compliance with the regulation. Education was provided to cooks regarding food and holding temperatures, use of plate warmer and steam table temperatures. Audits of Food Serving temperatures will be completed by RD or designee weekly x1 month and continue on-going audits as warranted with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Food Serving temperature audit will be reviewed by the QAPI	

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F 804	Continued From page 29 Temperature Log, dated 1/18/22, indicated temperatures were taken of the beef and tomato casserole and measured 168 degrees at 3:30 PM. The same log indicated the mixed vegetables had a temperature of 165 degrees and the time of the temperature taken was at 4:00 p.m. During this same observation period on 1/18/22, at 5:14 p.m. the test tray was placed in the hot cart and then taken from the kitchen to the Prairie Unit. The Dietary Manager (DM) was present during this observation. At 5:17 p.m. the meal trays began to be distributed by facility staff. At 5:28 p.m. the DM took the temperature of the test tray. The beef and tomato casserole had a temperature of 124.8 and the mixed vegetables had a temperature of 125.3. The DM sampled the beef and tomato casserole and the mixed vegetables. The DM stated the food was, "lukewarm." The food was sampled, and it tasted lukewarm. During an interview on 1/19/22 at 1:22 p.m. the registered dietician (RD) stated the kitchen staff could take temperatures of the food and hold the hot food for one half hour or less before serving. The RD stated she did participate in the resident food committee and typically the meeting consists of holiday menu selection and/or address the food complaints from the residents. The RD stated there has been no current complaints of food temperatures. An undated facility policy titled, Holding TCS (TCS foods or Time/Temperature Control for Safety Foods) Food: During service, identified hot foods should be held at 135 degrees or above. Staff were to track temperature of food no less	F 804	committee and committee□s recommendations for further action will be followed.	

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F 804	Continued From page 30 than every hour.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, the facility failed monitor food temperatures and the dish machine temperatures. These failures had the potential to increase the risk of food borne illnesses and affect 48 of 48 residents living at the facility as all residents received food from dietary services. There were no residents who required tube feedings. Findings include: Review of the Food and Drug Administration	F 812	F812-Food Safety Requirements How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Dish machine was run and found to have accurate temperatures. Temperature log was updated. Food temperatures were tested and log was updated. How the facility will identify other residents	2/14/22

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F 812	Continued From page 31 (FDA) Code 2017 included, "Adequate cleaning and sanitization of dishes and utensils using a ware-washing machine is directly dependent on the exposure time during the wash, rinse, and sanitizing cycles. Failure to meet manufacturer and Code requirements for cycle times could result in failure to clean and sanitize. For example, high temperature machines depend on the buildup of heat on the surface of dishes to accomplish sanitization. If the exposure time during any of the cycles is not met, the surface of the items may not reach the time-temperature parameter required for sanitization. Contact time is also important in ware-washing machines that use a chemical sanitizer since the sanitizer must contact the items long enough for sanitization to occur. In addition, a chemical sanitizer will not sanitize a dirty dish; therefore, the cycle times during the wash and rinse phases are critical to sanitization." Review of documents provided by the facility and titled, Temperature Chart, for the month of November 2021 indicated a log of the kitchen's dish machine was monitored from 11/01/21 through 11/08/21. There was no additional evidence provided to indicate the remaining days in November's log was monitored, nor was there evidence the facility monitored the temperatures from 12/01/21 through 01/18/22. Review of documents provided by the facility titled, Hot Food Production & Cooling Temperature Log, for the month of January 2022, indicated the food temperatures logs had omitted information/monitoring on the following days: 1/3/22 for all three meals; 1/4/22 dinner meal; 1/6/22 dinner meal; 1/7/22 dinner meal; 1/8/22 lunch and dinner meals; 1/10/22 dinner meal;	F 812	having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Dish Machine policy was reviewed and found to be in compliance with the regulation. Holding TCS Food During Service policy was reviewed and found to be in compliance with the regulation. Education was provided to dietary staff regarding dish machine temperature testing and Food Holding temperatures testing and recording results. Audits of Dish Machine temperatures and Food holding temperatures testing and result recording will be completed by RD or designee weekly x1 month and continue on-going audits as warranted with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Dish Machine temperatures testing and result recording audit will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	

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F 812	Continued From page 32	F 812		

1/14/22 dinner meal; and 1/17/22 dinner meal.

During the initial tour of the kitchen conducted on 1/18/22 at 11:50 a.m. the dietary manager (DM) provided the tour of the kitchen. At 12:00 p.m. a test was done of the dish machine. The machine was a high temperature machine. During the dish machine test (running the machine to ensure the temperatures were at manufacturer's requirements) the DM stated she was aware that the dish machine required more test-strips (test strip attaches to dish machine rack or utensil through slit in strip. The test-strip will turn an irreversible color change once temperature has been reached.) The DM stated the dish machine's temperatures have not been tested since November 2021 and stated the kitchen staff did not test the dish machine's temperature on a consistent basis. During this observation, there were no concerns with the dish machine's temperature.

During an interview on 1/19/22, at 1:22 p.m. the registered dietician (RD) stated it was her understanding kitchen staff were to take temperatures on the dish machine one time a day.

During an interview on 1/20/22, at 12:28 p.m. the lead server (LS)-A and DM were present. LS-A confirmed she was the staff member who takes the temperature/monitors the dish machine. LS-A stated she has explained she audits for the completeness of the monitoring logs for the dish machine to other staff, but on her days off, the other kitchen staff do not complete this duty. The DM confirmed she completes the temperatures for food but was out on leave from 11/18/21 through part of December 2021.

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F 812	Continued From page 33 Review of an undated document provided by the facility titled, Dishmachine [sic], indicated, "High Temperature Dishmachine Temperature Log. Check and record wash, rinse, final rinse and water pressure on the High Temperature Dishmachine Temperature Log prior to running dishes. Water pressure needs to be checked and record."	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 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:	F 880		2/14/22

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F 880	Continued From page 34 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. 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:	F 880		

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F 880	Continued From page 35 Based on observation, interview, and document review, the facility failed to follow current Center for Disease Control (CDC) guidance for use of a respirator for 3 of 3 residents (R203, R301, and R347) who were on respiratory precautions due to not being vaccinated against SARS CoV-2 (COVID-19) and newly admitted to facility. This practice had the potential to affect all 48 residents currently residing in the facility as well as all staff. The facility was in a current outbreak of COVID-19 status. Findings include: The current Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, from the CDC, include quarantine of newly admitted or readmitted resident's who are not fully vaccinated against SARS CoV-2 and use of an approved N95 equivalent, or higher-level respirator and eye protection during resident encounters. The current Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during Shortages, last updated 4/9/21, identified, "The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices." The Minnesota Department of Health (MDH) identified, facilities would be expected to calculate PPE (personal protective equipment) burn rate, if suspected will experience a shortage: work with usual vendor to secure supply; escalate to	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R203 has discharged. R347 has discharged. R301 is off isolation. Facility understand the importance of wearing N95 masks for residents in observation quarantine. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents in observation quarantine (including newly admitted, unvaccinated residents) have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Policies/Procedures/System Changes: Policy Review: According to the Directed Plan of Correction, the following policies were reviewed: Red, Yellow, Green Personal Protective Equipment, Resident Placement and Signage Supplemental Guidelines for Use During the COVID-19 Pandemic policy; Nebulizer Policy and Procedure for Residents with Suspected or Confirmed COVID-19 policy; Eye protection, Face Shields and Goggles policy and found to be in compliance with the regulation.	

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F 880	Continued From page 36 regional health care coalition, escalate to the state cache via RedCap. R203's face sheet identified an admission date of 1/13/22, with recent coronary artery bypass surgery. R347's COVID-19 Vaccination for Resident's Consent/Declination form dated 1/13/22, identified R203 had not been vaccinated against COVID-19 per her choice. During observation and interview on 1/20/22, at 11:10 a.m. outside of R203's room, there was a cart with surgical masks, disinfectant, hand sanitizer, and gowns on it, licensed practical nurse (LPN)-E donned gown and gloves, LPN-E had on a surgical mask. LPN-E stated R203 was on quarantine because she was a newly admitted resident and had not been vaccinated against COVID-19. LPN-E stated, they do not need to wear an N95 respirator or higher if on quarantine, only if the resident tests positive for COVID-19. LPN-E entered R347's room, R347 did not don a source protection mask, nor did LPN-E request she do so. LPN-E stood within 2 feet of R203 and checked blood sugar and performed a dressing change to R203's chest incisions. R203 stated she was moving rooms that day due to the facility needing her room to make a COVID unit. R203 stated she did not feel safe knowing there was a COVID outbreak in the facility. R203 stated, she feels you can get COVID-19 whether vaccinated or not and she chose not to get vaccinated. R203 stated the facility had provided education about the vaccine. During observation on 1/21/22, at 8:32 a.m. nursing assistant (NA)-A came out of R203's room with a meal tray, NA-A was wearing gloves, gown and surgical mask. NA-A stated, R203 was	F 880	Training/Education: Root Cause Analysis has been done with the assistance of The Director of Nursing, Staff Development Coordinator, Infection Preventionist and Executive Director in conjunction with the governing body and reviewed by QAPI. Process Improvement Project (PIP) Charter on Transmission Based Precautions on Newly Admitted Unvaccinated residents was developed. Education was provided to staff by the Director of Nursing, Staff Development Coordinator and Infection Preventionist on the following: Particulate Respirators and OSHA Fit Testing. Education training will include a post test and re-education on any incorrect answers and/or return demonstration for each training completed. Education was provided to Residents and their Representatives on Community COVID-19 updates that included the Core Principle of COVID-19 Infection Prevention including proper use of appropriate PPE. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Monitoring and Auditing: Infection Preventionist, DON and other nursing leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions utilizing the Eyes on Excellence audit on all shifts four times	

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	245626	A. BUILDING _____ B. WING _____	C 01/21/2022

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

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F 880	Continued From page 37 on quarantine as they were newly admitted and had not been vaccinated. NA-A stated the only resident encounters they are to wear an N95/respirator with are those who are COVID positive, not those on quarantine. R301's face sheet identified an admission date of 1/17/22, and diagnosis including a femur fracture. R301's COVID-19 Vaccination for Residents Consent/Declination form dated 1/18/22, identified she had refused the vaccine as it was medically contraindicated. During observation on 1/21/22, at 9:30 a.m. NA-C opened R301's door to her room and ask her what she needed, R301 stated she wanted to go to bed. NA-E put on gown and gloves, NA-E was wearing a surgical mask and did not don an N95 respirator or higher respiratory protection. NA-E stated R301 was on quarantine and he did not need to wear a respirator, just a surgical mask was fine and he did not need to change it when leaving the room, they wore the same surgical mask all day and with all residents except those who were COVID-19 positive. R347's face sheet identified he had been admitted on 1/14/22, with diagnosis of rib fractures. R347's COVID-19 Vaccination for Residents Consent/Declination form dated 1/14/22, identified he had declined the vaccine with no reason given. During observation on 1/21/22, at 9:16 a.m. NA-E brought R347 to his room from a scale in the hallway, NA-E stopped at the doorway to his room and put on an isolation gown and gloves, NA-E was wearing a surgical mask and did not don an N95 respirator or higher respiratory	F 880	per week for one week, then twice weekly for one week once compliance is met. Audits will continue until 100% compliance is met on source control masking N95 usage when entering an observation quarantine room. Audits of N95 usage with residents in observation quarantine (including newly admitted unvaccinated residents) will be completed by DON or designee weekly x1 month and continue on-going audits as warranted with follow-up and re-education provided as indicated. Results of Eyes on Excellence and N95 Infection Prevention audit will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	

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F 880	Continued From page 38	F 880		

protection prior to entering the room for personal cares. NA-E stated R347 was on quarantine as he was a recent admission and was on COVID precautions as he had not been vaccinated against COVID-19. NA-E stated they only needed to wear a respirator if the resident was positive for COVID-19.

When interviewed on 1/20/22, at 2:32 p.m. the infection preventionist registered nurse (RN)-K stated, they test the unvaccinated residents every day for COVID-19. If admitted and not fully vaccinated they place the resident on quarantine as they may have been exposed to COVID-19 prior to admission. RN-K stated, staff are expected to don a gown, gloves and wear a surgical mask prior to entering a room for a resident on quarantine, there was no need to change the surgical mask when entering or exiting the room, staff could wear the same surgical mask all day. RN-K stated, the facility policy was to only wear an N95 or higher respirator if the resident tested positive for COVID-19. RN-K stated they had a, "descent supply," of N95's and were not needing to ration them.

When interviewed on 1/21/22, at 9:10 a.m. supervisor RN-F stated, for resident's on quarantine, there was no need to wear an N95 respirator, but she may double mask to go into room. NA-F did not know what the facility policy was, nor did she know what the CDC directed.

The facility policy titled, Red, Yellow, Green, Personal Protective Equipment, Resident Placement and Signage Supplemental Guidelines for Use During the COVID-19 Pandemic, dated 8/20/21, included under Yellow: COVID-19

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F 880	Continued From page 39	F 880		

Observation Residents (Quarantine)- residents with one (or more) of the following criteria: New admissions that are not fully vaccinated, not "fully" vaccinated, or have an unknown vaccination status and have not had COVID-19 in the last 90 days confirmed by a COVID-19 test." Other criteria included readmissions not fully vaccinated, residents who have had an exposure to someone with COVID-19, and those with signs and symptoms of infection. The policy directed the PPE required for Yellow as: N95, "If unable to obtain a new N95 every shift, rotate at least every 72 hours and replace after 5 uses or if soiled or damaged."

When interviewed on 1/20/22, at 3:10 p.m. staff development RN-G stated, many of their PPE supplies were on back order, since the beginning of the pandemic they had been able to get a specific type of N95, but it is no longer available. Therefore, they were test fitting staff for different types of N95 masks. They have gone to the Rochester Mayo Clinic store a couple of times and have been successful at getting a supply. They now have 6-8 different styles of N95 masks. They have never run out of them, but if they used the N95 masks for their residents on quarantine, they would run out in a week. RN-G had not used a burn rate calculator and was unable to state their usual usage.

When interviewed on 1/20/22, at 3:40 p.m. the director of nursing (DON) stated, they are reliant on their parent company to allocate supplies and currently they were not able to obtain more N95 masks. The DON stated they had only had staff use a surgical mask for resident's on quarantine. They had never run out of N95 masks, and had not attempted to obtain additional supply with

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F 880	Continued From page 40 other vendors - other than the Mayo Store, and had not attempted to obtain any supply from the states warehouse supply via the Redcap survey.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/20/2022. At the time of this survey, ROCHESTER REHABILITATION AND LIVING CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2022

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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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

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

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

ROCHESTER REHABILITATION AND LIVING CENTER is a one-story building with a partial basement and parking garage.

The building was constructed in 2015 and was determined to be Type V (111) construction.

The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm

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K 000	Continued From page 2 system with smoke detection in corridors and spaces open to the corridors, which is monitored for automatic fire department notification. There is a 2-hour fire separation between the Skilled Nursing Facility and the Assisted Living. The facility has a capacity of 56 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 19.3.4, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.4.5.3 through 14.4.5.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 345	Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for all alleged deficiencies. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the	2/14/22

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K 345	Continued From page 3 On 01/20/2022 between 9:45 AM to 11:45 AM, it was revealed by a review of available documentation that the most current fire alarm sensitivity report on file was completed in 2016. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	deficiency. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Fire Alarm 2-Year sensitivity test is scheduled to be completed on 2/16/22. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. TELS preventative maintenance system updated by Maintenance Director to include 2-Year Fire Alarm Sensitivity test. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of fire alarm system sensitivity test will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		2/14/22

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K 353	Continued From page 4 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/20/2022 between 9:45 AM to 11:45 AM, it was revealed by a review of available documentation that no documentation was presented for review that could confirm that fire sprinkler system quarterly inspections were	K 353	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The 5-year sprinkler system test and quarterly sprinkler test were completed on 2/7/2022 and the next 5 year test was scheduled on or before 2/7/2027. Education was provided to maintenance staff regarding the frequency of sprinkler system testing and documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be	

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K 353	Continued From page 5 conducted or completed for the 1st and 2nd quarter of 2021. 2. On 01/20/2022 between 9:45 AM to 11:45 AM, it was revealed by a review of available documentation that an invoice for work completed in the 1st quarter of 2022 associated with the fire sprinkler system quarterly inspections was on file, but no inspection report was provided to be able to review the work and findings of the vendor. 3. On 01/20/2022 between 9:45 AM to 11:45 AM, it was revealed by a review of available documentation that no documentation was presented for review that could confirm that a 5-year inspection of the sprinkler system had been completed since the opening of the facility in 2015. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. NFPA 101 Sprinkler System Maintenance and Testing for quarterly and 5 year inspections task was uploaded in TELS Preventative Maintenance system schedule. Education was provided to maintenance staff regarding the frequency of sprinkler system testing and documentation. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Sprinkler System tests will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		2/14/22

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K 712	Continued From page 6 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 01/20/2022, between 9:45 AM to 11:45 AM, it was revealed during documentation review that no documentation was presented for review to confirm that a fire drill was conducted for 3rd shift staff in the 3rd quarter of 2021. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Fire drill procedure was reviewed and updated on 2/7/2022. Education was provided to maintenance staff regarding fire drill procedure. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Fire Drill procedure was reviewed and found to be in compliance with NFPA 101. Education was provided to maintenance staff regarding fire drill policy and how to schedule the drills for each shift. Maintenance Director or designee will audit the fire drill log monthly x3 months and continue on-going audits as warranted with follow-up and re-education provided as indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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K 712	Continued From page 7	K 712	Fire drill log audit will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, inspect and test fire-rated doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/20/2022 between 09:45 AM to 11:45 AM, it was revealed during documentation review that	K 761	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Fire rated door tests task was added to TELS Preventative Maintenance system to be completed annually. Fire rated door test will be completed on 2/14/2022. Education was provided to maintenance staff regarding the testing of fire rated doors.	2/14/22

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	245626	A. BUILDING **01 - BUILDING 1** B. WING _____	**01/20/2022**

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

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K 761	Continued From page 8 no documentation was presented for review to confirm that any records existed relative to the maintenance, inspection, and testing of fire-rated doors. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Fire Rated Door test procedure was reviewed and found to be in compliance NFPA 101. Education was provided to maintenance staff regarding the testing of fire rated doors. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of Fire Rated Doors test results will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914		2/14/22

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K 914	Continued From page 9 isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/20/2022 between 9:45 AM to 11:45 AM, it was revealed by a review of available documentation that documentation presented for review did not individually identify the results of the multi-point inspection for each of the individual outlets located in the resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The receptacle tests were completed per regulation; however, documentation did not identify outlets. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Electrical outlet testing procedure was reviewed and found to be in compliance with NFPA 101. Education was provided to maintenance staff regarding electrical	

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K 914	Continued From page 10	K 914	outlet testing documentation. TELS Preventative maintenance program will be updated with current procedure. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Electrical outlet testing results will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a	K 918		2/14/22

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K 918	Continued From page 11 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4, 5.6.4.5.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 01/20/2022 between 9:45 AM to 11:45 AM, it was revealed by a review of available documentation that documentation presented for review revealed that the batteries for the emergency power supply system were the last replaced in March 2019. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Interstate power systems replaced generator batteries on 1/27/22. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Emergency Preparedness Plan for facility was updated with battery replacement date. Preventative maintenance program (TELS)was updated to include future battery replacement task.	

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K 918	Continued From page 12	K 918	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. TELS system updates will be reviewed by the QAPI committee and committee's recommendations for further action will be followed.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/20/2022 between 9:45 AM to 11:45 AM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that a medical	K 926	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Medical gas training was reviewed and added to new hire and annual training schedule for staff. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be	2/14/22

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K 926	Continued From page 13 gas training program is currently in use by the facility. An interview with the Director of Nursing verified this deficient finding at the time of discovery.	K 926	affected by this practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Medical gas training materials were reviewed and found to be in compliance with the NFPA 101. Education was provided to staff regarding medical gas training (to be completed on-hire and annually). How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of medical gas training will be reviewed by the QAPI committee and committee□s recommendations for further action will be followed.	