DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

REVISED LETTER. PLEASE DISREGARD PREVIOUS LETTER RECEIVED.

Electronically delivered
May 18, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: March 25, 2021

Dear Administrator:

On April 15, 2021, we notified you a remedy was imposed. On May 4, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 28, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 30, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of April 15, 2021, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 30, 2021. 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 64970
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
May 11, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: March 25, 2021

Dear Administrator:

On April 15, 2021, we notified you a remedy was imposed. On May 4, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 4, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 30, 2021 be discontinued as of May 4, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of April 15, 2021, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 30, 2021. 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 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
April 15, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: March 25, 2021

Dear Administrator:

On March 25, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 April 30, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 30, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 30, 2021.

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 $11,160; 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 April 30, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester East Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 30, 2021. 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" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 September 25, 2021 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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 03/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/24/21 and 3/25/21, a standard abbreviated survey was conducted at your facility. 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 SUBSTANTIATED: H5184125C (MN71110 & 71145), with a deficiency cited at F600. The following complaints were found to be UNSUBSTANTIATED: H5184126C (MN68947). 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 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		4/28/21

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

Electronically Signed | 04/23/2021

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

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F 600	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents received care and services in accordance with their individual needs. R1 suffered neglect of care when the facility failed to ensure she was provided care and services in accordance with professional standards of practice for repositioning and incontinence care. R1 was actively dying, and was left for long periods of time in a feces soiled brief without being changed, or repositioned. This resulted in actual harm for R1 who developed open areas on her skin. Findings include: R1 had a significant change Minimum Data Set (MDS) assessment dated 2/17/21, completed following hospitalization and admission to hospice services. The MDS indicated R1 had adequate hearing and vision, clear speech, was able to make herself understood and could usually understand others. R1's BIMS score (brief interview for mental status) was identified as 99, indicating R1 could not complete the interview. Further, the MDS indicated R1 was dependent upon two staff for bed mobility (including repositioning), transferring in and out of bed, toileting, hygiene and bathing. R1 could not walk, and was assessed to have an indwelling urinary	F 600	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. R 1 is no longer at the facility. Residents who are nearing end of life have the potential to be impacted by this practice. Residents who are receiving hospice care and those who are identified as having a Braden score of 13 or less were reviewed beginning March 26, 2021 and care plans and task lists updated if needed. Contacts were made to contract hospice agencies by the Director of	

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F 600	Continued From page 2 catheter (tube in bladder draining urine into a bag) and was always incontinent of bowel. R1 was able to eat with assistance of one staff. A corresponding care area assessment (CAA) for pressure ulcers and pressure injury indicated R1 had the potential for alteration in skin integrity related to ongoing need for assistance with mobility, bowel incontinence, urinary catheter, and multiple medical issues with readmission to the facility on hospice services. The CAA indicated R1 had no skin issues noted at that time (2/17/21). The CAA indicated staff would continue to provide assistance to meet R1's needs related to oral intake, bowel elimination, urinary catheter care, assistance with activities of daily living, including mobility, and monitoring R1's overall skin status every shift and as needed when providing care. The CAA indicated interventions would remain ongoing per the care plan to assist with prevention of future skin issues. R1's plan of care printed 3/24/21, indicated "special instructions" at the top of the first page with included: assist with repositioning every two hours and prn (as needed). In addition, R1's care plan indicated R1 was at risk for pressure injury and a goal was for R1's skin to remain intact and the risk of developing a pressure ulcer would be minimized. Interventions to prevent pressure injury included weekly skin inspection, and for staff to assist with positioning and repositioning when in sitting position every two hours and as needed. R1's care plan had not been updated following R1's recent hospitalization and admission to hospice services in mid-February 2021. Interventions for prevention of pressure injuries were dated 2017 and 2018.	F 600	Clinical Services and the Social Services director beginning April 20, 2021 to discuss communication of concerns noted by hospice caregivers to the facility as well as any agency they felt needed To be informed. The purpose of the communication is to ensure timely follow up at the facility level. Educational materials were provided for hospice coordinators to share with direct care nursing staff. Sign in sheets from the hospice agencies validating education was provided are due back by April 27, 2021. Re-education was provided to licensed nurses and nursing assistants by the DON or designee beginning March 26, 2021 on end of life care and expectations for care during end of life. Re-education was provided to licensed nurses by the DON or designee on the need to validate care is completed beginning April 22, 2021 and to nursing assistants on documenting care provided to residents at end of life each time care is provided. Re-education was provided by the DON or designee to nursing staff on reporting changes noted during care and documenting these changes as they are reported. Audits of documentation will be completed by the DON or designee three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Results of audits will be forwarded to the QAPI committee for review and recommendations. Direct observation of compliance with repositioning schedules	

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F 600	Continued From page 3 The same care plan indicated R1 experienced alteration in elimination of bowel due to impaired mobility. A goal was for R1 to have a formed bowel movement at least every three days. Interventions included: bedside commode, monitor use and effectiveness of bowel medications, call bell within reach, encourage fluids, monitor bowel frequency, and use briefs/pads for incontinence protection. Interventions for alteration in elimination of bowel were dated 2018 and 2019. The care plan for bladder incontinence indicated R1 had an indwelling urinary catheter due to terminal condition. A goal, dated 3/5/21, indicated R1 would have no acute complications of urinary catheter use and would receive catheter care. The care plan also indicated R1 had a self-care deficit related to physical limitations, dementia and mood. A goal was for R1 to receive assistance necessary to meet activity of daily living needs to ensure R1 would be clean, dressed and well-groomed daily to promote dignity and psychosocial well being. Interventions included daily hygiene, grooming, dressing, and oral care. The care plan indicated R1 was on hospice/palliative care due to end of life, with a goal dated 2/21/21, indicating R1 would be made comfortable with assistance of staff from a hospice agency. R1's physician orders included: --Admit to hospice agency. Order date 2/12/21. --Daily catheter (urinary) care; empty bag each shift. Start date 2/12/21. --Weekly bathing and skin review. Start date 2/13/21. --Three PRN (as needed) medications for bowel elimination. None administered in March 2021.	F 600	including interviews of staff, family, resident and/or vendors will be completed three times weekly for four weeks then twice weekly for four weeks then weekly for four weeks. Results of audits will be forwarded to QAPI committee for review and recommendations.	

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F 600	Continued From page 4	F 600		

R1's physician's order summary report printed on 3/24/21, included diagnoses of dementia, dysphagia (inability to speak), hemiplegia (partial paralysis of one side of the body), and palliative care (care that focused on providing relief from the symptoms of serious illness, thus improving quality of life).

During a telephone interview on 3/24/21, at 1:28 p.m., family member (FM)-C reported the following concerns about R1's care:

FM-C stated that for the most part, R1's care had been very good until the last week of her life, which FM-C found to be "very disturbing." FM-C stated R1's condition declined significantly between 3/13 and 3/16/21, adding R1 could no longer get out of bed. FM-C stated she was there every day from 3/16 to 3/21/21, and took for granted R1 was being turned. FM-C stated, "I had been there multiple days, for long periods - and never saw her turned." FM-C stated, "On 3/19/21, I arrived at the facility at approximately 8:30 a.m. and left at approximately 9:30 a.m. When I returned at approximately 2:30 p.m., [R1] was in the exact same position as when I left at 9:30 a.m." FM-C further stated she was certain of this because she always tucked R1's gown in between her legs, and placed a teddy bear in R1's hands in a certain way, with R1's hands wrapped around the neck of the teddy bear, and these two things were unchanged.

FM-C also stated on 3/19/21, RN (registered nurse)-A arrived to R1's room at approximately 6:30 p.m. RN-A asked FM-C when R1 had last been repositioned and since FM-C stated she didn't know, they two decided to reposition R1.

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F 600	Continued From page 5 FM-C stated when they pulled R1's sheet back, they were hit with a strong smell of urine. To investigate further, they removed R1's pants and they discovered R1's brief was soaking wet. FM-C stated "it could not have held another drop." FM-C stated R1's brief was wet despite R1 having an indwelling urinary catheter because R1 had bladder spasms and sometimes leaked urine. FM-C stated R1's pants and draw sheet under her were wet. RN-A asked an unidentified nursing assistant (NA) to help asking her to bring supplies (basin, washcloths, brief and clean sheets). FM-C said RN-A asked the NA when the last time R1 had been changed and the NA stated she didn't know. FM-C stated the NA got the supplies, but added "we took over and she [the NA] helped by holding [R1's] leg. We told the [NA] that [R1] was completely soaked, but she didn't say anything. As we looked further, we could see [R1] had dried stool in her brief, on her butt cheeks and on the inside of her closed butt cheeks. The nursing assistant watched us wash [R1]. We were assertive in taking over and cleaning her, and the nursing assistant could see we were not happy." FM-C stated R1's skin was starting to break down in her vaginal area, stating "we spread her labia apart and the edges were raw, red and looked so tender." FM-C stated R1 grimaced and moaned when they cleaned her. When FM-C and RN-A turned R1 to change the linen, they saw solid red crease lines on her back from her shirt, including a deep red crease at the bottom of R1's right shoulder blade that looked like it could open up. In addition, FM-C described an area on R1's right butt check as a black blister about the size of a man's thumb nail. FM-C stated R1 had not had pressure ulcers before that. FM-C stated, "[RN-A] and I were dumbfounded about [R1] not being changed and repositioned.	F 600		

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F 600	Continued From page 6	F 600		

In order to verify whether R1's brief was being changed, we placed an X on the back of the incontinent brief. When [RN-A] and I returned to the facility the next day (3/20/21) at 8:30 a.m., [R1] was still wearing the brief with the X on it."

After being at the facility on the morning of 3/20/21 at 8:30 a.m., FM-C said she'd left and came back in the afternoon, staying with R1 until about 11:45 p.m. FM-C stated staff rarely came into R1's room. FM-C stated she repositioned R1 by herself at about 2 p.m. At about 8 p.m., RN-B came into the room and asked if the NA's had repositioned R1 yet. FM-C said she'd told RN-B no, the staff had not been coming into R1's room. FM-C said RN-B told her it was important for R1 to be repositioned and she would talk to the NA's. Following that conversation, two NA's came in and gave R1 a bed bath, changed her brief, applied lotion and repositioned her, "all in about four minutes, it was like wham bam." FM-C stated they cleaned one side of R1's leg, but not the back side. FM-C then stated, "If they did that when I was here, what are they doing when family isn't here?" FM-C stated even though she was there with R1 until about 11:45 p.m., no one came back to reposition R1. "In all the times I've been here, she was only repositioned once or twice at shift change - it wasn't every two hours." FM-C stated that when she left that night, she marked R1's brief again with a fine line on the tabs of the brief so she could tell if the brief had been checked or changed. FM-C said, "When I returned on 3/21/21, the lines I'd put on her brief still lined up, indicating the brief had not been checked or changed."

FM-C also reported staff did not consistently know where to position pillows under R1's feet to

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

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keep her heels off the bed. FM-C stated, "[R1's] heels elbows were red, but had no pressure ulcers yet. Her oral care was disgusting...I don't think it was being done. The oral mucous membranes were dry, and there were never toothettes in [R1's] room until I asked for them. She would have thick mucous in her mouth that was hard to remove, but I never noticed any sores in her mouth."

RN-A was interviewed by telephone on 3/24/21, at 3:35 p.m. RN-A stated she was R1's hospice case manager and saw her at the facility two times per week starting 2/12/21. RN-A stated initially her visits with R1 were not very long and sometimes R1 was sitting up in a wheelchair. RN-A stated she sometimes had to change R1's brief but didn't think anything of it. RN-A stated when she got to the facility, she usually asked the staff how R1 had been doing, then would check R1's vital signs and do a brief assessment. RN-A stated due to R1's declining condition, she had started daily visits on 3/17/21. RN-A stated, during the 3/19/21, hospice visit at 6:30 p.m., FM-C was there too. RN-A stated staff didn't know when R1 had been repositioned last, so RN-A and FM-C decided to reposition her. RN-A stated when FM-C pulled back the sheets, they caught a whiff of something really strong, even with with their masks on. RN-A stated they looked further and found R1's brief "saturated beyond belief...it shocked me." RN-A stated they obtained supplies to clean R1 and when they turned her onto her side, they found dried stool on her buttock at the gluteal fold, adding it had been there a long time as it was dried to her skin. RN-A stated they had to get wash cloths to soak the stool before they would wipe it off, adding it left an imprint on the skin because it had been there so

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long. RN-A stated they found R1 had a blood blister on her left upper buttocks, near the gluteal fold which had not been there before. RN-A stated she'd last looked at R1's bottom when she changed her urinary catheter on 3/10/21, adding that's when she would inspect R1's genitalia and buttocks. In addition to the blood blister on the buttocks, RN-A stated on 3/19/21, she'd observed new pressure areas to both elbows, mid back, lower back and right heel, adding "they were not there previously, they developed in that short time." RN-A stated she didn't tell anyone because it was a Friday night and administrative staff were gone. After R1 was cleaned and her brief changed, RN-A confirmed she and FM-C had marked the back of R1's brief with an X to verify whether the brief was changed when they returned the next day. RN-A stated, "I wanted to see if they were taking care of her. When I came back the next day at 8:30 a.m. with [FM-C], R1 was wearing the same brief with the X, and the brief was soiled with stool. We found [R1] pretty much in the same position and in the same same clothing." Before leaving the facility on 3/20/21, RN-A said she'd communicated to RN-C to make sure someone was going into R1's room to reposition her, change her and provide incontinence care. RN-A added, "I have honestly never seen anything this bad before."

A hospice visit note documented by RN-A dated 3/17/21, indicated: R1's lung sounds were diminished and she had 5-10 second periods of apnea (cessation of breathing) and her breathing was labored. R1's lower extremities were bluish and indicated poor oxygenation. R1 was moaning and had facial grimacing. The hospice physician was notified of change in status and new pain medication orders were issued. Urinary catheter

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was noted as being patent and draining amber colored urine.

A hospice visit note documented by RN-A dated 3/19/21, indicated: R1 was lying in bed; some restlessness was noted with facial grimacing. R1 had shallow respirations with 10 second periods of apnea. FM-C was present. When repositioning R1, FM-C verbalized "what is that smell?" R1's brief was heavily soiled with dark amber colored urine with a pungent odor and dried BM (bowel movement) to buttocks. Incontinence care was performed extensively. Noted new pressure areas to bilateral elbows, mid back, lower back, right heel and a 2 cm (centimeter) x 3 cm blood blister to left buttock.

A hospice visit note documented by RN-A dated 3/20/21, indicated: R1 had labored breathing, with 15-20 second periods of apnea. Scant amount of amber colored urine in catheter tubing. RN-A and FM-C turned and repositioned R1, and performed extensive incontinence care as the same brief that RN-A and FM-C put on last night at 6:30 p.m. was still present as evidenced by the marking of a X with pen on the outer side of the brief. Further, the note indicated RN-A had coordinated care with facility staff RN, encouraged pain medications, and encouraged the staff RN to make sure facility staff were turning, repositioning and providing incontinence care.

On 3/21/21, at 12:35 p.m.., R1 passed away.

During an interview on 3/25/21, at 8:38 a.m. director of clinical services (DCS)-A stated she became aware of FM-C's concerns about the care of R1 on 3/22/21, at 11:00 a.m. from the administrator. DCS-A stated, "This was

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immediately self-reported to the State Agency." DCS-A said she'd reviewed R1's medical record and completed several staff interviews. DCS-A stated, "I told [FM-C] I was sorry if that was your perception of the care." DCS-A further stated staff who were interviewed stated the urinary catheter wasn't leaking and that R1 had a strong urine smell due to decreased urine output from not drinking. DCS-A was aware FM-C changed R1's brief and marked it, but stated staff had changed the brief and had repositioned R1.

During a phone interview on 3/25/21 at 9:06 a.m., (RN)-B stated she worked with R1 for the first time on 3/20/21. RN-B stated she had checked R1's brief and looked at her skin when she turned her and did not see anything unusual, adding she did not see any skin discolorations. RN-B stated she told the NA's they needed to go into the room to reposition R1 and check her brief, even if a family member was in there. RN-B stated, "We needed to show that we cared."

According to a weekly skin review document from the electronic medical record, RN-B completed R1's weekly skin assessment 3/20/21 in the evening, and indicated the skin was intact with no redness or blisters, despite RN-A documenting on 3/19/21, that R1 had new pressure areas to bilateral elbows, mid back, lower back, right heel and a 2 cm x 3 cm blood blister to left buttock.

During an interview on 3/25/21, at 9:19 a.m., nursing assistant (NA)-A stated she worked with R1 on 3/19/21, when RN-A and FM-C were there. NA-A stated she helped clean R1 and reposition her, but didn't notice if R1's brief was wet or if there was stool in it, "I really couldn't see that part." NA-A couldn't recall when R1's brief was

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changed or whether she'd been repositioned prior to that, but stated they usually checked her brief and repositioned her every two hours. NA-A stated, the staff didn't always document when they toileted or repositioned the resident. NA-A stated she did not recall seeing any skin problems, other than red lines on R1's back from wrinkles in the sheets. NA-A stated she didn't report that to the nurse because those marks are common on residents who remain in bed. NA-A stated she did not see any marks on R1's buttocks, but confirmed she really couldn't see R1's buttocks closely. NA-A stated she didn't go into R1's room a lot because her family was there, and she wanted to respect their privacy.

During an interview on 3/25/21, at 9:33 a.m., NA-B stated the nursing assistants don't document if they check a residents brief and it is dry, and clarified they would document repositioning at the end of the shift not right after it was done. NA-B stated the status of a resident's brief and repositioning were communicated to the next shift. NA-B stated she had cared for R1, and stated, "Toward the end of her life, we checked her brief every hour. She had a urinary catheter, and at no time was she wet or soiled." NA-B also stated R1 had no pressure injuries or skin discoloration. However, NA-B verified she had not worked with R1 the weekend of 3/19 through 3/21/21.

During an interview on 3/25/21 at 9:47 a.m., RN-C acknowledged working with R1 the weekend she passed away. RN-C stated R1 was actively dying, adding that she seemed comfortable and was getting scheduled morphine. RN-C stated hospice was working with R1 and requested frequent dosing of R1's PRN

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(as needed) pain medications. RN-C said was not aware if R1 had pressure injuries, adding "the NA's didn't report it." RN-C didn't know whether the nurses had oversight over the nursing assistants regarding them repositioning, or checking and changing their briefs, but added it was hit or miss if they wrote those things down. RN-C stated, "I don't think we provided the best care to [R1] at the end of her life. There wasn't enough time or staff to ensure proper care was provided all of the time. I apologized to [R1's] daughter for that."

During an interview on 3/25/21, at 10:24 a.m., (NA)-C showed the surveyor the assignment sheets the nursing assistants carried. The sheet had six columns that included: room number/name, code status, diet, blood sugar, bath day, and a column titled additional information. NA-C acknowledged the sheet did not identify those residents who required repositioning or checking/changing briefs. NA-C stated they would find out that information from the nurses and nursing assistants from the previous shift. NA-C's assignment sheet did not include any hand-written notes about repositioning, toileting or checking and changing briefs. When asked how she remembered which residents required repositioning or having their brief checked and changed, NA-C stated "We just remember."

During an interview on 3/25/21 at 10:28 a.m., RN-D stated she had cared for R1 the week prior to her passing and R1 did not have any pressure injuries that she was aware of. RN-D stated the nurses were responsible to remind nursing assistants to reposition residents and to check and change them.

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F 600	Continued From page 13 During an interview on 3/25/21 at 11:49 a.m., DCS-A stated the facility was not able to validate FM-C's concerns. DCS-A was aware that FM-C put an X on R1's brief, but stated R1 may not have had a bowel movement on 3/19 or 3/20/21, and therefore the brief would not need to be changed, adding documentation showed R1 did not have a bowel movement from 3/18 through 3/21/21. When asked if staff would have to undo the brief to determine if it was wet or soiled, DCS-A stated not always. DCS-A also stated R1 could not have had a urine-saturated brief because she had a urinary catheter in place. DCS-A stated documentation from 3/17 to 3/21/21, did not indicate any urinary incontinence episodes related to R1's urinary catheter except for on 3/18/21. DCS-A also stated NA's documented repositioning under "bed mobility" in the medical record but were only required to document that once per shift. DCS-A stated, "I can't validate if [R1] was repositioned or not on 3/19 and 3/20/21, nor can I validate whether or not there was something on [R1's] skin that weekend." During interview on 3/25/21, at 12:07 p.m., the administrator stated he'd spoken to FM-C on 3/22/21, and took the information she provided, adding it seemed the concerns arose the week before R1 passed away. The administrator stated, "[FM-C] was very complementary of the care [R1] received prior to this." The administrator stated having shared the family's concerns with the director of nursing who along with a social worker, submitted the report to the State Agency. The administrator further stated their director of nursing (DON) had a family emergency so was out of work, and DCS-A was investigating the	F 600		

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concerns. The administrator stated he did not know if FM-C's concerns were valid, but acknowledged they were taking the concerns seriously and looking into it.

During a telephone interview on 3/25/21, at 1:47 p.m., FM-C stated she'd taken photos of R1's pressure injuries.

The facility's 6/1/17 policy titled, Residents Receiving Hospice Services, indicated:
1. The hospice and the nursing home agree upon a coordinated plan of care which reflects the hospice philosophy and based on an assessment of the individual's needs
2. The plan of care must include directives for managing pain and other uncomfortable symptons and revised and updated as necessary to reflect the individuals current status. The facility and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care.

The facility's October 2010 policy titled, Incontinence Care indicated:
1. Purpose: to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the residents skin condition.
2. Review the residents care plan for special needs. Incontinent residents need to be checked on a regular basis and provided incontinence care with every change of brief.
3. After continence care is provided, the following was to be recorded in the residents medical record: date and time perineal care given, any problems noted at the catheter-urethral junction.

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The facility's 2/22/21 policy, Indwelling Catheter Care, indicated:
1. Purpose: to prevent infection and reduce irritation.
2. Procedural steps were listed.
3. Inspect meatus (opening leading to the interior of the body) for redness, irritation, and drainage.
4. Check the catheter where it enters the meatus for encrusted material and drainage.
5. Clean the meatus with soap and water during daily bathing.
6. Be sure tubing is not kinked, twisted, obstructed, or caught on bed parts.

The facility's June 2017 policy, Positioning the Resident, indicated:
1. Purpose: to relieve pressure and prevent skin breakdown, to relieve pain.
2. Procedural steps were listed.
3. Document date, time, body position; frequency of positioning, condition of skin.
4. Care plan guidelines: identify the appropriate problem under which to list appropriate positioning procedures.

The facility's 12/17 policy, Skin Management System, indicated:
1. A head to toe body evaluation will be completed on every resident upon admission or readmission and weekly thereafter and documented on the Weekly Skin Integrity Review form or electronic medical record.
2. Routine weekly checks will be completed on every resident.
3. NA's will note any alteration in skin integrity during routine care and report it to the charge nurse.
4. Braden Scale (used to predict pressure sore risk) will be completed upon admission,

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F 600	Continued From page 16 readmission, weekly for three weeks, change of condition, then quarterly thereafter. 5. Facility DON's are responsible to establish a system to monitor and assure skin management system compliance.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 15, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Event ID: HBGI11

Dear Administrator:

The above facility survey was completed on March 25, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/24/21 and 3/25/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 UNSUBSTANTIATED: H5184126C (MN68947). The following complaint was found to be SUBSTANTIATED: MN71110 & 71145), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		