

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 30, 2021

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

RE: CCN: 245184 Cycle Start Date: June 28, 2021

Dear Administrator:

On August 18, 2021, we notified you a remedy was imposed. On September 21, 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 September 8, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2021 be discontinued as of September 8, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 21, 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 July 28, 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,

Mi Ping

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



#### Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

September 30, 2021

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

Re: Reinspection Results Event ID: FPE412

Dear Administrator:

On September 21, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 28, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

M. Ping

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



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

August 18, 2021

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

RE: CCN: 245184 Cycle Start Date: June 28, 2021

Dear Administrator:

On July 21, 2021, we informed you that we may impose enforcement remedies.

On July 28, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

### REMOVAL OF IMMEDIATE JEOPARDY

On July 28, 2021, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

### 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 September 2, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 2, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 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 payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

# SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Rochester East Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 28, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## 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, Minnesota 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 December 28, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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,

Michig

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	FORM APPROVED					
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY IPLETED	
		245184	B. WING				C <b>28/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	٤	STREET ADDRESS, CITY, STATE, ZIP CODE	077	20/2021	
ROCHES	STER EAST HEALTH	SERVICES			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	ſS	FC	000				
	survey was conduc was found to be NC requirements of 42 Requirements for L The survey resulted (IJ) at F689 when the manufacturer's guid for eight residents ( R12, R9) of 14 resid lifts. This deficient p immediate jeopardy full body lift and had R11, R18, R13, R8, not following the map proper use. Furthe assess and evaluat failed to ensure adde interventions were for 2 of 2 resident ( sustained multiple f The above findings quality of care, and conducted on 7/28/ The following comp SUBSTANTIATED: H5184140C (MN00 with a deficiency cit The facility's plan o as your allegation of Department's accep enrolled in ePOC, y	constituted substandard an extended survey was 21. Plaint was found to be 1074970 and MN00074948),						
LABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	
Electron	ically Signed						08/27/2021	

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.

PRINTED: 09/06/2021

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION (X3	B) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:		a	COMPLETED		
		245184	B. WING		С		
	PROVIDER OR SUPPLIER	243104	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	07/28/2021		
	TER EAST HEALTH S	BERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904				
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F 000	Continued From pa form. Your electroni be used as verificat	c submission of the POC will	F 00	0			
F 689 SS=K	on-site revisit of you validate that substa regulations has bee your verification. Free of Accident Ha	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with azards/Supervision/Devices 1)(2)	F 68	9	9/8/21		
	supervision and ass accidents.	resident receives adequate sistance devices to prevent NT is not met as evidenced					
	review, the facility fa guidelines for proper residents (R2, R11, of 14 residents who deficient practice re- jeopardy (IJ) for R1 and had the potenti R13, R8, R10, R12, following the manufuse. Furthermore, evaluate causal fac- ensure adequate su- were implemented	ion, interview and document ailed to follow manufacturer's er use of slings for eight R18, R13, R8, R10, R12, R9) outilized full body lifts. This esulted in an immediate , who fell from the full body lift al for injury for R2, R11, R18, , R9 as a result of not facturer's guidance for proper the facility failed to assess and tors for falls, and failed to upervision and interventions to reduce falls for 2 of 2 4) reviewed who sustained		This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicab long term care providers. The submiss 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, that the scope and severity regarding of the deficiencies cited are correctly applied. The submission of this requir Plan of Correction does not constitute admission or acknowledgement of noncompliance or liability on the part of	or any ed an		

Facility ID: 00953

If continuation sheet Page 2 of 19

	-	AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO.	APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C 07/28/2021	
		245184	B. WING				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
ROCHES	STER EAST HEALTH S	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
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F 689	licensed practical n assistant (NA)-A we body lift and R1 fell The administrator a were notified of the The IJ was remove however, noncomp scope and severity harm, but potential Findings include: R1's facesheet prin diagnoses which in sclerosis (ALS) (ne functionality in the r dysphasia (languag person's ability to c quadriplegia (paraly R1's admission Min assessment dated cognitively intact, ha vision, unclear spee make self understo understand. R1 req was dependent upo full body lift for bed toileting, and movin R1's plan of care in a) self-care deficit a dependence on oth daily living related t diagnosed ALS, and mechanical lift and	ge 2 18/21, at 11:00 p.m. when urse (LPN)-A and nursing ere transferring R1 with a full out of the sling to the floor. and director of nursing (DON) IJ on 7/26/21, at 7:04 p.m. d on 7/28/21, at 3:30 p.m. liance remained at the lower level of E, pattern, no actual for more than minimal harm. ted on 7/19/21, listed cluded amyothrophic lateral rve cells break down, reducing nuscles they supply), te disorder that affects a ommunicate), anxiety,and vsis of all four limbs). imum Data Set (MDS) 5/26/21, indicated R1 was ad adequate hearing and ech, was sometimes able to od and could usually uired extensive assistance or on two staff and/or the use of a mobility, transfers, dressing, g about in a wheelchair. itiated on 5/14/21, indicated: as evidenced by increased ers to complete activities of o disease progress and newly d would require transfer with a assistance of two. b) impaired as evidenced by diagnosis of	F 6	<ul> <li>R 1 no longer resides at the and R4 falls were reviewed of Clinical Services and post assessment or falls risk assisummary completed with caupdates as indicated.</li> <li>Residents who use the full I mechanical lift for transfers experience falls have the point impacted by the alleged pratof falls since June 1, 2021 won July 30 by the Director of Services or designee. Falls to 8/25 have been/will be at Director of Clinical Services and care plans and assessible been/will be updated as ind those residents reviewed. M slings were ordered 7/23/20 received 7/27/2021 and put Generic loop slings were reuse on 7/27/2021. Lift assest completed for residents and and size identified and care Process for falls review dur clinical meetings was updat compliance will be monitore 8/25/2021.</li> <li>Director of Nursing or desig fall event and verify that an apimmediate care plan interver prevent further falls or injury and review the root cause were cause on root cause were the root cause were the root cause were cause on the root cause were cause were cause on the root cause were cause were cause were cause were cause were cause were cause on the root cause were cause wer</li></ul>	by the Director it fall sessment and are plan body or who biential to be actice. Review was completed f Clinical since July 31 udited by the or designee ments have icated for Mechanical lift 21 and into use. moved from ssments were d sling type planned. ing morning ed and daily ed starting nee will review post fall tation are ppropriate ention to y was initiated,		

Facility ID: 00953

If continuation sheet Page 3 of 19

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER	243104	B. WING _		CITY, STATE, ZIP CODE	/28/2021	
	TER EAST HEALTH	SERVICES		501 EIGHTH AVENU ROCHESTER, MN	JE SOUTHEAST		
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F 689	two staff. R1's care of sling nor size of body lift. R1's progress note LPN-A indicated: R lift used for a full bod feet from floor while hit her head and bad apparent injury but hospital via ambula hoyer occurred. R1's progress note by LPN-A indicated hospital with three and would probably days. During a telephone a.m., family member call on 7/18/21, that hospital. FM-D was mechanical lift and her to fall three fee back on the ground happened. FM-D si full body lift; it scare certain staff using i and ask her why sh right way every time FM-D stated R1 way uncertain if R1 wou fear of being move	dated 7/19/21, at 4:15 a.m. by 1 fell from Hoyer (mechanical ody lift) approximately three e transferring to commode. R1 ack on the leg of hoyer. No R1 transferred to local ance. Unsure how fall from dated 7/19/21, at 4:30 a.m., 1: R1 was admitted to the rib fractures on the right side y be in the hospital for two interview on 7/26/21, at 10:02 er (FM)-D stated he received a t R1 was being sent to the s told R1 had been in the something happened causing t hitting her head and lower d; but they didn't know how it tated R1 did not like using the ed her and she didn't trust t, but no one would listen to R1 he was afraid. "If they did it the e, she wouldn't be afraid." as still in the hospital and was ild return to facility due to her d with the mechanical lift.	F 68	<ul> <li>clinical meetin identified, like to determine i their plan of ca submitted mo Assurance/Per committee for recommendat</li> <li>Education was Clinical Service of the mechar inspection of s 7/26/2021. Sta education will working their n being trained lifts during their documentation for licensed nu Director of Cli beginning Aug falls review was of Clinical Ser Director on 8/ by the Executi interdisciplina</li> <li>Audits of mec the week of 7/ observations a will continue for weekly for fou four weeks. R submitted to the</li> </ul>	tions. s provided by the Director of ces or designee on the use nical lift, sling selection, and slings before use beginning aff who have not received be educated prior to next shift. New hires are on the use of mechanical e orientation process. Falls n requirements education urses was initiated by the nical Services or designee gust 19, 2021. Education on as provided by the Director vices to the Executive 19/2021 and will be provided ive Director to the ry team on 08/25/2021. hanical lift use were initiated /26/2021 and three are completed weekly and or eight weeks, then twice ir weeks, then weekly for tesults of these audits will be he Quality erformance Improvement	k	
	uncertain if R1 wou fear of being move During an interview (NA)-B stated there	Ild return to facility due to her		four weeks. R submitted to t Assurance/Pe committee for recommendat	esults of these audits will be he Quality erformance Improvement		

Facility ID: 00953

If continuation sheet Page 4 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE S COMPLE C         NAME OF PROVIDER OR SUPPLIER       245184       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE S COMPLE C         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904       STREET ADDRESS	
245184     B. WING     07/28       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BOCHESTER FAST HEALTH SERVICES     501 EIGHTH AVENUE SOUTHEAST	3/2021
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BOCHESTER FAST HEALTH SERVICES       501 EIGHTH AVENUE SOUTHEAST	
I BOCHESTER FAST HEALTH SERVICES	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)IDPREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)C	(X5) COMPLETION DATE
<ul> <li>F 689 Continued From page 4 two different manufacturer slings being used with the lifts: Invacare and MedCare, adding "MedCare slings were not made for the Invacare lifts but we use them."</li> <li>During document review, the Invacare User Manual dated 10/18/18, indicated the following warning: Invacare slings and patient lift accessories are specifically designed to be used in conjunction with Invacare patient lifts. Slings and accessories designed by other manufacturers are not to be utilized as a component of Invacare's patient lift system.</li> <li>During an interview and observation on 7/26/21, at 12:40 p.m. with NA-B, R2 was sitting in a wheelchair in the dining rom on a MedCare sling."</li> <li>During an interview on 7/26/21, at 12:45 p.m., (NA)-C stated the facility used more than one brand of sling for the mechanical lift, but didn't know the brand names. Stated staff always crisscrossed the legs on the sling, adding that was how she was trained. NA-C was aware of R1's fall from a lift and stated she had recent retraining after the incident, and the training included to use an Invacare sling with an Invacare lift. Stated prior to recent training, (id not know a sling specified by the lift manufacturer should be used.</li> <li>During a telephone interview on 7/26/21, at 1:10 p.m. LPN-A verified she was involved in the 7/18 incident in which R1 fell from the full body lift.</li> </ul>	

If continuation sheet Page 5 of 19

		AND HUMAN SERVICES			FORM	09/06/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING			C 28/2021
NAME OF I	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	STER EAST HEALTH	SERVICES		01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
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F 689	looking at the comr were when suddent floor. LPN-A stated her back was over recalled the sling be didn't remember the LPN-A was certain crisscrossed aroum how she fell out; we before and nothing During an interview corporate director of stated she knew re- specified by the me was not until the ind she became aware more than one brar she became aware were ordered, but h residents who used still using MedCare R13, R8, R10, R12 sling had been use a large Invacare slin inspected the sling abnormalities, tears During an observat observed NA-B and wheelchair to bed u MedCare sling. During an interview administrator ackno until R1's incident th lift manufacturer co result of the facility	node to see how close they ly R1 fell out of the sling to the R1's head hit the ground and the leg of the lift. LPN-A eing royal blue in color, but e trim color or the brand name. the legs of the sling were d R1's legs. "I have no idea e have done this many times was out of the ordinary." on 7/26/21, at 1:14 p.m. of clinical services (DCS)-C sidents should be using slings echanical lift manufacturer. It cident with R1 on 7/18, that the facility had been using nd of sling. DCS-C stated once of this, more Invacare slings had not arrived yet. Of the 14 d the full body lift, eight were e brand slings: R2, R11, R18, , R9. DCS-C stated the correct d for R1 at the time of her fall, ng. After the fall DCS-C and there were no				

If continuation sheet Page 6 of 19

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/06/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245184	B. WING				_ 28/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	the proper sling. Fu was aware that non be used with the Inv R13, R8, R10, R12, slings arrived. During an interview director of nursing ( slings were acquire wanted dialysis resi the facility acquired were being used on with the Invacare fu was after R1's fall th manufacturer speci designed for their m aware that non-Inva used with the Invaca R8, R10, R12, R9 u arrived. During a telephone p.m. with the Invaca asked if it were pos was crisscrossed u and if the legs were person fall out of th was too big, it's plau stated the most like wasn't attached to t of two reasons a re not hooked up to lift sling isn't secure in end falls off the hoo the sling at the legs wouldn't likely fall th was attached proper	ge 6 residents who used the lift had rthermore, the administrator i-Invacare slings continued to vacare lift for R2, R11, R18, R9 until additional Invacare on 7/26/21, at 2:55 p.m., the DON) stated the MedCare d from the local hospital who idents on this sling. Over time more of the slings and they non-dialysis residents and all body lift. The DON stated it hat she became aware of lift fications to use only slings bechanical lift. The DON was acare slings continued to be are lift for R2, R11, R18, R13, intil additional Invacare slings interview on 7/26/21, at 3:07 are representative (IR)-E, was sible when a split leg sling nder and over a person's leg, e sticking out rigid, could a e sling. IR-E stated if the sling usible, but very unlikely. IR-E ely cause would be that it he hanger bar properly. "One sident falls from a lift: usually t properly the loop on the the hook on the lift and one ok. Or they didn't crisscross . Someone of that size prough the middle if the sling erly." IR-E added, at 163 R1), a person would use a	Fθ	689			

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		AND HUMAN SERVICES			FORM	09/06/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING			C 28/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	STER EAST HEALTH	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	large sling, adding were used, it would would fall out. IR-E use of our slings wit test anyone else's s can't guarantee sor properly in our lifts unaware of this inci- informed him. During an interview DON stated the Inv been contacted to i company's lift, or to problem solving or thought of that." Training records we involved in R1's fall DCS-C, NA-A and I Relias online learni Mechanical Lifts. D document dated 20 of the training and I use of mechanical emphasis on abidin guidelines for opera part of an individua mechanical lift devi the manufacturer's spe are using. Never as one practice or piec mechanical lift that	even if an extra large sling I be highly unlikely a person stated "we're very strict with ith our equipment. We can't slings. Our stance is clear: we meone else's sling will work and vice versa." IR-E was ident as the facility had not on 7/28/21, at 10:10 a.m. the racare representative had not nform him of a fall from their o utilize his expertise for for staff education; "we hadn't ere reviewed for the two staff from lift on 7/18. According to LPN-A's training included a ng module titled: Safe Use of CS-C provided a 19 page 017, which outlined the content listed "the safe and proper lifts was illustrated with an ng by the manufacturer's ation, and the most important I's responsibility in using ces was complying with both instructions and the es and procedures." And also a bide by all of the ecific instructions for the lift you ssume that because you used ce of equipment for one you can use it for another type y result in equipment failure or	F 689			

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		AND HUMAN SERVICES				FORM	: 09/06/2021 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245184	B. WING	i			C <b>28/2021</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	STER EAST HEALTH S	SERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	<ul> <li>NA-A's training trahad been complete testing for mechani 9/20/19.</li> <li>-LPN-A's transcript 2018 to 2020, did n Relias's online learn Mechanical Lifts. The provide evidence the on safe use of mechanical Lifts with revisindicated: In order to protect swould use appropriation of the mechanical lifts Residents who required the mechanical lifts Residents who required the assess and size using the I Registered nursing upon admission, wi an ongoing basis for This information we care plan and karder required by resident times, and mainten checks who utilize the mechanical lifting consistent with guidance.</li> </ul>	which included dates from indicate completion of the ning module titled Safe Use of he facility was not able to nat LPN-A completed training	F	689			

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DEPARTMENT OF HEALTH A					FORM	09/06/2021 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
	245184	B. WING				C <b>28/2021</b>
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROCHESTER EAST HEALTH SI	ERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
<ul> <li>use of the previously all residents on 7/27, color-coded list for s attached to each Inv. as laminated instruct provide a quick, easi staff who completed staff on the Lift Mobi assessment was corvendor specific lift sl style. The facility nur on the use of full boor regarding the use of and sizing and use of and sizing and use of the DON or designed staff demonstrated usize and proper appl mechanical lifts. However the noncom lower scope and sev actual harm, but pote harm.</li> <li>Falls</li> <li>R3</li> <li>R3's facesheet printed diagnoses of orthope surgical amputation weakness, chronic o bone caused by infer schizophrenia (serior people interpret reali</li> <li>R3's admission Minin assessment dated 5, cognitively intact, hard</li> </ul>	ed on 7/28/21, indicated	F	689			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/06/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245184	B. WING				C 28/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	TER EAST HEALTH S	SERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	required extensive a mobility, transfers, I dressing, toileting, a R3's care area asse 5/24/21, indicated F when he was back with therapy followin toe. Used a wheelc prior to hospitalizati illness. R3's admission fall 5/19/21, and compl nurse (LPN)-D, indi had a history of one days, including a fra past 6 month prior t factors related to m or balance problem R3's plan of care in R3 was at risk for fa of right great toe an included: Have commonly u Medications as or Provide assistanc needed. Reinforce need to Reinforce wheelcl locking breaks. Therapy evaluatio All of the above inte 5/27/21. No new int	Id understand others. R3 assistance of two staff for bed ocomotion on and off the unit, and hygiene. R3 did not walk. essment (CAA) for falls dated R3 would return to group home to his baseline, was working ng amputation of right great hair and walker. R3 had a fall on due to weakness and risk assessment, dated eted by licensed practical cated R3 was at risk for falls; to two falls in the past 30 acture related to falls in the to admission. He had fall risk edications and exhibited gait s. itiated on 5/27/21, indicated alls due to recent amputation id history of falls. Interventions used articles within easy reach. dered. e to transfer and ambulate as	F	\$89			

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		AND HUMAN SERVICES				FORM	09/06/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245184	B. WING				28/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROCHES	TER EAST HEALTH	SERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Four fall incident refollowing: 6/2/21: At 2:50 a.r floor next to the been NA in the room, R3 wheelchair while sh leaned forward and from the wheelchai sustained. 6/3/21: At 11:04 p the floor next to the his back. R3 told R stand up and lost h sustained. 7/17/21: At 5:57 p self from bed to wh and assisted him to wheelchair and beo get in the chair but 7/18/21: At 2:50 p hallway with his knew the floor and his wh resident informed s in his wheelchair ar was sent to the hose returned to the facil R4 R4's facesheet prind diagnoses of traum space around the b consciousness, mu of gait and mobility. age-related cognitiv cataracts (clouding R4's admission Mir	ports for R3 indicated the m., R3 was found sitting on the d. According to an unnamed had been sitting in his he changed his bedding. R3 the NA assisted him to slide r to the floor. No injury .m., R3 was found sitting on bed with wheelchair behind N-C that he was trying to is balance. No injury .m., R3 attempted to transfer eelchair. Staff were present the floor between the d. R3 stated he was trying to slipped. No injury sustained. .m., R3 was found in the ees, hands and forehead on heelchair behind him. Another taff he saw R3 leaning forward nd assisted him to the floor. R3 spital for evaluation and lity on 7/27/21. ted on 7/28/21, indicated atic subarachnoid (fluid filled vrain) hemorrhage with loss of scle weakness, abnormalities , dementia, depression, ve decline, and bilateral of the lens of the eye).	F 6	89			
		5/25/21, indicated R4 was ad moderate difficulty hearing,					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/06/2021 APPROVED 0938-0391
STATEMENT OF I	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245184	B. WING				C 28/2021
NAME OF PROV	IDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHESTER	R EAST HEALTH S	SERVICES			01 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
add sel rec mo on hyg R4 5/1 nuu had 30 me pro R4 R4 and H N P ned R loc T All 5/2 car add R3 Thi foll 5, the goi haj	f understood and quired extensive a obility, transfers, y and off the unit, giene. 's admission fall 8/21, and comple- rse (LPN)-D, indi- d a history of one and 60 days. R4 edications and ex- oblems. 's plan of care ini- twas at risk for fa- d cognitive impai- lave commonly u redications as one rovide assistance eded. Reinforce need to Reinforce need to Reinforce wheelch king breaks. 'herapy evaluatio of the above inte 27/21. No new inte re plan after falls dition, R4's fall in 's fall intervention ree fall incident re- owing: /19/21: At 5:15 a e floor in his room ing to the bathroo- ppened.	ear speech, was able to make a could understand others. R3 assistance of one staff for bed walking in room, locomotion dressing, toileting, and risk assessment, dated eted by licensed practical cated R4 was at risk for falls; to two falls in both the past had fall risk factors related to hibited gait or balance itiated on 5/18/21, indicated alls/injury due to history of falls rment. Interventions included: sed articled within easy reach. dered. to transfer and ambulate as call for assistance. nair safety as needed such as n and treat as ordered. erventions were initiated on erventions were added to the on 5/19, 5/29 and 5/30/21. In terventions were identical to	F 6	589			

		AND HUMAN SERVICES				FORM	
		& MEDICAID SERVICES					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		
			A. BUILD				0
		245184	B. WING				
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BOCHES	TER EAST HEALTH	SERVICES			501 EIGHTH AVENUE SOUTHEAST		
nooneo		SENTIOLO			ROCHESTER, MN 55904		
(X4) ID			ID				(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
			1				
F 689	Continued From pa	-	F 6	689	9		
		, and told staff he slipped out					
	of bed. No injury.	.m., R4 was found on floor in					C 7/28/2021
	his room. No injury.						
		on 7/28/21, at 10:10 a.m., R4, however did recall R3,					
		I and a riser had been placed					
		ent him from having to get up					
		w position. When asked what					
		erventions were used for R3,					
		moved clutter from his room ure his call light was within					
		s in the room to remind him to					
	use the call light. W	hen asked how she was					
		interventions for a resident,					
		fall, management updated					
		with interventions. Use of a an intervention on R3's care					
		ed recent training on slings					
	and lifts, including b	brand of sling must match the					
	lift manufacturer.						
	During an interview	on 7/28/21, at 11:12 a.m.,					
		asked how resident falls were					
		ally determining causal factors					
		fying existing fall risk					
		DON presented three					
		Var Meeting Key Indicators" e discussed at this meeting.					
	The documents pro						
	information:	J					
		d C/0/01 bod two bond with a					
		ed 6/8/21, had two handwritten r a section titled "falls" which					
	indicated:						
	a) Date 6/2, R3's na	ame and the word "self." When					07/28/2021
		eant, the DON stated R3 fell					
	while self transferring	ng. The DON admitted no new					

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		AND HUMAN SERVICES				FORM	: 09/06/2021 APPROVED . 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245184	B. WING	i		07	/ <b>28/2021</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROCHES	TER EAST HEALTH	SERVICES			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	after that fall. b) Date 6/3, R3's na written. When aske stated they added a "call, don't fall." c) There was no do and 7/18. One document date under a section title a) Date 5/19, R4's n When asked what t they added a sign to don't fall." Asked if intervention for som DON didn't reply. Another documente for R4 under a sect indicated: a) Date 5/29, R4's n slid from bed - matt meant, the DON sta thought R4 was giv further falls, but did mattress, adding th would know but he b) Date 5/30, R4's n therapy evaluate ch from May through J not include an evalue During the same intif fall interventions are nursing staff, the Do report. When asked	een identified or put into place ame and "call don't fall" was of what that meant, the DON a sign to R3's room that read ocumentation for falls on 7/17 ed 5/25/21, had an entry for R4 ed "falls" which indicated: name and "call don't fall." that meant, the DON stated o R4's room that read "call a sign was the most effective neone with a brain injury, the ed dated 6/3/21, had an entry ion titled "falls" which name and "crawl on floor said tress." When asked what that ated R4 slid off his bed and en a new mattress to prevent not know what kind of at the maintenance supervisor was on vacation. name and "slid out of chair - nair." Physical therapy notes lune were reviewed and did uation of R4's wheelchair. terview, when asked how new e communicated to the ON stated it was done at shift d what new fall interventions	F	889			
	During the same int fall interventions are nursing staff, the Dureport. When asked were identified for F	terview, when asked how new e communicated to the ON stated it was done at shift					

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		AND HUMAN SERVICES				FORM	09/06/2021 APPROVED 0938-0391
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		245184	B. WING				C 2 <b>8/2021</b>
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES		-	01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	the 6/3 fall, but had plan. The DON veri had been discussed on 6/2, 7/17 and 7/1 During the same int fall interventions we R4 after his three fa had been identified However the DON of mattress as the res facility. In addition, chair," but unable to The DON verified th been added to R4's DON admitted if the the care plan, nursi them. During an interview when asked for pos R4, DCS-C stated " you, but they don't of When pointed out th management guide completed, DCS-C and could not explat the expectation was fall. During an interview when asked what o prevent further falls nurse that a resider the DON, and the D new interventions. N about new fall interv "through the nursing	not been added to R3's care fied that no new interventions d or identified after R3's falls	F	589			

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		AND HUMAN SERVICES			FORM	09/06/2021 APPROVED 0938-0391
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		245184	B. WING			C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER EAST HEALTH S	SERVICES		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	department determ required to sign off fall and confirmed r including sling to m During an interview asked what her res fell, RN-B stated sh obtained vital signs completed a risk m informed the DON a can recommend fal moving the bed aga mat. When asked r would get passed o was passed on duri stated there were n care plan that she w RN-B, "when we se wheelchair, we hav fall." That had been 7/18/21. RN-B state leaning forward for and fell out of his w her evening shift at the hospital for eva 7/26/21). RN-B did and/or fall intervent training on slings ar resident fell from th During an interview TMA-A stated after out a way so it does the nurse and the D and tell them what the therapy was involve sign off on any new	ined an intervention, staff were on it. NA-G was aware of R1's re-training on lifts and slings, atch the lift manufacturer. on 7/28/21, at 2:20 p.m. when ponsibility was after a resident the assessed the resident and , notified the provider, anagement report and and family. RN-B stated she II interventions, for example ainst a wall or adding a fall now her recommendation onto other staff, RN-B stated it ing the 24 hour report. RN-B to new fall interventions in R3's was aware of and according to be R3 leaning forward in his to to lay him down to prevent a n passed on in report on ed apparently R3 had been most of the day on 7/18/21, wheelchair at the beginning of 2:50 p.m. RN-B sent R3 to luation (he returned on not recall R4 and his falls ions. RN-B verified recent nd mechanical lift after a	F 689			

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		AND HUMAN SERVICES				FORM	09/06/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245184	B. WING				C 28/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	not always." TMA-A fall interventions for interventions such a in the room remindi and floor mats. TMA training on use of lif slings and lifts bran During an interview administrator stated weekly WAR (week at-risk residents we team also reviewed by nursing staff on discussed everythir from there nursing and communicated administrator assur added to resident c to that. The adminis workload for nurse due to recent resign The facility Fall Pre Guidelines with revi fall as an episode w balance and would person or if he or sl Facility policy titled Management Guide 3/10/21, indicated th fall program for res for falls. A fall referr to rest on the grour resident lost his/her fallen, if not for ano not caught him/hers	age 17 A was not able to state specific r either R3 or R4, only general as call light within reach, a sign ing a resident to use call light A-A verified she had recent fts and slings and specifically ds needed to match. To n 7/28/21, at 3:57 p.m. the d falls were discussed at the dy at risk) meeting where ere discussed. The leadership the 24 hour report (generated each shift) each morning and ng from falls to behaviors, and identified fall prevention tactics them to the staff. The med interventions were being are plans, but could not speak strator was aware the leaders had been challenging nations of nurse managers. vention and Management ised date of 3/10/21, defined a where a resident lost his/her have fallen, if not for another he had not caught him/herself. Fall Prevention and elines with revised date of he facility would implement a idents determined to be at risk red to unintentionally coming nd. An episode where a r balance and would have ther person or if he or she had self, was considered a fall. ns would be developed based	F	689			

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		AND HUMAN SERVICES				FORM	09/06/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED
		245184	B. WING	i			C 28/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	individualized plan and communicated and comprehensive completed. After re assessment, a nurs with new intervention no longer appropria the interdisciplinary may include the rev potential root cause and revisions to the to the staff of any c review, it was deter interventions in the the rationale was to additional actions ta staff were to receiv	e fall assessment. An of care would be developed with staff. An investigation e fall risk assessment would be view, investigation, and se would update the care plan ons and remove interventions ate. Each fall was reviewed at r team meeting (IDT), which view of the investigation and e for the fall, review of updates e plan of care, and education are plan revisions. If after IDT	F	689			

Facility ID: 00953

If continuation sheet Page 19 of 19



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 18, 2021

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

Re: State Nursing Home Licensing Orders Event ID: FPE411

Dear Administrator:

The above facility was surveyed on July 26, 2021 through July 28, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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, Minnesota 56001 Email: elizabeth.silkey@state.mn.us Office: (507) 344-2742 Mobile: (651) 368-3593

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

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

Please feel free to call me with any questions.

Mi Thing

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

Minneso	ta Department of He	alth					
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				
	AND PLAN OF CORRECTION     DENTIFICATION NUMBER:     A BUILDINS:     C     C       00953     B. WING     C     07/28/2021       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     C     07/28/2021       ROCHESTER EAST HEALTH SERVICES     STREET ADDRESS, CITY, STATE, ZIP CODE     C     07/28/2021       MAKE OF PROVIDER OR SUPPLIER     SUMMARY STATEMENT OF DEPICENCIES     BCHCHENTER, MN 53904       PREFX     PREFX     PREFX     PREFX     PREFX     CROSS-REFERENCED TO THE APPROPRIATE     OWE       7AG     Initial Comments     2 000     PREFX     PREFX						
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	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item					
	that may result from orders provided tha the Department with	n non-compliance with these t a written request is made to hin 15 days of receipt of a					
	On 7/26/21 and 7/2 conducted at your f Minnesota Departm facility was found N State Licensure. Pla plan of correction you and identify the date	8/21, a complaint survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders					
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 08/27/21	

Electronically Signed

STATE FORM

If continuation sheet 1 of 20

ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00953	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00953	B. WING			28/2021
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The following complaint was found to be SUBSTANTIATED: H5184140C (MN00074948 and MN00074970) with a licensing order issued at 4658.0520.						
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-I Tag." The state sta listed in the "Summ column and replace the correction orde the findings which a statute after the sta as evidence by." Fo are the Suggested Time Period for Co You have agreed to receipt of State lice the Minnesota Dep Informational Bullet	participate in the electronic nsure orders consistent with				

Minnesota Department of Health STATE FORM

FPE411

If continuation sheet 2 of 20

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
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	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Proper Nursing Car	) Subp. 1 Adequate and e; General	2 830			9/8/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility fa guidelines for proper residents (R2, R11, of 14 residents who deficient practice re- jeopardy (IJ) for R1 and had the potenti R13, R8, R10, R12 following the manuf	ent is not met as evidenced on, interview and document ailed to follow manufacturer's er use of slings for eight R18, R13, R8, R10, R12, R9) o utilized full body lifts. This esulted in an immediate , who fell from the full body lift al for injury for R2, R11, R18, , R9 as a result of not facturer's guidance for proper the facility failed to assess and		See above		

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 830	Continued From pa	age 3	2 830			
	were implemented	upervision and interventions to reduce falls for 2 of 2 4) reviewed who sustained				
	licensed practical r assistant (NA)-A we body lift and R1 fel The administrator a were notified of the The IJ was remove however, noncomp scope and severity	(18/21, at 11:00 p.m. when hurse (LPN)-A and nursing ere transferring R1 with a full I out of the sling to the floor. and director of nursing (DON) e IJ on 7/26/21, at 7:04 p.m. ed on 7/28/21, at 3:30 p.m. bliance remained at the lower level of E, pattern, no actual for more than minimal harm.				
	Findings include:					
6 5 6 7 7 8 7 8 7 8 7 8 7 8 8 7 8 8 7 8	diagnoses which in sclerosis (ALS) (ne functionality in the dysphasia (languag person's ability to c	nted on 7/19/21, listed included amyothrophic lateral erve cells break down, reducing muscles they supply), ge disorder that affects a communicate), anxiety,and ysis of all four limbs).	3			
	assessment dated cognitively intact, h vision, unclear spe make self understo understand. R1 rec was dependent up full body lift for bed	nimum Data Set (MDS) 5/26/21, indicated R1 was ad adequate hearing and ech, was sometimes able to ood and could usually quired extensive assistance or on two staff and/or the use of a mobility, transfers, dressing, ng about in a wheelchair.				
	a) self-care deficit a dependence on oth	nitiated on 5/14/21, indicated: as evidenced by increased hers to complete activities of to disease progress and newly				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED C
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2 830	diagnosed ALS, an mechanical lift and functional mobility a ALS. Nursing would needed for transfer two staff. R1's care of sling nor size of body lift. R1's progress note LPN-A indicated: R lift used for a full bo feet from floor while hit her head and ba apparent injury but hospital via ambula hoyer occurred. R1's progress note by LPN-A indicated hospital with three and would probably days. During a telephone a.m., family member call on 7/18/21, tha hospital. FM-D was mechanical lift and her to fall three fee back on the ground happened. FM-D st full body lift; it scare certain staff using i and ask her why sh right way every time FM-D stated R1 wa	ige 4 d would require transfer with a assistance of two. b) impaired as evidenced by diagnosis of d provide assistance as s via total mechanical lift and plan did not indicate the type sling to be used with the full dated 7/19/21, at 4:15 a.m. by 1 fell from Hoyer (mechanical ody lift) approximately three e transferring to commode. R1 tck on the leg of hoyer. No R1 transferred to local unce. Unsure how fall from dated 7/19/21, at 4:30 a.m., : R1 was admitted to the rib fractures on the right side v be in the hospital for two interview on 7/26/21, at 10:02 er (FM)-D stated he received a t R1 was being sent to the something happened causing t hitting her head and lower l; but they didn't know how it tated R1 did not like using the ed her and she didn't trust t, but no one would listen to R1 te was afraid. "If they did it the e, she wouldn't be afraid." ts still in the hospital and was lid return to facility due to her				

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00953		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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2 830	Continued From page 5		2 830				
	During an interview on 7/26/21, at 11:10 a.m., (NA)-B stated there were three Invacare brand full body lifts one on each floor, and there were two different manufacturer slings being used with the lifts: Invacare and MedCare, adding "MedCare slings were not made for the Invacare lifts but we use them."						
	Manual dated 10/1 warning: Invacare s accessories are sp in conjunction with and accessories de manufacturers are	eview, the Invacare User 8/18, indicated the following slings and patient lift pecifically designed to be used Invacare patient lifts. Slings esigned by other not to be utilized as a care's patient lift system.					
	at 12:40 p.m. with wheelchair in the d sling, color navy wi	v and observation on 7/26/21, NA-B, R2 was sitting in a ining room on a MedCare ith gold trim. Per NA-B, R2 was t she ended up on a MedCare					
	(NA)-C stated the f brand of sling for th know the brand na crisscrossed the le was how she was t R1's fall from a lift retraining after the included to use an lift. Stated prior to	v on 7/26/21, at 12:45 p.m., facility used more than one ne mechanical lift, but didn't mes. Stated staff always gs on the sling, adding that trained. NA-C was aware of and stated she had recent incident, and the training Invacare sling with an Invacare recent training, did not know a he lift manufacturer should be	Ð				
	p.m. LPN-A verified	e interview on 7/26/21, at 1:10 d she was involved in the 7/18 1 fell from the full body lift.					

		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 07/28/2021		
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2 830	Continued From page 6		2 830				
	the commode. LPN looking at the comm were when sudden floor. LPN-A stated her back was over recalled the sling b didn't remember th LPN-A was certain crisscrossed aroun how she fell out; we before and nothing During an interview corporate director of stated she knew re specified by the me was not until the inter- she became aware more than one bran she became aware were ordered, but h residents who used still using MedCare R13, R8, R10, R12 sling had been use a large Invacare slii inspected the sling abnormalities, tears During an observat observed NA-B and						
	administrator ackne until R1's incident t lift manufacturer co	v on 7/26/21, at 1:46 p.m. the owledged he was unaware hat only slings specified by the ould be used with a lift. As a investigation of the fall, he had					

STATE FORM

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	slings to ensure all the proper sling. Fu was aware that nor be used with the In R13, R8, R10, R12 slings arrived. During an interview director of nursing slings were acquired wanted dialysis res the facility acquired were being used on with the Invacare fu was after R1's fall t manufacturer spec designed for their r aware that non-Inva used with the Invaca R8, R10, R12, R9 u arrived. During a telephone p.m. with the Invaca asked if it were pos was crisscrossed u and if the legs were person fall out of th was too big, it's pla stated the most like	hase of additional Invacare residents who used the lift hac urthermore, the administrator n-Invacare slings continued to avacare lift for R2, R11, R18, 2, R9 until additional Invacare v on 7/26/21, at 2:55 p.m., the (DON) stated the MedCare ed from the local hospital who sidents on this sling. Over time d more of the slings and they n non-dialysis residents and ull body lift. The DON stated it that she became aware of lift iffications to use only slings mechanical lift. The DON was acare slings continued to be care lift for R2, R11, R18, R13, until additional Invacare slings e interview on 7/26/21, at 3:07 are representative (IR)-E, was ssible when a split leg sling under and over a person's leg, e sticking out rigid, could a ne sling. IR-E stated if the sling usible, but very unlikely. IR-E ely cause would be that it the hanger bar properly. "One				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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	were used, it would would fall out. IR-E use of our slings w test anyone else's can't guarantee son properly in our lifts	even if an extra large sling be highly unlikely a person stated "we're very strict with ith our equipment. We can't slings. Our stance is clear: we meone else's sling will work and vice versa." IR-E was ident as the facility had not				
	DON stated the Inv been contacted to i company's lift, or to	y on 7/28/21, at 10:10 a.m. the vacare representative had not inform him of a fall from their o utilize his expertise for for staff education; "we hadn't				
	involved in R1's fall DCS-C, NA-A and Relias online learni Mechanical Lifts. D document dated 20 of the training and use of mechanical emphasis on abidir guidelines for opera part of an individua mechanical lift devi the manufacturers organizations polici included "You must manufacturer's spe are using. Never as one practice or piece mechanical lift that	ecific instructions for the lift you ssume that because you used ce of equipment for one you can use it for another type y result in equipment failure or				
		anscript listed the lift training				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
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		d on 7/14/19, and competency cal lift was validated on				
	2018 to 2020, did n Relias's online lear Mechanical Lifts. T	which included dates from not indicate completion of the ning module titled Safe Use of he facility was not able to nat LPN-A completed training hanical lifts.				
	Residents with revi indicated: In order to protect s would use appropri lift and move reside training and comple the mechanical lifts Residents who requ lift would be assess and size using the Registered nursing upon admission, wi an ongoing basis for This information wo care plan and karder required by residen times, and mainten	Safe Lifting and Movement of sed date of 8/19/2020, staff and residents, the facility ate techniques and devices to ents. Staff would receive ete a competency for use of prior to providing direct care. uired the use of a mechanical sed for the appropriate lift type Lift Mobility Status UDA. staff would assess residents th significant change, and on or need for transfer assistance. buld be documented in the exes. Sufficient slings in sizes its would be available at all ance would perform routine nance of equipment used for th the manufacturers				
	was removed on 7/ reviewed the Lift M residents who utiliz and kardexes were sling for each resid	pardy that began on 7/18/21, 28/21, when the facility's DON obility Status Assessment for ed full body lifts, care plans updated with size and type of ent. The facility initiated the ly ordered Invacare slings for				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	age 10	2 830			
	color-coded list for attached to each Ir as laminated instru- provide a quick, ea staff who complete staff on the Lift Mo assessment was co- vendor specific lift style. The facility mo on the use of full bo regarding the use of and sizing and use The DON or design staff demonstrated size and proper ap mechanical lifts However the nonco- lower scope and se	27/21. The facility developed a sling sizes were laminated and hvacare Reliant 450 Lift as well lictions for each type of sling to usily accessible reference for d training. The DON educated bility Assessment to ensure the ompleted in full and specified sling for type of lift and proper ursing staff were re-educated ody lift and specifically of Invacare slings, selection of these slings was provided. hee performed audits to ensure understanding of sling types, plication for full body ompliance remained at the everity level of E, pattern, no otential for more than minimal				
	diagnoses of ortho surgical amputation weakness, chronic bone caused by inf schizophrenia (seri people interpret rea R3's admission Min assessment dated cognitively intact, h vision, clear speec understood and co	nted on 7/28/21, indicated pedic aftercare following n of great toe, muscle osteomyelitis (inflammation of fection) of right foot and ankle, ious mental disorder in which ality abnormally), and diabetes. nimum Data Set (MDS) 5/24/21, indicated R3 was nad adequate hearing and h, was able to make self uld understand others. R3 assistance of two staff for bed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00953	B. WING		C 07/28/2021	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER EAST HEALTH	SERVICES 501 EIGI	HTH AVENUE S	OUTHEAST		
040 15			STER, MN 559	PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	dressing, toileting,	and hygiene. R3 did not walk.				
	5/24/21, indicated I when he was back with therapy followi toe. Used a wheel	essment (CAA) for falls dated R3 would return to group home to his baseline, was working ng amputation of right great chair and walker. R3 had a fall ion due to weakness and	9			
	5/19/21, and compl nurse (LPN)-D, ind had a history of one days, including a fr past 6 month prior	risk assessment, dated leted by licensed practical icated R3 was at risk for falls; e to two falls in the past 30 acture related to falls in the to admission. He had fall risk nedications and exhibited gait ns.				
	R3 was at risk for f of right great toe ar included:	nitiated on 5/27/21, indicated alls due to recent amputation and history of falls. Interventions				
	Medications as or Provide assistance	used articles within easy reach rdered. Se to transfer and ambulate as				
	Reinforce wheelc locking breaks.	o call for assistance. hair safety as needed such as				
	All of the above into 5/27/21. No new in	on and treat as ordered. erventions were initiated on terventions were added to the s on 6/2/21, 6/3/21, 7/17/21,				
	following:	ports for R3 indicated the m., R3 was found sitting on the	e			

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·····		PLETED
		00953	B. WING			C 28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SEBVICES	ITH AVENUE S			
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	wheelchair while sh leaned forward and from the wheelchair sustained. 6/3/21: At 11:04 p the floor next to the his back. R3 told R stand up and lost h sustained. 7/17/21: At 5:57 p self from bed to wh and assisted him to wheelchair and bed get in the chair but 7/18/21: At 2:50 p hallway with his know the floor and his wh resident informed s in his wheelchair and was sent to the hos returned to the faci	<ul> <li>a had been sitting in his the changed his bedding. R3</li> <li>d the NA assisted him to slide in to the floor. No injury</li> <li>b.m., R3 was found sitting on the bed with wheelchair behind RN-C that he was trying to his balance. No injury</li> <li>b.m., R3 attempted to transfer theelchair. Staff were present to the floor between the d. R3 stated he was trying to slipped. No injury sustained.</li> <li>b.m., R3 was found in the ees, hands and forehead on theelchair behind him. Another staff he saw R3 leaning forward nd assisted him to the floor. R3 spital for evaluation and lity on 7/27/21.</li> </ul>				
	diagnoses of traum space around the b consciousness, mu of gait and mobility age-related cognitiv cataracts (clouding	nted on 7/28/21, indicated natic subarachnoid (fluid filled prain) hemorrhage with loss of uscle weakness, abnormalities r, dementia, depression, ve decline, and bilateral g of the lens of the eye).				
	assessment dated cognitively intact, h adequate vision, cl self understood and required extensive mobility, transfers,	himum Data Set (MDS) 5/25/21, indicated R4 was ad moderate difficulty hearing, ear speech, was able to make d could understand others. R3 assistance of one staff for bed walking in room, locomotion dressing, toileting, and				

	PLETED	
	С	
	28/2021	
R'S PLAN OF CORRECTION	(X5)	
RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE	

STATE FORM

FPE411

If continuation sheet 14 of 20

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CONTRECTION	IDENTIFICATION NOWIDEN.	A. BUILDING: _			
		00953	B. WING			C 28/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OCHES	TER EAST HEALTH	SEBVICES	ITH AVENUE S STER, MN 559			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	and that R3 was ta on his toilet to prev and down from a lo other kind of fall int NA-F stated they re and floors, made su reach, and put sign use the call light. W made aware of fall NA-F stated after a residents care plan toilet riser was not plan. NA-F confirm	R4, however did recall R3, Il and a riser had been placed ent him from having to get up ow position. When asked what rerventions were used for R3, emoved clutter from his room ure his call light was within as in the room to remind him to Vhen asked how she was interventions for a resident, a fall, management updated with interventions. Use of a an intervention on R3's care ed recent training on slings brand of sling must match the				
	when the DON was addressed, specific and adding or mod interventions. The I documents titled "V and stated falls we	v on 7/28/21, at 11:12 a.m., s asked how resident falls were cally determining causal factors ifying existing fall risk DON presented three Var Meeting Key Indicators" re discussed at this meeting. ovided the following				
	entries for R3 under indicated: a) Date 6/2, R3's na asked what that me while self transferri interventions had b after that fall. b) Date 6/3, R3's na written. When asket stated they added a "call, don't fall."	ed 6/8/21, had two handwritten er a section titled "falls" which ame and the word "self." Wher eant, the DON stated R3 fell ng. The DON admitted no new been identified or put into place ame and "call don't fall" was ed what that meant, the DON a sign to R3's room that read ocumentation for falls on 7/17	1			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	<u></u>		
		00953	B. WING			C 28/2021
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	STER EAST HEALTH	SERVICES	ITH AVENUE S TER, MN 559			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	and 7/18.					
	under a section title a) Date 5/19, R4's When asked what they added a sign t don't fall." Asked if	ed 5/25/21, had an entry for R4 ed "falls" which indicated: name and "call don't fall." that meant, the DON stated to R4's room that read "call a sign was the most effective neone with a brain injury, the				
	for R4 under a sect indicated: a) Date 5/29, R4's slid from bed - mat meant, the DON st thought R4 was giv further falls, but dic mattress, adding th would know but he b) Date 5/30, R4's therapy evaluate ch from May through	ed dated 6/3/21, had an entry tion titled "falls" which name and "crawl on floor said tress." When asked what that ated R4 slid off his bed and yen a new mattress to prevent d not know what kind of nat the maintenance supervisor was on vacation. name and "slid out of chair - nair." Physical therapy notes June were reviewed and did uation of R4's wheelchair.				
	fall interventions ar nursing staff, the D report. When asked were identified for I admitted only the s the 6/3 fall, but hac plan. The DON ver	terview, when asked how new re communicated to the ON stated it was done at shift d what new fall interventions R3 after his four falls, the DON ign had been identified after a not been added to R3's care ified that no new interventions d or identified after R3's falls 18.				
	fall interventions w	terview, when asked what new ere discussed and identified for alls, the DON stated the sign				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING: _			
		00953	B. WING			C 28/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OCHES	TER EAST HEALTH	SERVICES	HTH AVENUE S STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	However the DON mattress as the res facility. In addition, chair," but unable t The DON verified t been added to R4's DON admitted if th	I, as well as new mattress. could not verify what type of sident was no longer in the therapy was to "evaluate to determine if that was done. hese interventions had not s care plan after his falls. The e fall interventions were not on ing staff would not be aware of				
	when asked for por R4, DCS-C stated you, but they don't When pointed out to management guide completed, DCS-C and could not expla	v on 7/28/21, at 1:42 p.m., st-fall assessments for R3 and "I wish I could give them to exist, they weren't done." the facility fall prevention and elines indicated they must be s stated she was aware of that ain why they were not done; is they were done after each				
	when asked what of prevent further falls nurse that a reside the DON, and the I new interventions. about new fall inter "through the nursin someone tells us." department determ required to sign off fall and confirmed	v on 7/28/21, at 2:10 p.m., occurred after a resident fall to s, NA-G stated NA's inform a nt fell and the nurse informs DON and therapy decided any When asked how NA's learned ventions, NA-G stated og channel." "Usually verbal; NA-G added that if the therapy nined an intervention, staff were to nit. NA-G was aware of R1's re-training on lifts and slings, natch the lift manufacturer.	/			
	asked what her res fell, RN-B stated sh	v on 7/28/21, at 2:20 p.m. wher sponsibility was after a resident ne assessed the resident and s, notified the provider,				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00953	B. WING			C 28/2021
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROCHES	TER EAST HEALTH	SERVICES	HTH AVENUE S STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	informed the DON can recommend fa moving the bed aga mat. When asked H would get passed of was passed on dur stated there were r care plan that she RN-B, "when we se wheelchair, we hav fall." That had been 7/18/21. RN-B state leaning forward for and fell out of his w her evening shift at the hospital for eva 7/26/21). RN-B did and/or fall intervent	anagement report and and family. RN-B stated she Il interventions, for example ainst a wall or adding a fall how her recommendation onto other staff, RN-B stated it ring the 24 hour report. RN-B no new fall interventions in R3's was aware of and according to be R3 leaning forward in his re to lay him down to prevent a n passed on in report on ed apparently R3 had been most of the day on 7/18/21, wheelchair at the beginning of t 2:50 p.m. RN-B sent R3 to aluation (he returned on not recall R4 and his falls tions. RN-B verified recent nd mechanical lift after a ne lift.	6			
	TMA-A stated after out a way so it does the nurse and the I and tell them what therapy was involve sign off on any new new interventions of not always." TMA-A fall interventions fo interventions such in the room remind and floor mats. TM training on use of li	y on 7/28/21, at 2:50 p.m., a resident fell, "they figured sn't happen again," adding tha DON would get back to them to do for fall interventions. If ed, they required nursing to y interventions. "Sometimes get added to the care plan but A was not able to state specific r either R3 or R4, only general as call light within reach, a sig ing a resident to use call light A-A verified she had recent fts and slings and specifically nds needed to match.				
		on 7/28/21, at 3:57 p.m. the d falls were discussed at the				

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		501 FIG				
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(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
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2 830	Continued From pa	age 18	2 830			
	weekly WAR (weel	kly at risk) meeting where				
		ere discussed. The leadership				
	team also reviewed	d the 24 hour report (generated	k			
		each shift) each morning and				
		ng from falls to behaviors, and				
		identified fall prevention tactics	5			
		them to the staff. The				
		med interventions were being care plans, but could not speak				
		strator was aware the				
		leaders had been challenging				
		nations of nurse managers.				
		evention and Management				
		vised date of 3/10/21, defined a	L			
		where a resident lost his/her				
		have fallen, if not for another he had not caught him/herself.				
	person or in the or s	she had not caught him/hersell				
	Facility policy titled	Fall Prevention and				
		elines with revised date of				
	3/10/21, indicated	the facility would implement a				
		idents determined to be at risk				
		red to unintentionally coming				
		nd. An episode where a				
		r balance and would have				
		other person or if he or she hac self, was considered a fall.	1			
		ons would be developed based				
		e fall assessment. An				
		of care would be developed				
		with staff. An investigation				
		e fall risk assessment would be	e			
		eview, investigation, and				
		se would update the care plan				
		ons and remove interventions				
		ate. Each fall was reviewed at				
		y team meeting (IDT), which				
		view of the investigation and				
	potential root caus	e for the fall, review of updates				

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 07/28/2021	
		00953				
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETE	
2 830	Continued From page 19		2 830			
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
Vinnesota Department of Health						