Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 11, 2025

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

RE: CCN: 245184
Cycle Start Date: September 9, 2025

Dear Administrator:

On November 18, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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December 11, 2025

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

Re: Reinspection Results
Event ID: 1D4BDB-H1

Dear Administrator:

On November 18, 2025, 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 September 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0899
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Protecting, Maintaining and Improving the Health of All Minnesotans

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September 22, 2025

Administrator
Rochester East Health Services
501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

RE: CCN:245184

Cycle Start Date: September 10, 2025

Dear Administrator:

On September 10, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 10, 2025, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 10, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

INFORMAL DISPUTE RESOLUTION (IDR)
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

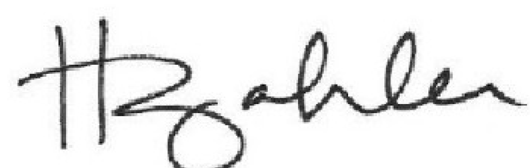
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245184**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 9/9/25 and 9/10/25, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51842601C (2594126) and H51843181C (2601468) with deficiencies cited at F842 and F554. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F0000		10/01/2025
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to complete a comprehensive assessment for self-administration of medications for 1 of 1 resident (R1) reviewed for respiratory and oxygen. Findings include: R1's face sheet dated 9/10/25, identified diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe) and asthma (a condition in which a person's airway becomes inflamed, narrows, swells, and produces mucus). R1's Admission Minimum Data Set (MDS) dated 8/18/25 identified R1was oxygen dependent and had moderate impaired cognition.	F0554	On 9/10/25, Resident R1 received a comprehensive assessment for self-administration of medications, including oxygen. The assessment was documented in the resident's clinical record and incorporated into the comprehensive care plan. On 9/26/25, the attending physician was notified and nursing requested a an order to store medications in room and self administer inhaler medications per resident request. No adverse outcomes were identified for R1. On 9/25/25, the Director of Nursing (DON) initiated a facility-wide audit of all residents who currently self-administer medications, including respiratory and oxygen therapy. On 9/26/25, residents identified were reviewed to ensure a comprehensive assessment for self-administration of medications had been completed and documented. No other residents were found to be without a completed assessment. On 9/22/25, the facility revised the Person-Centered Medication Administration Policy to specify that a	09/30/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0554 SS = D	Continued from page 1 R1’s care plan focus dated 8/12/25, identified R1 was at risk for respiratory impairment with a goal to not develop acute respiratory distress. Interventions were as followed: administer medications as ordered; administer oxygen as ordered; encourage deep breathing exercises; and elevate head of bed. R1’s physician orders included the following: -Ventolin (inhaler used to treat or prevent bronchospasm-airway tightening) inhaler to take one puff every four hours as needed (PRN) for wheezing or shortness of breath (start date of 8/12/25). -Dulera (corticosteroid) inhaler to take two puffs twice daily for COPD (start date of 8/12/25). R1’s progress note dated 8/14/25, identified R1 self-administered Dulera inhaler due it being in her pocket. R1’s progress note dated 9/9/25 at 5:33 p.m., identified R1 had taken her Dulera inhaler shortly after lunch and had medication in pocket. R1's record did not include a comprehensive self-administration of medication assessment nor a physician's order for R1 to self-administering medications per facility policy. During an interview and observation on 9/9/25 at 4:52 p.m., registered nurse (RN)-A entered R1’s room to administer Dulera inhaler. R1 informed RN-A that she would not take another dose, because she had already self-administered the medication earlier. RN-A then informed R1 that the dose of Dulera was scheduled and she still would need to take the dose. R1 stated to RN-A, “I don’t want to take it, because then I would get a double dose.” R1 then removed a clear baggie out of her left pocket that contained two inhalers (Ventolin and Dulera). R1 stated she had asked her daughter to bring the inhalers from home, because in the event she becomes short of breath she needed to have quick access to her inhalers, and “I do not have time to find a nurse to get them for me.” R1 had informed staff she wanted to be able to continue to administer them herself, however, staff told her the	F0554	Continued from page 1 comprehensive self-administration of medication assessment must be completed: prior to initiation of resident self-administration of any medication or treatment, including oxygen, and reviewed quarterly, upon change of condition, and annually. Nursing staff and interdisciplinary team members were re-educated starting on 9/30/25, regarding Minnesota Rule 4658.0400, Subp. 5, and CMS requirements for resident self-administration assessments. Beginning 9/29/25, the DON or designee will review all new admissions and any residents initiating self-administration of medications to ensure a comprehensive assessment for self-administration of medications is completed and documented. Reviews will be conducted weekly for four weeks, then monthly for three months, and results will be presented to the QAPI Committee for monitoring. Completion date: September 30, 2025. Responsible party: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245184**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/10/2025**

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F0554 SS = D	Continued from page 2 inhalers need to be kept in the medication cart, so R1 stated “I just keep them in my pocket then”. During an interview on 9/9/25 at 5:10 p.m., RN-A stated a self-administration medication assessment needed to be completed prior to a resident to be able to keep medications at bedside and be able to self-administer such medications. RN-A stated she had been aware that R1 had the Ventolin and Dulera inhalers in her possession for at least two weeks and had been self-administering the medications herself at times, however, R1 had not had a comprehensive assessment completed to determine if she was able to self-administer the inhalers. During an interview and observation on 9/10/25 at 7:23 a.m., R1 was in her wheelchair sitting in the doorway of her room and informed RN-B she administered her Dulera inhaler and would not need to have a dose. RN-B stated she had been aware R1 had two inhalers (Ventolin and Dulera) in her pocket for the last couple of weeks and had been administering them herself, however, R1 had not had a comprehensive assessment completed to determine if she was capable to administer the medications. During an interview on 9/10/25 at 1:43 p.m., director of nursing (DON) stated R1 had not had a self-administer medication assessment completed due to her not being aware R1 had the inhalers on her person and wanted to self-administer and keep at bedside. DON stated all residents who chose to self-administer medication should have a comprehensive assessment completed to determine if they are able to administer the medications safely and appropriately, however, R1 had not had this completed. Review of the facility’s Self-Administration by Resident Policy dated 1/23, identified residents who desire to self-administer medications are permitted to do so with a prescriber’s order and if the nursing care center’s interdisciplinary team (IDT) has determined that the practice would be safe and the medications are appropriate and safe for self-administration.	F0554		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F0842	On 9/10/25, the medical records of R1 and R4 were immediately reviewed. Missing or incomplete documentation was corrected and entered in each resident’s chart.	09/30/2025

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F0842 SS = D	Continued from page 3 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F0842	Continued from page 3 On 9/10/25, Each resident's physician and responsible party were notified of the corrections. No adverse outcomes were identified for R1 or R4. On 9/30/25, Director of Nursing (DON) initiated process to have all signed orders received to be uploaded under documents on EHR. An audit of all resident medical records was completed on 9/29/25 to verify that they are complete, accurate, and readily accessible. Any identified deficiencies were corrected promptly.\ On 9/22/25, the facility updated its Release of Medical Records Policy to clarify responsibilities for timely, accurate, and complete documentation, in accordance with Minnesota Rule 4658.1325. Nursing staff, department heads, and medical records personnel were re-educated starting on 9/30/25 regarding documentation standards, timely entry, and procedures for maintaining accessibility of records. Beginning 10/6/25, the Director of Nursing or designee will review 5 resident charts weekly for four weeks, then 3 charts monthly for three months, to ensure records are complete, accurate, and readily accessible according to signed physician orders. Audit results will be reviewed in monthly QAPI meetings. Any concerns identified will be corrected immediately, and staff re-educated as needed. Completion date: September 30, 2025 Responsible party: Director of Nursing	

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F0842 SS = D	Continued from page 4 §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to maintain a complete, accurate, and readily accessible medical record for 2 of 4 residents (R1, R4) reviewed for medical record accuracy. Findings include: R1’s face sheet dated 9/10/25, identified diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), asthma (a condition in which a person’s airway becomes inflamed, narrow, and swell, and produce mucus). R1’s Admission Minimum Data Set (MDS) dated 8/18/25, identified R1was oxygen dependent. R1’s care plan focus dated 8/12/25, identified R1 was at risk for respiratory impairment with a goal to not develop acute respiratory distress. Interventions were	F0842		

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F0842 SS = D	Continued from page 5 as followed: administer medications as ordered; administer oxygen as ordered; encourage deep breathing exercises; and elevate head of bed. R1’s physician orders included the following: -Oxygen continuous at 3 liters/minute (L/min) via nasal cannula (NC) (start date 8/12/25 with an end date of 9/9/25) R1’s physician progress note dated 8/19/25, included order placed for oxygen at 2 L/min via NC-wean as tolerable; R1’s electronic health record (EHR) did not identify the order for oxygen 2 L was transcribed into the physician’s orders as directed. R1’s August and September 2025 treatment administration record (TAR), identified the physician order for oxygen at 3 L via NC every shift but did not identify the order written by the physician on 8/19/25. In review of the TAR in conjunction with progress notes, it could not be ascertained how much oxygen R1 was administered; R1’s TAR identified R1 received 3 L of oxygen from 8/12/25 through 9/8/25 except when documentation identified R1 refused oxygen the evening shifts of 8/26/25 and 9/7/25, and on the day shift of 9/9/25. Even though the TAR identified 3L was administered, R1’s progress notes identified R1 was administered 2L of oxygen on 8/14/25; 8/19/25; 8/25/25; 8/29/25; 8/31/25; 9/1/25; and 9/7/25. R1’s progress note dated 9/9/25, included a Situation Background Assessment Response (SBAR) was sent to the physician to inform them that R1 refused to wear continuous oxygen and had not used for two days and would like to change oxygen to as needed (PRN). During an interview on 9/10/25 at 10:40 a.m., registered nurse (RN)-C stated R1’s TAR was not accurate. R1's TAR consistently showed that R1 was receiving 3 L of oxygen, however, R1's progress notes identified R1 was administered 2 L of oxygen at times. RN-C indicated she had written the SBAR notification to the physician pertaining to R1's oxygen usage. RN-C noted R1's record did not have documentation of refusals. RN-C had received verbal reports from nurses that R1 had been refusing her oxygen; she based the notification to the physician on verbal reports and not what was documented.	F0842		

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F0842 SS = D	Continued from page 6 During an interview on 9/10/25 at 7:43 a.m. RN-B stated he documented in R1’s progress notes that 2 L of oxygen was administered, however, documented in the TAR that R1 received 3 L of oxygen. RN-B stated that this would make R1’s medical record inaccurate. During an interview on 9/10/25 at 1:43 p.m., director of nursing (DON) stated R1’s 8/19/25 physician order to change oxygen to 2 L per minute- wean as tolerable, was not entered into R1’s medical record and the physician order for R1’s oxygen remained at 3 L continuous, however, R1’s progress notes identified that R1 had been getting oxygen at 2 L and the TAR was being signed since 8/12/25 that R1 was getting 3 L of oxygen. DON stated R1’s record was inaccurate due to conflicting information regarding oxygen use. R4’s face sheet dated 9/11/25, identified diagnoses of chronic kidney disease, cellulitis of left toe, diabetes, and heart failure. R4’s Significant Change Minimum Data Set (MDS) dated 9/2/25, identified R4 received dialysis and was taking an antibiotic. R4’s hospital after visit summary (AVS) dated 8/27/25, included a physician order for Augmentin (antibiotic) 500 milligram (mg)-125 mg take one tablet by mouth two times per day for 28 doses. R4’s electronic health record (EHR) physician orders identified an order entered into the system as a verbal order dated 8/28/25 for Augmentin 500 mg-125 mg give one tablet twice daily for 28 administrations with a start date of 8/28/25. The order was updated on 8/29/25 to identify a stop date of 8/29/25. There was no further information regarding the stop date of the order. In review of R4's record which included but was not limited to progress notes, physician's orders, and documents electronically scanned into the "MISC" tab of the facility's EHR system there was no corresponding written order and/or physician note that addressed the discontinuation of the antibiotic that was on the hospital AVS dated 8/27/25.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245184**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = D	Continued from page 7 During an interview on 9/10/25 at 5:30 p.m. RN-D reviewed R4's facility electronic records and was unable to find a physician order and/or visit note that addressed the discontinuation of the Augmentin on 8/29/25 and indicted she did not know where it would be or came from. During an interview on 9/10/25 at 9:06 a.m. health unit coordinator (HUC) stated she had access to the outside medical records but was not aware of the process on who was responsible for pulling the notes out of the outside EHR to make sure they got into the resident's medical record at the facility. During an interview on 9/10/25 at 5:40 p.m., DON reviewed R4's facility electronic records and confirmed the record did not address the discontinuation of Augmentin. DON referenced a clinic/hospital outside record system that the facility staff had access to so that they could retrieve clinic and/or hospital records. DON logged into the outside EHR system and was able to locate a nurse practitioner note dated 8/29/25 that identified R4 was to receive intravenous cefepime (antibiotic) with dialysis through 9/5/25. DON explained there was only certain staff that had access to the clinic/hospital EHR; herself, nurse managers, and health unit coordinator. During the interview the DON did not specify a process/system pertaining to how the documents were downloaded from the outside EHR and uploaded to the facility's EHR. Review of the facility's Medical Record Policy dated 11/12/19, identified medical record documentation will be done according to the resident's level of care. Documentation will occur when an activity, event, or incident that is not usual for the resident or change in level of assistance occurs.	F0842		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 22, 2025

Administrator
Rochester East Health Services
501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

Re: State Nursing Home Licensing Orders
Event ID: 1D4BDB-H1

Dear Administrator:

The above facility survey was completed on September 10, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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 only a suggestion 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/9/25 and 9/10/25, a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		10/01/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

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20000	Continued from page 1 The following complaints were reviewed: H51842601C (2594126) and H51843181C (2601468) with a licensing order issued at 0625 and 1565. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation /infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure,	20625	Corrected	09/30/2025

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20625	Continued from page 2 according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent	20625		

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20625	Continued from page 3	20625		

Continued from page 3

comprehensive assessments as described in part 4658.0400.

This LICENSURE REQUIREMENT is NOT MET as evidenced by:

Based on interview and document review the facility failed to maintain a complete, accurate, and readily accessible medical record for 2 of 4 residents (R1, R4) reviewed for medical record accuracy.

Findings include:

Findings include:

R1's face sheet dated 9/10/25, identified diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), asthma (a condition in which a person's airway becomes inflamed, narrow, and swell, and produce mucus).

R1's Admission Minimum Data Set (MDS) dated 8/18/25, identified R1was oxygen dependent.

R1's care plan focus dated 8/12/25, identified R1 was at risk for respiratory impairment with a goal to not develop acute respiratory distress. Interventions were as followed: administer medications as ordered; administer oxygen as ordered; encourage deep breathing exercises; and elevate head of bed.

R1's physician orders included the following:

-Oxygen continuous at 3 liters/minute (L/min) via nasal cannula (NC) (start date 8/12/25 with an end date of 9/9/25)

R1's physician progress note dated 8/19/25, included order placed for oxygen at 2 L/min via NC-wean as tolerable; R1's electronic health record (EHR) did not identify the order for oxygen 2 L was transcribed into the physician's orders as directed.

R1's August and September 2025 treatment administration record (TAR), identified the physician order for oxygen at 3 L via NC every shift but did not identify the order written by the physician on 8/19/25. In review of the TAR in conjunction with progress notes, it could not be ascertained how much oxygen R1 was administered; R1's TAR identified R1 received 3 L of

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20625	Continued from page 4 oxygen from 8/12/25 through 9/8/25 except when documentation identified R1 refused oxygen the evening shifts of 8/26/25 and 9/7/25, and on the day shift of 9/9/25. Even though the TAR identified 3L was administered, R1’s progress notes identified R1 was administered 2L of oxygen on 8/14/25; 8/19/25; 8/25/25; 8/29/25; 8/31/25; 9/1/25; and 9/7/25. R1’s progress note dated 9/9/25, included a Situation Background Assessment Response (SBAR) was sent to the physician to inform them that R1 refused to wear continuous oxygen and had not used for two days and would like to change oxygen to as needed (PRN). During an interview on 9/10/25 at 10:40 a.m., registered nurse (RN)-C stated R1’s TAR was not accurate. R1's TAR consistently showed that R1 was receiving 3 L of oxygen, however, R1's progress notes identified R1 was administered 2 L of oxygen at times. RN-C indicated she had written the SBAR notification to the physician pertaining to R1's oxygen usage. RN-C noted R1's record did not have documentation of refusals. RN-C had received verbal reports from nurses that R1 had been refusing her oxygen; she based the notification to the physician on verbal reports and not what was documented. During an interview on 9/10/25 at 7:43 a.m. RN-B stated he documented in R1’s progress notes that 2 L of oxygen was administered, however, documented in the TAR that R1 received 3 L of oxygen. RN-B stated that this would make R1’s medical record inaccurate. During an interview on 9/10/25 at 1:43 p.m., director of nursing (DON) stated R1’s 8/19/25 physician order to change oxygen to 2 L per minute- wean as tolerable, was not entered into R1’s medical record and the physician order for R1’s oxygen remained at 3 L continuous, however, R1’s progress notes identified that R1 had been getting oxygen at 2 L and the TAR was being signed since 8/12/25 that R1 was getting 3 L of oxygen. DON stated R1’s record was inaccurate due to conflicting information regarding oxygen use. R4’s face sheet dated 9/11/25, identified diagnoses of chronic kidney disease, cellulitis of left toe, diabetes, and heart failure.	20625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

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20625	Continued from page 5 R4's Significant Change Minimum Data Set (MDS) dated 9/2/25, identified R4 received dialysis and was taking an antibiotic. R4's hospital after visit summary (AVS) dated 8/27/25, included a physician order for Augmentin (antibiotic) 500 milligram (mg)-125 mg take one tablet by mouth two times per day for 28 doses. R4's electronic health record (EHR) physician orders identified an order entered into the system as a verbal order dated 8/28/25 for Augmentin 500 mg-125 mg give one tablet twice daily for 28 administrations with a start date of 8/28/25. The order was updated on 8/29/25 to identify a stop date of 8/29/25. There was no further information regarding the stop date of the order. In review of R4's record which included but was not limited to progress notes, physician's orders, and documents electronically scanned into the "MISC" tab of the facility's EHR system there was no corresponding written order and/or physician note that addressed the discontinuation of the antibiotic that was on the hospital AVS dated 8/27/25. During an interview on 9/10/25 at 5:30 p.m. RN-D reviewed R4's facility electronic records and was unable to find a physician order and/or visit note that addressed the discontinuation of the Augmentin on 8/29/25 and indicted she did not know where it would be or came from. During an interview on 9/10/25 at 9:06 a.m. health unit coordinator (HUC) stated she had access to the outside medical records but was not aware of the process on who was responsible for pulling the notes out of the outside EHR to make sure they got into the resident's medical record at the facility. During an interview on 9/10/25 at 5:40 p.m., DON reviewed R4's facility electronic records and confirmed the record did not address the discontinuation of Augmentin. DON referenced a clinic/hospital outside record system that the facility staff had access to so that they could retrieve clinic and/or hospital records. DON logged into the outside EHR system and was able to locate a nurse practitioner note dated 8/29/25	20625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER: **Rochester East Health Services**		STREET ADDRESS, CITY, STATE, ZIP CODE: **501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**	

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20625	Continued from page 6 that identified R4 was to receive intravenous cefepime (antibiotic) with dialysis through 9/5/25. DON explained there was only certain staff that had access to the clinic/hospital EHR; herself, nurse managers, and health unit coordinator. During the interview the DON did not specify a process/system pertaining to how the documents were downloaded from the outside EHR and uploaded to the facility's EHR. Review of the facility’s Medical Record Policy dated 11/12/19, identified medical record documentation will be done according to the resident’s level of care. Documentation will occur when an activity, event, or incident that is not usual for the resident or change in level of assistance occurs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to verifying and transcribing orders in the electronic medical record and/or develop a monitoring system to ensure resident records are true and accurate. The director of nursing or designee should educate staff and perform measurable audits. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20625		
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: F554 Based on observation, interview, and document review, the facility failed to complete a comprehensive assessment for self-administration of medications for 1 of 1 resident (R1) reviewed for respiratory and oxygen. Findings include:	21565	Corrected	09/30/2025

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

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21565	Continued from page 7	21565		

Continued from page 7

R1’s face sheet dated 9/10/25, identified diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe) and asthma (a condition in which a person’s airway becomes inflamed, narrows, swells, and produces mucus).

R1’s Admission Minimum Data Set (MDS) dated 8/18/25 identified R1was oxygen dependent and had moderate impaired cognition.

R1’s care plan focus dated 8/12/25, identified R1 was at risk for respiratory impairment with a goal to not develop acute respiratory distress. Interventions were as followed: administer medications as ordered; administer oxygen as ordered; encourage deep breathing exercises; and elevate head of bed.

R1’s physician orders included the following:

-Ventolin (inhaler used to treat or prevent bronchospasm-airway tightening) inhaler to take one puff every four hours as needed (PRN) for wheezing or shortness of breath (start date of 8/12/25).

-Dulera (corticosteroid) inhaler to take two puffs twice daily for COPD (start date of 8/12/25).

R1’s progress note dated 8/14/25, identified R1 self-administered Dulera inhaler due it being in her pocket.

R1’s progress note dated 9/9/25 at 5:33 p.m., identified R1 had taken her Dulera inhaler shortly after lunch and had medication in pocket.

R1's record did not include a comprehensive self-administration of medication assessment nor a physician's order for R1 to self-administering medications per facility policy.

During an interview and observation on 9/9/25 at 4:52 p.m., registered nurse (RN)-A entered R1’s room to administer Dulera inhaler. R1 informed RN-A that she would not take another dose, because she had already self-administered the medication earlier. RN-A then informed R1 that the dose of Dulera was scheduled and she still would need to take the dose. R1 stated to RN-A, “I don’t want to take it, because then I would get a double dose.” R1 then removed a clear baggie out of her left pocket that contained two inhalers (Ventolin and Dulera). R1 stated she had asked her daughter to bring the inhalers from home, because in the event she becomes short of breath she needed to

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21565	Continued from page 8	21565		

have quick access to her inhalers, and “I do not have time to find a nurse to get them for me.” R1 had informed staff she wanted to be able to continue to administer them herself, however, staff told her the inhalers need to be kept in the medication cart, so R1 stated “I just keep them in my pocket then”.

During an interview on 9/9/25 at 5:10 p.m., RN-A stated a self-administration medication assessment needed to be completed prior to a resident to be able to keep medications at bedside and be able to self-administer such medications. RN-A stated she had been aware that R1 had the Ventolin and Dulera inhalers in her possession for at least two weeks and had been self-administering the medications herself at times, however, R1 had not had a comprehensive assessment completed to determine if she was able to self-administer the inhalers.

During an interview and observation on 9/10/25 at 7:23 a.m., R1 was in her wheelchair sitting in the doorway of her room and informed RN-B she administered her Dulera inhaler and would not need to have a dose. RN-B stated she had been aware R1 had two inhalers (Ventolin and Dulera) in her pocket for the last couple of weeks and had been administering them herself, however, R1 had not had a comprehensive assessment completed to determine if she was capable to administer the medications.

During an interview on 9/10/25 at 1:43 p.m., director of nursing (DON) stated R1 had not had a self-administer medication assessment completed due to her not being aware R1 had the inhalers on her person and wanted to self-administer and keep at bedside. DON stated all residents who chose to self-administer medication should have a comprehensive assessment completed to determine if they are able to administer the medications safely and appropriately, however, R1 had not had this completed.

Review of the facility’s Self-Administration by Resident Policy dated 1/23, identified residents who desire to self-administer medications are permitted to do so with a prescriber’s order and if the nursing care center’s interdisciplinary team (IDT) has determined that the practice would be safe and the medications are appropriate and safe for self-administration.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies for self-administration of medication according to evidence-based practices/procedures. Nursing staff should be educated as necessary to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
21565	Continued from page 9 importance of ensuring the resident is deemed capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff should also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, should audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee should take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		