Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 26, 2023

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: CCN: 245306
Cycle Start Date: August 22, 2023

Dear Administrator:

On September 20, 2023, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 26, 2023

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

Re: Reinspection Results
Event ID: 156712

Dear Administrator:

On September 20, 2023, 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 August 22, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 5, 2023

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: CCN: 245306
Cycle Start Date: August 22,2023

Dear Administrator:

On August 22, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 November 22, 2023, (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 February 22, 2024, (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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September 5, 2023

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: 156711

Dear Administrator:

The above facility was surveyed on August 21, 2023, through August 22, 2023, 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 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.

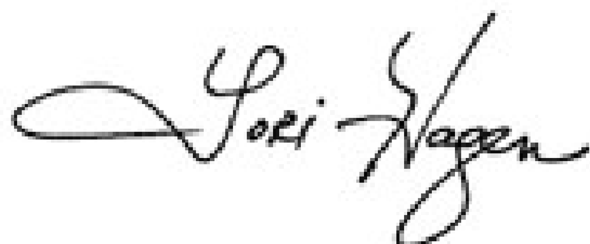
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 contact me with any questions regarding this letter.

Sincerely,



Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING ______ B. WING ______	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/21/23 and 8/22/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53064490C (MN95820) and H53064618C (MN85200) with a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a resident's environment	F 689	Plan of Correction	9/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/11/2023

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

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F 689

Continued From page 1

remained free from accidents as possible to prevent falls for 2 of 3 residents (R2 and R3) reviewed for falls when there was a lack of evaluation of factors to prevent future falls.

Findings include:

R2's face sheet printed 8/22/23 indicated R2's original admission date was 7/25/19, R2 readmitted to the facility on 7/19/22, discharged and was readmitted again on 12/26/22. R2's diagnosis included but not limited to chronic obstructive pulmonary disease, abnormalities of gait and mobility, dementia, blindness of right eye, and low vision in left eye.

R2's care plan admission date 12/26/22 initiated, revised on:
-Revised on 6/15/23, initiated on 7/25/19, R2 was at risk for falls due to deconditioning, weakness, and had a history of falls. Interventions included to anticipate and meet resident needs, to use call light, provide education on fall prevention measures, assure resident that using the call light is not a bother, encourage complete seated chair exercises for strength, use appropriate footwear, follow therapy recommendations for transfers, mobility and ambulation, no pillows behind her back while in recliners, encourage good seated positioning, R2 to use recliner remote, answer call light promptly, leave bedside lamp on lowest setting during overnight hours, review information on past falls and attempt to determine cause, prevention, to minimize falls, wear grippy socks and shoes.
-Revised on 6/15/23, initiated on 8/5/19, R2 was incontinent of urine due to functional and stress incontinence. Interventions included staff to assist R2 to the bathroom on nightly rounds, awaken

F 689

This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied.

R2 continues to receive care and services at the facility. Care plans were reviewed and updated based on IDT review and focused root cause analysis. R3 no longer resides at the facility.

Residents who experience a fall have the potential to be impacted by the alleged practice. Falls packets were revised to include root cause analysis worksheets. The morning meeting agenda was revised to include IDT review of falls with a focus on root cause analysis.

Education was provided to licensed nurses and nursing assistants by the Director of Nursing beginning August 22, 2023. Education included review of the updated falls packets, basic components of root cause analysis and required documentation after a fall event.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 2 around 2:00 a.m. for toileting and that the resident believe this routine would help with early morning incontinence. Check R2 for incontinence for before and after meals, and as needed. Communicate any changes in urinary status to the nurse and physician immediately. When offering toileting, if R2 refuses remind R2 she needs assistance and she should not toilet herself as resident has cognitive impairment and watch for signs of restlessness, agitation, holding peri area, crying, calling out, and verbalizing need. -Revised on 6/15/23, initiated on 11/19/19, R2 was at risk for adverse effects related to medications. Interventions included notify physician of decline in activities of daily living ability for positioning and ambulation. -Revised on 6/15/23, initiated on 1/17/22, R2 had alteration to bowel incontinence. Interventions included to keep call light close to R2 and remind to use, limit caffeine and foods with sugar alcohols, monitor bowel frequency, provide assistance to toilet, use incontinent briefs for protection. -Revised on 6/15/23, initiated on 4/28/22, R2 had alteration in respiratory status due to chronic obstructive pulmonary disease. Interventions included staff were to monitor for hypotension, dizziness, unsteady gait, seating, nausea, and cramping that may increase the risk of falls. -Revised on 6/15/23, initiated on 4/28/22, R2 had impaired vision. Interventions included to keep frequently used items within easy reach, provide assistances as needed. -Revised on 6/15/23, initiated on 7/22/22, R2 was resistive to care, frequently attempts to self-transfer, cognitive impairment, and lack of understanding for personal safety. Interventions included to allow for flexibility in activities of daily	F 689	The director of nursing or designee will complete formal audits of falls twice weekly for four weeks then weekly for four weeks. Results of audits will be submitted to the Quality Assurance committee for review and recommendations. Audits will begin the week of September 11th. Date of compliance is Sept 18, 2023	

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F 689	Continued From page 3	F 689		

living, use a chair alarm that notifies the nursing station, include family for best approaches, reapproach, inform in advance of cares to deliver, give two choice options.
-Revised on 7/6/23, initiated on 8/6/19, R2 had a self-care deficit related to physical limitations. Interventions included R2 required assistance with showers, assistance with one staff with a gait belt for all transfers, R2 was independent with bed mobility. R2 required prompt voiding program upon rising in the morning after breakfast, before and after lunch/supper, on nightly rounds and as needed, R2 is blind in right eye is to wear glasses and has hearing loss.
-Revised on 7/6/23, initiated on 1/24/20, R2 had a history of refusing to use the gait belt for walking and toileting. Interventions included staff to document refusal and ensure R2 wore grippy socks at all times when not wearing shoes.

R2's therapy recommendations dated 3/15/23, identified R3 to use four wheeled walker and staff assist when ambulating in the hallway and to assist with transfers to the bathroom due to decreased safety awareness and fall risk.

R2's progress notes and risk management reports indicated R2 had a history of falls - 3/28/23, 5/20/23, 6/16/23 where the facility followed the care plan and/or evaluated the fall to mitigate the risk of future falls.

R2's quarterly, minimum data set (MDS) dated, 6/27/23, indicated R2's cognition was intact with diagnoses of dementia, schizophrenia, right eye blindness and unilateral mixed conductive and sensineural hearing loss. R2 required extensive assist of one staff for toileting, was frequently incontinent of bladder and had two or more falls

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F 689	Continued From page 4	F 689		

without injury and one fall with injury.

R2 had a pharmacy review of medication on 7/20/23 indicated no recommendations or irregularities identified at the time of the review.

R2's risk management report dated 7/31/23, at 5:48 a.m. indicated R2 was ambulating without assistance while using her walker and fell in her room. R2 told the NA she fell when walking to her closet to get clothes to wear for the day. Additional contributions to the fall included gait imbalance, weakness, glasses not on. R2's vital signs were taken, R2 was assessed for injury and treated. R2 had swelling and bruising to left elbow and a hematoma to the right side of head.

R2's nursing progress alert noted dated 7/31/23 summarized the 7/31/23 risk management report and indicated R2's physician was notified and to send R2 to the hospital for evaluation. R2's family was notified of the fall and physician recommendations.

R2's medical record lacked an evaluation of the fall to mitigate the risk of future falls.

R2's ED note dated 7/31/23, indicated R2 was diagnosed with a left sided neck strain and sent back to wear a Miami J collar (a neck device that It supports your neck muscles and gives your spinal cord and ligaments time to heal).

During an interview on 8/21/23, at 2:56 p.m. registered nurse (RN)-A indicated that R2 had cognitive issues and needed help with toileting. RN-A stated R2 does not have an attention span, would prefer if one of us would be in her room at all times to help her, when R2 stands up on her

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F 689	Continued From page 5 own R2 easily loses her balance and needed frequent checks. R2 could use her call light or yells out for help. R2 had an increase in falls. RN-A stated, the fall process for the floor nurse is to assess the resident provide assist as needed, then make a note in risk management and that will automatically populate the event into the resident's progress note. For residents with cognitive issues, we determine if their basic needs were met to try and figure out why they fell, then put an intervention in place. We are not the ones that would update the care plan, the department heads do that at their meeting they have the next day. During an interview on 8/21/23, at 3:53 p.m. director of nursing (DON) indicated R2 had a diagnosis of dementia and can be forgetful. DON stated, R2 does have a history of falls and will not use her call light to ask for help to go to the bathroom, R2 is dependent of one staff for toileting needs, should be offered to be toileted before and after meals. The DON stated the facility tried an intervention for a chair alarm and R2 refused. Then on 7/31/23 R2 fell trying to get clothes out of the closet to get dressed for the day which resulted in a hematoma to R2's head and a bruising to her left elbow. The DON stated an unawareness of R2's preference of time to get up and dressed for the day. The DON stated there was no documentation to ensure that R2's basic needs were met or personalized prevention interventions for the root cause of R2's fall. The DON stated the day after a residents fall the interdisciplinary team (IDT) meets and discusses falls to determine appropriate interventions have been updated to the care plan. During an interview on 8/22/23, at 11:58 a.m. the	F 689		

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F 689	Continued From page 6	F 689		

vice president of success (VPOS)-A stated after the floor nurse assesses a resident after a fall, it should be documented in risk management which populates a progress note in the medical record. Then a post fall risk assessment should be completed to determine a root cause and a personalized prevention intervention to reduce the risk for falls. Then the floor nurses will fill out post fall events each shift for 72 hours to assess the resident for ongoing injuries.

R3's face sheet printed 8/22/23 indicated R3's admission date was 2/9/22. R3's diagnosis included but was not limited to cancer, palliative care, and dementia.

R3's care plan admission dated 2/9/22 initiate, revised on:
- Revised on 4/17/23, initiated 3/10/22 R3 indicated R3 had self-care deficits. Interventions included the assistance of one staff with ambulating using a gait belt, and four wheeled walker to and from activities, and assistance with daily activities of daily.
-Revised on 4/17/23, initiated 4/16/22 indicated R3 was incontinent of urine. Interventions included staff were to check resident before and after meals and as needed for incontinent episodes, monitor for nonverbal cues for toileting, keep call light within reach.
-Revised on 4/17/23, initiated 2/15/22 indicated R3 was at risk for falls and had a history of falls. Interventions included staff to provide the assistance of one with gait belt and walker, signs in place to call, encourage slow transfer and change of position, have commonly used items in reach, medication as needed, report changes in ADLs to physician, and therapy to evaluate and treat as ordered.

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F 689	Continued From page 7	F 689		

Continued From page 7

R3's therapy recommendations dated 2/16/23, indicated to please encourage R3 to toilet before and after meals, please cue R3 for: checking brief for bowel movement (BM), changing brief if soiled and performing thorough peri care.

R3's quarterly MDS, dated 7/5/23, indicated R3's to have diagnoses of cancer, dementia, and iron deficiency anemia. R3's cognition was severely impaired and required limited assist of one staff with walking and toileting and was frequently incontinent of bowel and bladder.

R3's progress note dated 7/22/23, at 12:22 a.m. indicated R3 was found in her room kneeling on the floor incontinent of bowel, wearing gripping socks, no injuries were noted. R3's physician and family were notified.

R3's medical record lacked an evaluation of the fall to mitigate the risk of future falls.

During an interview on 8/21/23, at 11:51 a.m. NA-B stated R3 was a check and change for toileting and was not sure if R3 had any falls. NA-B stated R3's bed was in a low position for a prevention intervention for falls.

During an interview on 8/21/23, at 2:42 p.m. RN-A stated, R3 had memory issues, does not speak unless spoken to and has had falls when needing to use the bathroom. RN-A stated R3 will not request assistance for ambulation and staff are to anticipate her needs. R3 required staff assistance to use the bathroom.

During an interview on 8/21/23, at 4:27 p.m. DON stated R3 has a history of confusion and required

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F 689	Continued From page 8 the assistance of one staff for toileting. R3's current toileting schedule was to offer toileting before and after meals. The facility was not able to determine the root cause of the fall and the prevention intervention was more frequent checks, which meant to check R3 every two hours. The DON stated they do not have documentation of the intervention or the effectiveness. Facility policy, "Fall Prevention and Management Guidelines," dated 11/8/2022, indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. 7. When any resident experiences a fall, the facility will: a. Complete a post-fall assessment and review: 1) Physical assessment with vital signs 2) Neuro checks for any unwitnessed fall or witnessed fall where resident hits their head: o Initially then q15 minutes x 3, o Q30 minutes x2, o Hourly x4, o Q8 hours x 9; 3) Check for orthostatic blood pressure changes if postural hypotension suspected, 4) Resident and/or witness statements regarding fall, 5) Environmental review for possible factors, 6) Contributing factors to the fall, 7) Medication changes (new or discontinued), 8) Mental status changes, 9) Any new diagnoses, b. Complete an incident report in Risk Management. c. Notify physician and family/responsible party., d. Review the resident's care plan and update with any new interventions put in place to try to prevent additional falls., e. Document all assessments and actions., f. Obtain witness statements from other staff with possible knowledge or relevant information, 8. Review each fall/fall investigation during the next morning meeting/clinical meeting	F 689		

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F 689	Continued From page 9 with the interdisciplinary Team (IDT). Actions of the IDT may include a. Review of investigation and determination of potential root cause of fall, b. Review of fall risk care plan and any updates to plan of care completed post-fall, c. Additional revisions to the plan of care including any physical adaptation to room, furniture,, wheelchair, and/or assistive devices, d. Education of staff as to any care plan revisions, e. Scheduling resident/family conferences, f. Verification of timely notification of physician and responsibly party of the fall. Note: If after IDT review, it is determined that existing interventions in the care plan are most appropriate, document rationale and describe any additional actions taken.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/21/23 and 8/22/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H53064490C (MN95820) and H53064618C (MN85200) with a licensing order issued at 0830. 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure a resident's environment remained free from accidents as possible to prevent falls for 2 of 3 residents (R2 and R3) reviewed for falls when there was a lack of evaluation of factors to prevent future falls. Findings include: R2's face sheet printed 8/22/23 indicated R2's original admission date was 7/25/19, R2	2 830	Plan of Correction This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or	9/18/23

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2 830	Continued From page 3 readmitted to the facility on 7/19/22, discharged and was readmitted again on 12/26/22. R2's diagnosis included but not limited to chronic obstructive pulmonary disease, abnormalities of gait and mobility, dementia, blindness of right eye, and low vision in left eye. R2's care plan admission date 12/26/22 initiated, revised on: -Revised on 6/15/23, initiated on 7/25/19, R2 was at risk for falls due to deconditioning, weakness, and had a history of falls. Interventions included to anticipate and meet resident needs, to use call light, provide education on fall prevention measures, assure resident that using the call light is not a bother, encourage complete seated chair exercises for strength, use appropriate footwear, follow therapy recommendations for transfers, mobility and ambulation, no pillows behind her back while in recliners, encourage good seated positioning, R2 to use recliner remote, answer call light promptly, leave bedside lamp on lowest setting during overnight hours, review information on past falls and attempt to determine cause, prevention, to minimize falls, wear grippy socks and shoes. -Revised on 6/15/23, initiated on 8/5/19, R2 was incontinent of urine due to functional and stress incontinence. Interventions included staff to assist R2 to the bathroom on nightly rounds, awaken around 2:00 a.m. for toileting and that the resident believe this routine would help with early morning incontinence. Check R2 for incontinence for before and after meals, and as needed. Communicate any changes in urinary status to the nurse and physician immediately. When offering toileting, if R2 refuses remind R2 she needs assistance and she should not toilet herself as resident has cognitive impairment and watch for signs of restlessness, agitation, holding	2 830	severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. R2 continues to receive care and services at the facility. Care plans were reviewed and updated based on IDT review and focused root cause analysis. R3 no longer resides at the facility. Residents who experience a fall have the potential to be impacted by the alleged practice. Falls packets were revised to include root cause analysis worksheets. The morning meeting agenda was revised to include IDT review of falls with a focus on root cause analysis. Education was provided to licensed nurses and nursing assistants by the Director of Nursing beginning August 22, 2023. Education included review of the updated falls packets, basic components of root cause analysis and required documentation after a fall event. The director of nursing or designee will complete formal audits of falls twice weekly for four weeks then weekly for four weeks. Results of audits will be submitted to the Quality Assurance committee for review and recommendations. Audits will begin the week of September 11th. Date of compliance is Sept 18, 2023	

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peri area, crying, calling out, and verbalizing need.
-Revised on 6/15/23, initiated on 11/19/19, R2 was at risk for adverse effects related to medications. Interventions included notify physician of decline in activities of daily living ability for positioning and ambulation.
-Revised on 6/15/23, initiated on 1/17/22, R2 had alteration to bowel incontinence. Interventions included to keep call light close to R2 and remind to use, limit caffeine and foods with sugar alcohols, monitor bowel frequency, provide assistance to toilet, use incontinent briefs for protection.
-Revised on 6/15/23, initiated on 4/28/22, R2 had alteration in respiratory status due to chronic obstructive pulmonary disease. Interventions included staff were to monitor for hypotension, dizziness, unsteady gait, seating, nausea, and cramping that may increase the risk of falls.
-Revised on 6/15/23, initiated on 4/28/22, R2 had impaired vision. Interventions included to keep frequently used items within easy reach, provide assistances as needed.
-Revised on 6/15/23, initiated on 7/22/22, R2 was resistive to care, frequently attempts to self-transfer, cognitive impairment, and lack of understanding for personal safety. Interventions included to allow for flexibility in activities of daily living, use a chair alarm that notifies the nursing station, include family for best approaches, reapproach, inform in advance of cares to deliver, give two choice options.
-Revised on 7/6/23, initiated on 8/6/19, R2 had a self-care deficit related to physical limitations. Interventions included R2 required assistance with showers, assistance with one staff with a gait belt for all transfers, R2 was independent with bed mobility. R2 required prompt voiding program upon rising in the morning after breakfast, before

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and after lunch/supper, on nightly rounds and as needed, R2 is blind in right eye is to wear glasses and has hearing loss.
-Revised on 7/6/23, initiated on 1/24/20, R2 had a history of refusing to use the gait belt for walking and toileting. Interventions included staff to document refusal and ensure R2 wore grippy socks at all times when not wearing shoes.

R2's therapy recommendations dated 3/15/23, identified R3 to use four wheeled walker and staff assist when ambulating in the hallway and to assist with transfers to the bathroom due to decreased safety awareness and fall risk.

R2's progress notes and risk management reports indicated R2 had a history of falls - 3/28/23, 5/20/23, 6/16/23 where the facility followed the care plan and/or evaluated the fall to mitigate the risk of future falls.

R2's quarterly, minimum data set (MDS) dated, 6/27/23, indicated R2's cognition was intact with diagnoses of dementia, schizophrenia, right eye blindness and unilateral mixed conductive and sensineural hearing loss. R2 required extensive assist of one staff for toileting, was frequently incontinent of bladder and had two or more falls without injury and one fall with injury.

R2 had a pharmacy review of medication on 7/20/23 indicated no recommendations or irregularities identified at the time of the review.

R2's risk management report dated 7/31/23, at 5:48 a.m. indicated R2 was ambulating without assistance while using her walker and fell in her room. R2 told the NA she fell when walking to her closet to get clothes to wear for the day. Additional contributions to the fall included gait

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imbalance, weakness, glasses not on. R2's vital signs were taken, R2 was assessed for injury and treated. R2 had swelling and bruising to left elbow and a hematoma to the right side of head.

R2's nursing progress alert noted dated 7/31/23 summarized the 7/31/23 risk management report and indicated R2's physician was notified and to send R2 to the hospital for evaluation. R2's family was notified of the fall and physician recommendations.

R2's medical record lacked an evaluation of the fall to mitigate the risk of future falls.

R2's ED note dated 7/31/23, indicated R2 was diagnosed with a left sided neck strain and sent back to wear a Miami J collar (a neck device that It supports your neck muscles and gives your spinal cord and ligaments time to heal).

During an interview on 8/21/23, at 2:56 p.m. registered nurse (RN)-A indicated that R2 had cognitive issues and needed help with toileting. RN-A stated R2 does not have an attention span, would prefer if one of us would be in her room at all times to help her, when R2 stands up on her own R2 easily loses her balance and needed frequent checks. R2 could use her call light or yells out for help. R2 had an increase in falls. RN-A stated, the fall process for the floor nurse is to assess the resident provide assist as needed, then make a note in risk management and that will automatically populate the event into the resident's progress note. For residents with cognitive issues, we determine if their basic needs were met to try and figure out why they fell, then put an intervention in place. We are not the ones that would update the care plan, the department heads do that at their meeting they

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have the next day.

During an interview on 8/21/23, at 3:53 p.m. director of nursing (DON) indicated R2 had a diagnosis of dementia and can be forgetful. DON stated, R2 does have a history of falls and will not use her call light to ask for help to go to the bathroom, R2 is dependent of one staff for toileting needs, should be offered to be toileted before and after meals. The DON stated the facility tried an intervention for a chair alarm and R2 refused. Then on 7/31/23 R2 fell trying to get clothes out of the closet to get dressed for the day which resulted in a hematoma to R2's head and a bruising to her left elbow. The DON stated an unawareness of R2's preference of time to get up and dressed for the day. The DON stated there was no documentation to ensure that R2's basic needs were met or personalized prevention interventions for the root cause of R2's fall. The DON stated the day after a residents fall the interdisciplinary team (IDT) meets and discusses falls to determine appropriate interventions have been updated to the care plan.

During an interview on 8/22/23, at 11:58 a.m. the vice president of success (VPOS)-A stated after the floor nurse assesses a resident after a fall, it should be documented in risk management which populates a progress note in the medical record. Then a post fall risk assessment should be completed to determine a root cause and a personalized prevention intervention to reduce the risk for falls. Then the floor nurses will fill out post fall events each shift for 72 hours to assess the resident for ongoing injuries.

R3's face sheet printed 8/22/23 indicated R3's admission date was 2/9/22. R3's diagnosis included but was not limited to cancer, palliative

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care, and dementia.

R3's care plan admission dated 2/9/22 initiate, revised on:
- Revised on 4/17/23, initiated 3/10/22 R3 indicated R3 had self-care deficits. Interventions included the assistance of one staff with ambulating using a gait belt, and four wheeled walker to and from activities, and assistance with daily activities of daily.
-Revised on 4/17/23, initiated 4/16/22 indicated R3 was incontinent of urine. Interventions included staff were to check resident before and after meals and as needed for incontinent episodes, monitor for nonverbal cues for toileting, keep call light within reach.
-Revised on 4/17/23, initiated 2/15/22 indicated R3 was at risk for falls and had a history of falls. Interventions included staff to provide the assistance of one with gait belt and walker, signs in place to call, encourage slow transfer and change of position, have commonly used items in reach, medication as needed, report changes in ADLs to physician, and therapy to evaluate and treat as ordered.

R3's therapy recommendations dated 2/16/23, indicated to please encourage R3 to toilet before and after meals, please cue R3 for: checking brief for bowel movement (BM), changing brief if soiled and performing thorough peri care.

R3's quarterly MDS, dated 7/5/23, indicated R3's to have diagnoses of cancer, dementia, and iron deficiency anemia. R3's cognition was severely impaired and required limited assist of one staff with walking and toileting and was frequently incontinent of bowel and bladder.

R3's progress note dated 7/22/23, at 12:22 a.m.

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ROCHESTER HEALTH SERVICES WEST	**2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901**

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2 830	Continued From page 9 indicated R3 was found in her room kneeling on the floor incontinent of bowel, wearing gripping socks, no injuries were noted. R3's physician and family were notified. R3's medical record lacked an evaluation of the fall to mitigate the risk of future falls. During an interview on 8/21/23, at 11:51 a.m. NA-B stated R3 was a check and change for toileting and was not sure if R3 had any falls. NA-B stated R3's bed was in a low position for a prevention intervention for falls. During an interview on 8/21/23, at 2:42 p.m. RN-A stated, R3 had memory issues, does not speak unless spoken to and has had falls when needing to use the bathroom. RN-A stated R3 will not request assistance for ambulation and staff are to anticipate her needs. R3 required staff assistance to use the bathroom. During an interview on 8/21/23, at 4:27 p.m. DON stated R3 has a history of confusion and required the assistance of one staff for toileting. R3's current toileting schedule was to offer toileting before and after meals. The facility was not able to determine the root cause of the fall and the prevention intervention was more frequent checks, which meant to check R3 every two hours. The DON stated they do not have documentation of the intervention or the effectiveness. Facility policy, "Fall Prevention and Management Guidelines," dated 11/8/2022, indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: ______ B. WING ______	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 10 of injury. 7. When any resident experiences a fall, the facility will: a. Complete a post-fall assessment and review: 1) Physical assessment with vital signs 2) Neuro checks for any unwitnessed fall or witnessed fall where resident hits their head: o Initially then q15 minutes x 3, o Q30 minutes x2, o Hourly x4, o Q8 hours x 9; 3) Check for orthostatic blood pressure changes if postural hypotension suspected, 4) Resident and/or witness statements regarding fall, 5) Environmental review for possible factors, 6) Contributing factors to the fall, 7) Medication changes (new or discontinued), 8) Mental status changes, 9) Any new diagnoses, b. Complete an incident report in Risk Management. c. Notify physician and family/responsible party., d. Review the resident's care plan and update with any new interventions put in place to try to prevent additional falls., e. Document all assessments and actions., f. Obtain witness statements from other staff with possible knowledge or relevant information, 8. Review each fall/fall investigation during the next morning meeting/clinical meeting with the interdisciplinary Team (IDT). Actions of the IDT may include a. Review of investigation and determination of potential root cause of fall, b. Review of fall risk care plan and any updates to plan of care completed post-fall, c. Additional revisions to the plan of care including any physical adaptation to room, furniture,, wheelchair, and/or assistive devices, d. Education of staff as to any care plan revisions, e. Scheduling resident/family conferences, f. Verification of timely notification of physician and responsibly party of the fall. Note: If after IDT review, it is determined that existing interventions in the care plan are most appropriate, document rationale and describe any additional actions taken.	2 830		

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2 830	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment, root cause analysis and person centered interventions are being implemented to reduce the future risk of falls. In addition ensure residents who are dependent on staff; ensuring their basic needs are being met as part of the fall investigation to determine a root cause. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		