Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2022

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

RE: CCN: 245306
Cycle Start Date: November 2, 2022

Dear Administrator:

On November 21, 2022, we notified you a remedy was imposed. On December 19, 2022 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 5, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 6, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 21, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 6, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 5, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 29, 2022

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

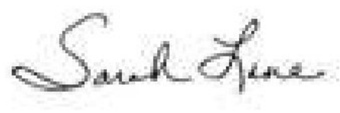
Re: Reinspection Results
Event ID: 10Q612

Dear Administrator:

On December 19, 2022 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 November 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 21, 2022

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

RE: CCN: 245306
Cycle Start Date: November 2, 2022

Dear Administrator:

On November 2, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 6, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 6, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 6, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by December 6, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester Health Services West will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 6, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 2, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
November 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 10Q611

Dear Administrator:

The above facility was surveyed on October 31, 2022 through November 2, 2022 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.

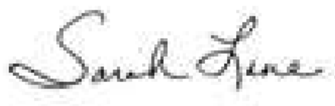
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 11/02/2022

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 10/31/22, through 11/02/22, a standard abbreviated survey was conducted at your facility. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H53065343C (MN87921), with a deficiency cited at F684. The following complaint was found to be unsubstantiated: H53065398C (MN87875/MN87887). 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 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		12/5/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/09/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 1 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess and monitor a change in condition in respiratory and mental status and failed to notify the physician for 1 of 3 residents (R3). The facility's failures resulted in harm when R1 was emergently transferred to the hospital after an unwitnessed fall which resulted in shoulder and rib fractures. Findings include: R1's Face Sheet indicated she was admitted to the facility on 9/21/22, and discharged on 10/5/22. R1's admitting diagnosis's included pneumonia with dependence on supplemental oxygen, atrial fibrillation (irregular heart rhythm), heart failure, and long term/current use of anticoagulants (blood thinning medication). R1's Minimum Data Set (MDS) dated 9/28/22, indicated R1 was unable to complete a Brief Interview for Mental Status evaluation, however a progress note dated 9/23/22, at 10:41 a.m. documented R1 was alert and oriented and able to communicate her needs. R1 also required extensive assistance from staff for bed mobility, transferring, walking, dressing and toileting. R1's undated comprehensive care plan was printed and provided on 11/2/22. Care plan identified R1 had a self-care deficit as evidenced by physical limitations requiring assistance of one and a four-wheel walker for ambulation. Further	F 684	R 1 no longer resides in the facility. Residents who experience a change in condition have the potential to be impacted by alleged practice. Review of resident progress notes and assessments was completed on 11-01-2022 by Director of nursing or designee to determine if any changes in condition had been observed in the past 72 hours and to ensure appropriate follow up and notifications had been made to medical providers. The director of nursing re-implemented review of resident progress notes and assessments prior to a.m. clinical meeting to ensure these were reviewed and validate clinical follow up and notifications were completed. The INTERACT change in condition reference was printed and placed at the nurses station to ensure nurses have access to the information and the suggested response to changes in condition. Facility Licensed Nurses were educated on the location and use of the reference. Education was initiated by the director of nursing or designee on 11-01-2022 on responding to change in condition. Education was presented to licensed nurses. Education included review of policy, documentation, notification, monitoring, reporting, and responding to changes in condition. Review of the INTERACT tool for change in condition was also completed during education. A	

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 684	Continued From page 2 identified R1 was at risk for falls related to de-conditioning and weakness. R1 showed a potential for discharge. R1's Physician Orders included an order dated 9/21/22, to administer R1 oxygen at 1 liter per minute (LPM) while asleep, and 2 LPM as needed with exertion via nasal cannula. Further directed to check blood oxygen saturations every shift. Review of R1's treatment administration record (TAR) for September and October 2022, identified R1 received 1-2 L of oxygen; R1's oxygen saturations ranged from 92-97% (normal oxygen saturations are 97% to 99% on room air.) During an interview on 10/31/22, at 2:10 p.m. assistant director of nursing (ADON) stated she completed R1's admission assessment to the facility. R1's speech was clear, and she was able to communicate her care needs. During an interview on 11/02/22, at 2:00 p.m. nursing assistant (NA)-A stated throughout R1's stay at the facility, R1 was alert and able to voice her care needs. R1 was described as cooperative and did not have slurred speech. R1's progress note created by registered nurse (RN)-A dated 10/5/22, at 12:15 a.m. documented R1 was yelling, "I can't breathe, I can't breathe." R1 was noted to have slurred speech and RN-A documented she was unable to understand what R1 was saying. R1's medical record lacked a comprehensive assessment(s), lacked documentation of vital signs were recorded, and lacked identification of what interventions were attempted or offered to stabilize R1. However, during an interview on	F 684	posttest was required to validate understanding of the information presented. INTERACT reference includes comprehensive respiratory and mental status assessments, monitoring and corresponding interventions. Formal audits of change in condition will be completed by the director of nursing or designee five times weekly eight weeks or until substantial compliance is maintained. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations.	

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F 684	Continued From page 3 11/2/22, at 11:45 a.m. RN-A stated she placed the nasal cannula oxygen tubing back on R1 and calmed her down. RN-A stated she did not perform any other cares nor complete any other assessments. Further, R1's record did not identify if the physician was notified of a new onset of slurred speech or R1's difficulty breathing. R1's progress note created by RN-A dated 10/5/22, at 4:25 a.m. documented R1 yelled out and was found sitting on the floor. RN-A's assessment of R1 indicated R1 had a pulse oximetry reading of 76%. R1's progress note created by RN-A dated 10/5/22, at 5:30 a.m. indicated R1 was now sleeping but quiet. R1's medical record did not identify comprehensive assessment(s) were completed after identification of R1's low oxygen saturations, nor identify interventions implemented to stabilize R1's respiratory status, or evidence of ongoing monitoring. Further, it was not evident physician notification of the change in R1's respiratory status and R1 had sustained a fall. R1's progress noted created by RN-B dated 10/5/22, at 11:02 a.m. documented R1 had an unwitnessed fall that morning around 4:30 a.m. and now R1 was having neck and mid-shoulder pain. R1 was described as very pale and lethargic. Further, R1 was able to answer orientation questions appropriately, however, R1 was very slow to respond. RN-B additionally documented R1 was unable to keep her eyes open earlier in the morning. After an assessment and consulting with the assistant director of nursing (ADON), it was determined that R1	F 684		

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F 684	Continued From page 4 should be transported to the ED for further evaluation of the fall. During an interview on 11/2/22, at 11:45 a.m. RN-A stated R1 had been agitated, restless, uncooperative, and had strange and odd behaviors that started the evening of her shift on 10/4/22. At approximately midnight, R1 was yelling out and it was discovered R1 had taken her nasal cannula oxygen tubing off and the tubing was tangled in her night gown. R1 reported to RN-A that she could not breath and R1 had slurred speech. RN-A stated this was the first time she heard R1 slur her words. RN-A placed the nasal cannula oxygen tubing back on R1 and she seemed to calm down. RN-A stated she thought about contacting the doctor at the time, but she did not. RN-A stated at approximately 4:30 a.m. on 10/5/22, R1 was yelling out and upon entering her room, it was discovered R1 was sitting on the floor, next to her bed. RN-A asked R1 how she fell and R1 replied she sat down hard. RN-A obtained R1's vital signs and it was discovered R1's oxygen saturation was 76%. RN-A stated she again thought about contacting the physician on call, but she did not. RN-A indicated the reason she did not contact the physician was she was tired and had been assigned a double shift that included an overnight shift. RN-A further stated, it was a standard of practice to contact the physician for an unwitnessed fall, hypoxia, and change in condition. During an interview on 10/31/22, at 2:52 p.m. RN-B stated RN-A received an end of shift report the morning (at an unknown time) of 10/25/22, from RN-A. RN-A had reported to her R1 had had been awake all night, was having intermittent	F 684		

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	245306	A. BUILDING _____ B. WING _____	C 11/02/2022

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

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F 684	Continued From page 5 confusion, and had an unwitnessed fall while self-transferring. RN-B had questioned why R1 had not been sent into the hospital after the fall and change in condition, however she had not notified the physician of R1's change in condition after she had received report. RN-B described on 10/5/22, at approximately 11:00 a.m. R1 was complaining of shoulder and neck pain and seemed confused. RN-B stated when she attempted to obtain an oximetry reading that initially it did not read on the oximeter and when it did register, it was 71%. RN-B called ADON to assist in an assessment, and it was determined that R1 should be transported to the ED. During an interview on 11/2/22, at 10:37 a.m. DON stated R1 was a matter of a fact speaker and could verbalize her care needs. The DON stated when R1 had her first change in condition on 10/05/22, at 12:15 a.m., RN-A should have contacted the physician for instructions, but this did not happen. Further, when R1 had an unwitnessed fall on 10/5/22, at 4:30 a.m. and R1 had a low oximeter reading, RN-A should have immediately contacted the physician and R1 should have been transferred to the ED for evaluation. The DON stated that was facility policy and RN-A did not follow the policy. Review of the ED assessment, evaluation, and encounter summary dated 10/5/22 identified R1 was admitted to the ED for evaluation of falls and shortness of breath. MD-A documented the results of a computerized tomography scan and identified the following impressions: 1. new subacute (between acute and chronic) comminuted displaced intra-articular fracture of the left clavicular head (broken bone in the shoulder/neck area) and 2. new acute and	F 684		

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F 684	Continued From page 6 subacute non-displaced fractures of the right anterolateral 5th and 6th ribs (broken ribs). The ED final diagnoses included delirium (confusion) and hypoxia (low oxygenation). Review of Minnesota Document of Death dated 10/13/22, indicated a significant condition contributing to R1's death included, "multiple blunt force injuries (left clavicle and right rib fracture), (fall)." A review of the facility Change in Condition of the Resident policy dated 9/20/22, directed the facility should immediately consult with the resident's physician of a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). Further, the provider should be immediately notified of acute or sudden onset of symptoms or a marked change in the residents condition. Resident assessment is to include vital signs, oxygen saturation, personality, behavioral and/or cognitive changes, speech disorder, and dyspnea (problems breathing). The policy also directs, but not limited to, staff documenting a description of change in condition and assessments or observations of findings.	F 684		

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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 document review the facility failed to comprehensively assess and monitor a change in condition in respiratory and mental status and failed to notify the physician for 1 of 3 residents (R3). The facility's failures resulted in harm when R1 was emergently transferred to the hospital after an unwitnessed fall which resulted in shoulder and rib fractures. Findings include: R1's Face Sheet indicated she was admitted to the facility on 9/21/22, and discharged on 10/5/22. R1's admitting diagnosis's included pneumonia with dependence on supplemental oxygen, atrial fibrillation (irregular heart rhythm), heart failure, and long term/current use of anticoagulants (blood thinning medication). R1's Minimum Data Set (MDS) dated 9/28/22,	2 830	see poc	12/5/22

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

Electronically Signed | 12/09/22

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2 830	Continued From page 1 indicated R1 was unable to complete a Brief Interview for Mental Status evaluation, however a progress note dated 9/23/22, at 10:41 a.m. documented R1 was alert and oriented and able to communicate her needs. R1 also required extensive assistance from staff for bed mobility, transferring, walking, dressing and toileting. R1's undated comprehensive care plan was printed and provided on 11/2/22. Care plan identified R1 had a self-care deficit as evidenced by physical limitations requiring assistance of one and a four-wheel walker for ambulation. Further identified R1 was at risk for falls related to de-conditioning and weakness. R1 showed a potential for discharge. R1's Physician Orders included an order dated 9/21/22, to administer R1 oxygen at 1 liter per minute (LPM) while asleep, and 2 LPM as needed with exertion via nasal cannula. Further directed to check blood oxygen saturations every shift. Review of R1's treatment administration record (TAR) for September and October 2022, identified R1 received 1-2 L of oxygen; R1's oxygen saturations ranged from 92-97% (normal oxygen saturations are 97% to 99% on room air.) During an interview on 10/31/22, at 2:10 p.m. assistant director of nursing (ADON) stated she completed R1's admission assessment to the facility. R1's speech was clear, and she was able to communicate her care needs. During an interview on 11/02/22, at 2:00 p.m. nursing assistant (NA)-A stated throughout R1's stay at the facility, R1 was alert and able to voice her care needs. R1 was described as cooperative and did not have slurred speech.	2 830		

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2 830	Continued From page 2 R1's progress note created by registered nurse (RN)-A dated 10/5/22, at 12:15 a.m. documented R1 was yelling, "I can't breathe, I can't breathe." R1 was noted to have slurred speech and RN-A documented she was unable to understand what R1 was saying. R1's medical record lacked a comprehensive assessment(s), lacked documentation of vital signs were recorded, and lacked identification of what interventions were attempted or offered to stabilize R1. However, during an interview on 11/2/22, at 11:45 a.m. RN-A stated she placed the nasal cannula oxygen tubing back on R1 and calmed her down. RN-A stated she did not perform any other cares nor complete any other assessments. Further, R1's record did not identify if the physician was notified of a new onset of slurred speech or R1's difficulty breathing. R1's progress note created by RN-A dated 10/5/22, at 4:25 a.m. documented R1 yelled out and was found sitting on the floor. RN-A's assessment of R1 indicated R1 had a pulse oximetry reading of 76%. R1's progress note created by RN-A dated 10/5/22, at 5:30 a.m. indicated R1 was now sleeping but quiet. R1's medical record did not identify comprehensive assessment(s) were completed after identification of R1's low oxygen saturations, nor identify interventions implemented to stabilize R1's respiratory status, or evidence of ongoing monitoring. Further, it was not evident physician notification of the change in R1's respiratory status and R1 had sustained a fall. R1's progress noted created by RN-B dated	2 830		

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2 830	Continued From page 3 10/5/22, at 11:02 a.m. documented R1 had an unwitnessed fall that morning around 4:30 a.m. and now R1 was having neck and mid-shoulder pain. R1 was described as very pale and lethargic. Further, R1 was able to answer orientation questions appropriately, however, R1 was very slow to respond. RN-B additionally documented R1 was unable to keep her eyes open earlier in the morning. After an assessment and consulting with the assistant director of nursing (ADON), it was determined that R1 should be transported to the ED for further evaluation of the fall. During an interview on 11/2/22, at 11:45 a.m. RN-A stated R1 had been agitated, restless, uncooperative, and had strange and odd behaviors that started the evening of her shift on 10/4/22. At approximately midnight, R1 was yelling out and it was discovered R1 had taken her nasal cannula oxygen tubing off and the tubing was tangled in her night gown. R1 reported to RN-A that she could not breath and R1 had slurred speech. RN-A stated this was the first time she heard R1 slur her words. RN-A placed the nasal cannula oxygen tubing back on R1 and she seemed to calm down. RN-A stated she thought about contacting the doctor at the time, but she did not. RN-A stated at approximately 4:30 a.m. on 10/5/22, R1 was yelling out and upon entering her room, it was discovered R1 was sitting on the floor, next to her bed. RN-A asked R1 how she fell and R1 replied she sat down hard. RN-A obtained R1's vital signs and it was discovered R1's oxygen saturation was 76%. RN-A stated she again thought about contacting the physician on call, but she did not. RN-A indicated the reason she did not contact the physician was she was tired and had been assigned a double shift that included an overnight	2 830		

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2 830	Continued From page 4 shift. RN-A further stated, it was a standard of practice to contact the physician for an unwitnessed fall, hypoxia, and change in condition. During an interview on 10/31/22, at 2:52 p.m. RN-B stated RN-A received an end of shift report the morning (at an unknown time) of 10/25/22, from RN-A. RN-A had reported to her R1 had had been awake all night, was having intermittent confusion, and had an unwitnessed fall while self-transferring. RN-B had questioned why R1 had not been sent into the hospital after the fall and change in condition, however she had not notified the physician of R1's change in condition after she had received report. RN-B described on 10/5/22, at approximately 11:00 a.m. R1 was complaining of shoulder and neck pain and seemed confused. RN-B stated when she attempted to obtain an oximetry reading that initially it did not read on the oximeter and when it did register, it was 71%. RN-B called ADON to assist in an assessment, and it was determined that R1 should be transported to the ED. During an interview on 11/2/22, at 10:37 a.m. DON stated R1 was a matter of a fact speaker and could verbalize her care needs. The DON stated when R1 had her first change in condition on 10/05/22, at 12:15 a.m., RN-A should have contacted the physician for instructions, but this did not happen. Further, when R1 had an unwitnessed fall on 10/5/22, at 4:30 a.m. and R1 had a low oximeter reading, RN-A should have immediately contacted the physician and R1 should have been transferred to the ED for evaluation. The DON stated that was facility policy and RN-A did not follow the policy. Review of the ED assessment, evaluation, and	2 830		

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2 830	Continued From page 5 encounter summary dated 10/5/22 identified R1 was admitted to the ED for evaluation of falls and shortness of breath. MD-A documented the results of a computerized tomography scan and identified the following impressions: 1. new subacute (between acute and chronic) comminuted displaced intra-articular fracture of the left clavicular head (broken bone in the shoulder/neck area) and 2. new acute and subacute non-displaced fractures of the right anterolateral 5th and 6th ribs (broken ribs). The ED final diagnoses included delirium (confusion) and hypoxia (low oxygenation). Review of Minnesota Document of Death dated 10/13/22, indicated a significant condition contributing to R1's death included, "multiple blunt force injuries (left clavicle and right rib fracture), (fall)." A review of the facility Change in Condition of the Resident policy dated 9/20/22, directed the facility should immediately consult with the resident's physician of a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). Further, the provider should be immediately notified of acute or sudden onset of symptoms or a marked change in the residents condition. Resident assessment is to include vital signs, oxygen saturation, personality, behavioral and/or cognitive changes, speech disorder, and dyspnea (problems breathing). The policy also directs, but not limited to, staff documenting a description of change in condition and assessments or observations of findings Suggested Method of Correction: The Directior of Nursing or designee could review policies and	2 830		

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2 830	Continued From page 6 procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		