Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2024

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

RE: CCN: 245306
Cycle Start Date: October 24, 2023

Dear Administrator:

On November 22, 2023, we notified you a remedy was imposed. On January 17, 2024 the Minnesota Departments of Health and Public Safety 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 January 9, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 22, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 24, 2023. 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.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the October 24, 2023 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 18, 2024

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

Re: Reinspection Results
Event ID: 41KJ12 and 8ZQK12

Dear Administrator:

On November 27, 2023 and January 17, 2024 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 surveys completed on October 24, 2023 and November 30, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 2, 2023

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

RE: CCN: 245306
Cycle Start Date: October 24, 2023

Dear Administrator:

On October 24, 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 immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E),whereby corrections were required.

REMOVAL OF IMMEDIATE JEOPARDY

On October 9, 2023, the situation of immediate jeopardy to potential health and safety cited at F760 was removed.

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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 24, 2024

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective January 24, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 24, 2024.

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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

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

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Rochester Health Services West is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 24, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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.

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 April 24, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

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
202-795-7490

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 2, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 41KJ11

Dear Administrator:

The above facility was surveyed on October 24, 2023 through October 24, 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:

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 10/24/2023

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 10/24/23, 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 complaint was reviewed: H53066530C (MN97607 and MN97604) with deficiencies issued at F554, F755, and F880. In addition, a deficiency was cited at F760 for PAST NON-COMPLIANCE IJ. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction for F760 is required for a finding of past non-compliance. 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		11/21/23

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

Electronically Signed | 11/10/2023

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.

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 10/24/2023

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 554	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and determine safety for self-administration of medications (SAM) for 2 of 6 residents (R3 and R4) reviewed for medication administration. Findings include: R3's admission Minimum Data Set (MDS) 8/23/23, indicated R3 had severely impaired cognition, and diagnoses of chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia (lack of oxygen), Alzheimer's disease with late onset, and dementia. During an observation on 10/24/23, at 8:39 a.m., licensed practical nurse (LPN)-A prepared R3's -Duo neb inhalation (breathing medication). At 8:45 a.m. LPN-A entered R3's room as he was seated in a wheelchair. LPN-A put the Duo neb fluid into the nebulizer reservoir and started the nebulizer machine and placed the mask on R3, stated she set a timer (did not report how long), and left R3 unattended in his room. At 9:07 a.m. R3 remained seated in his wheelchair with the nebulizer mask on his face with the treatment running. At 9:12 a.m. R3 took his mask off and hung it on the nebulizer machine. R4's quarterly MDS dated 8/8/23, indicated R4's cognition was intact and had diagnoses of diabetes and lack of coordination. During an observation on 10/24/23, at 9:08 a.m. LPN-A prepared R4's morning medications. Medications included:	F 554	R3 and R4 were assessed for Self-administration of medications by RN (10/25/2023). Care plans and assessments were updated as required. MD notification completed and responsible party updated by Director of Nursing. Residents who self-administer medications have the potential to be impacted by the alleged practice. Care plans and assessments were reviewed for residents who self administer medications and updated as needed. An initial assessment is completed at admission if the resident voices a desire to self-administer medications. These are followed by quarterly assessments on self-administration to ascertain resident remains able to safely self-administer medications. Education was provided by the Director of Nursing or designee to licensed nurses. Education was initiated on 10/25/2023. Nurses were advised that completion of the self administration assessment in PCC is used to help determine if the resident can safely administer their own medications. Nurses were informed of the need to remain with residents who are not able to safely self administer medications and to observe the resident take the medication if self-administration is not approved. Audits of medication pass for compliance will be completed three times weekly for four weeks then two times weekly for four weeks. Results of audits will be submitted	

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 10/24/2023

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 554	Continued From page 2 -Amlodipine 2.5 mg (hypertension medication) -Metformin 1000 mg (diabetic medication) -Metoprolol tartrate 25 mg (hypertension medication) -Novolin N 10 units (insulin) subcutaneous injection At 9:14 a.m. LPN-A walked into R4's room as R4 was seated in his wheelchair. LPN-A placed the medication cup that contained the pills and a small cup of applesauce on R4's bedside table. LPN-A then left the room without watching R4 take the medications. At 9:21 a.m. LPN-A returned to R4's room the pills on the bedside table were no longer there. LPN-A asked R4 if the medications went down ok, R4 indicated, yes. During an interview on 10/24/23 at 2:37 p.m., LPN-A indicated she left R3 unattended with his nebulizer and R4 unattended with his medications. Further verified they did not have self-administration assessments completed to determine if they were safe to take medications safely themselves. During an interview on 10/24/23 at 2:52 p.m., director of nursing (DON) indicated the only time a self-administration assessment was completed on a resident to determine if they were able to safely self-administer their own medications was upon request. DON indicated R3 and R4 have not been assessed to safely to self-administer their own medications. Facility policy, Self-Administration by Resident, dated, 11/17, identified residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, and	F 554	to the Quality Assurance committee for review and recommendations	

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 10/24/2023

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 554	Continued From page 3 the medications are appropriate and safe for self-administration. 2. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted as part of the care plan process. The nursing care center may use the following as a guideline or establish an alternate procedure: The resident is instructed in the use of the package, purpose of the medication, reading of the label, and scheduling of medication doses. The resident is then requested to read the label on each package and indicate at what time the medication should be taken and any other special instructions for use and know what conditions they are taken for. Resident is able to tell time to know when medications need to be taken. Resident comprehends instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff. The resident is asked to demonstrate the removal of the medication from the package and, in the case of nonsolid dosage forms such as an inhaler, to verbalize the steps involved in administration. The resident's physical capacity to swallow without difficulty and to open medication bottles. The resident is asked to complete a bedside record indicating the administration of the medication. Resident understands what refusal of medication is, and appropriate steps taken by staff to educate when this occurs. 3. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is placed in the resident's medical record. Facility policy, Nebulizer Administration, dated 09/10, identified 2. Assemble equipment and supplies on the resident ' s overbed table, with a barrier between supplies/medication and table. 3.	F 554		

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 10/24/2023

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 554	Continued From page 4 Perform hand hygiene. 4. Position resident in semi-fowler ' s position. 5. Obtain baseline pulse, respiratory rate and lung sounds. 6. Draw up the medication to be nebulizer if the medication is not in a unit-dose container. 7. Pour medication into a clean nebulizer cup. 8. Add the diluent, if ordered or required by the manufacturer (see package insert). 9. Assemble nebulizer equipment and attach to nebulizer compressor or gas source per manufacturer ' s instructions. Adjust the flow rate as ordered or per facility protocol.10. Turn on the nebulizer and check the outflow port for visible mist. 11. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask).12. Instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughout treatment.13. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer. 14. Monitor for medication side effects, including rapid pulse, restlessness and nervousness. 15. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits. 16. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup. 17. Encourage the resident to cough and expectorate as needed. 18. Administer therapy until medication is gone (mist has stopped) or until the designated time of treatment has been reached. 19. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. 20. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings on the MAR or in the resident ' s medical record following facility policy. 21. Rinse and disinfect the nebulizer equipment according to manufacturer ' s recommendations and facility policy. 22. Wash	F 554		

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 10/24/2023

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 554	Continued From page 5 hands thoroughly. 23. When equipment is completely dry, store in a plastic bag with the resident ' s name and the date on it. 24. Change equipment and tubing per nursing facility policy. 25. Disinfect outside of the compressor between residents, according to manufacturer ' s instructions and facility policy.	F 554		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		11/21/23

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 10/24/2023

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 755	Continued From page 6 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure insulin was administered in accordance with manufacturer recommendations for 1 of 1 resident (R4) reviewed for insulin administration. Findings include: R4's quarterly Minimum Data Set (MDS) dated 8/8/23, indicated R4's did not have cognitive impairment and had diagnoses of diabetes and lack of coordination. MDS further identified R4 received daily insulin injections. R4's medication administration record (MAR) dated 10/9/223, included the physicians order to inject NPH (Human) (Isophane) insulin 10 units subcutaneously at 8:00 a.m. During an observation on 10/24/23 at 9:08 a.m., licensed practical nurse (LPN)-A prepared R4's insulin. During preparation LPN-A did not clean the rubber seal of the insulin flex pen with an alcohol wipe, put the disposable needle on, pulled off the inner needle cap and dialed up 8 units of insulin without priming the needle. At 9:14 a.m. LPN-A administered the insulin to R4 in the abdomen. LPN-A informed R4 she needed to get 2 more units of insulin. LPN-A walked to the medication room, obtained a new insulin pen, did not clean the rubber seal of the insulin flex pen with alcohol, and did not prime the needle, and dialed up 2 units. At 9:21 a.m. LPN-A returned to R4's room and administered the remaining 2 units	F 755	R4 did not have any signs or symptoms of hypoglycemia or hyperglycemia following the administration of insulin. 2. Facility in house residents who receive insulin have ability to be affected by alleged practice. 3. The facility licensed nursing staff were re-educated on insulin administration processes by the Director of nursing starting on 10/25/2023. The facility will audit medication passes. Director of Nursing or designee will complete medication competencies by 11/21/2023. 4. The Director of Nursing or designee will complete audits starting date. Audit will be completed 3 times per week on varying shift for 8 weeks or until substantial compliance is Maintained. Results of Audits will be brought to QAPI for review and recommendation.	

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 10/24/2023

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 755	Continued From page 7 of insulin without first priming the insulin. During an interview on 10/24/23, at 2:37 p.m. LPN-A confirmed she did not prime the insulin pen with 2 units to ensure the correct dose of insulin was delivered when she administered R4's insulin. During an interview on 10/24/23, at 2:52 p.m. director of nursing (DON) confirmed staff should be priming insulin pens with 2 units prior to dialing up the ordered dose of insulin. Facility policy, Subcutaneous Insulin, dated 01/22, identified to administer subcutaneous insulin as ordered in a safe, accurate and effective manner. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly and removing air bubbles. A. Select the dose of units by turning the dosage selector. You can set the dose in steps of 1 unit, from a minimum of 1 unit to a maximum of 80 units. If you need a dose greater than 80 units, you should give it as two or more injections. Check that the dose window shows "0" following the safety test. Select your required dose (in the example below, the selected dose is 30 units). If you turn past your dose, you can turn back down. C. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. D. Hold the pen with the needle pointing upwards. E. Tap the insulin reservoir so that any air bubbles rise up towards the needle. F. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. If no insulin comes out, check for air bubbles, and	F 755		

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 10/24/2023

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 755	Continued From page 8 repeat the safety test two more times to remove them. If still no insulin comes out, the needle may be blocked. Change the needle and try again. If no insulin comes out after changing the needle, the pen may be damaged. Do not use this pen. Do not push the injection button while turning, as insulin will come out. You cannot turn the dosage selector past the number of units left in the pen. Do not force the dosage selector to turn. Manufacturer Recommendations, Humulin N KwikPen (insulin isophane human) injectable solution for subcutaneous use, revised June 2022, identified preparing your pen; Step 1 Pull the Pen Cap straight off. Do not remove the Pen Label. Wipe the Rubber Seal with an alcohol swab. Do not attach the Needle before mixing. Step 2: Gently roll the Pen between your hands 10 times. Step 3: Move the Pen up and down (invert) 10 times. Mixing by rolling and inverting the Pen is important to make sure you get the right dose. Step 4: check the liquid in the Pen. HUMULIN N should look white and cloudy after mixing. Do not use if it looks clear or has any lumps or particles in it. Step 5: Select a new Needle. Pull off the Paper Tab from the Outer Needle Shield. Step 6: Push the capped Needle straight onto the Pen and twist the Needle on until it is tight. Step 7: Pull off the Outer Needle Shield. Do not throw it away. Pull off the Inner Needle Shield and throw it away. Priming your pen; Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 8: To prime your Pen, turn the Dose Knob to select 2 units. Step 9: Hold your Pen with the Needle pointing up. Tap	F 755		

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 10/24/2023

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 755	Continued From page 9 the Cartridge Holder gently to collect air bubbles at the top. Keep Outer Needle Shield Throw Away Inner shield. Step 10: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 8 to 10, no more than 4 times. If you still do not see insulin, change the Needle, and repeat priming steps 8 to 10. Small air bubbles are normal and will not affect your dose.	F 755		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to administer the right prescribed medications to right residents for 1 of 3 residents (R1). R1 had developed hypotension (low blood pressure) and bradycardia (low heart rate) that required emergency medical treatment and admitted to the hospital ICU (intensive care unit) to stabilize R1's condition which resulted in an immediate jeopardy (IJ). The immediate jeopardy (IJ) began on 10/9/23, when registered nurse (RN)-A failed to identity R1 prior to the administration of prescribed medications. The director of nursing (DON) and vice president of success (VPOS) were notified of the IJ on 10/24/23, at 6:30 p.m. The facility immediately implemented corrective action on 10/9/23, the deficient practice was corrected on	F 760	Past noncompliance: no plan of correction required.	

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 10/24/2023

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 760	Continued From page 10 10/9/23, prior to the start of the survey and was therefore issued at Past Noncompliance. Findings include: Facility reported incident (FRI) dated 10/9/23, indicated registered nurse (RN)-A (who was in training as new employee) was orienting with RN-B working together on the cart to dish up medications. RN-A stated to R1 is your name (R2's name), R1 stated yes. RN-A went to the med cart and told RN-B that R1 did not want the nasal spray. RN-B went to check in the bathroom and realized RN-A had accidentally given R2's medications to R1. Vitals signs were checked, provider called, R1 was visually monitored throughout the shift, and R1 was sent to the ED. Education provided to RN-A and RN-B on medication competency checklist, review of cardiac medications, side effects and policies of medication administration and errors. All trained medication assistants (TMAs) and licensed staff will be educated prior to the start of their next shift. R1's quarterly Minimum Data Set (MDS) dated 8/28/23, indicated R1's cognition to be moderately impaired and included diagnoses of multiple sclerosis (a neurological disease that results in nerve damage that disrupts communication between the brain and the body), hypertension (high blood pressure), and dementia. Further, the MDS identified R1 had adequate hearing without hearing aides. R1's medication administration record (MAR) dated 10/9/23, at 9:08 a.m. indicated R1 received the following scheduled medications per physician orders: amlodipine besylate 10	F 760		

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 10/24/2023

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 760	Continued From page 11 milligrams (mg) (a calcium channel blocker that helps to lower blood pressure), lisinopril 20 mg (relaxes blood vessels to help lower blood pressure), lactase 9,000 units (an enzyme that helps break down milk), acetaminophen 1,000 mg (pain reliever), and cholecalciferol (vitamin D),1000 units. R1's progress note dated 10/9/23, at 9:35 a.m. indicated R1 was given the wrong medications this morning, and received her own scheduled medications. R1 received in error, diltiazem (blood pressure medication)120 milligrams (mg), furosemide 20 mg (diuretic medication), metoprolol 20 mg (blood pressure medication), quetiapine fumarate 20 mg (antipsychotic medication), senna (stimulant laxative) and Tylenol 1000 mg (pain medication). Provider team notified, family notified. Blood pressure-151/51, pulse-66, O2 sats 94% on room air and temperature was 97.3, no pain noted. R1's med error report, dated 10/9/23, at 9:30 a.m. identified RN-B was mentoring RN-A had medications dished up and gave them to the wrong resident (R1). RN-B administered crushed medications to R1 instead of R2. R1 was aware she was given the wrong medications and vital signs are stable, no signs and symptoms of overdose at this time. Nursing at this time will continue to monitor. RN-B educated orientee RN-A about importance of following the medication administration rights. Also discussed not to go by what the resident says, some may not be able to answer accurately. There were no progress notes or vital signs records from 9:35 a.m. until 1:15 pm, to identify staff were monitoring R1's condition as a result of	F 760		

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 10/24/2023

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 760	Continued From page 12 the medication error which she received medications diltiazem, furosemide, metoprolol, and quetiapine that could potential to lower blood pressure and/or heart rate. R1's progress note dated 10/9/23 at 1:15 p.m., indicated R1's vital signs were rechecked, blood pressure 55/32, pulse 32, respirations-12, and oxygen saturations were 96% on room air. R1 appeared pale cool, very lethargic, was able to respond to verbal commands. 911 was called, emergency medical services (EMS) arrived at 1:20 p.m. Intravenous (IV) started, fluids started IVP Atropine (used to treat slow heart rate) was given by EMS at 1:30 p.m. EMS obtained blood sugar 192 mg/dl (normal 80-120 mg/dl). Blood pressure 55/23 and pulse 26. Family member (FM)-A was called and wanted all action to be taken at this time. EMS took R1 via ambulance at 1:35 p.m. According to the American Heart Association a normal blood pressure for an adult is a systolic (top number) reading that is below 120 and a diastolic (bottom number) reading that is below 80. A blood pressure would be considered low if under 90/60. A normal pulse is 60 - 100. R1's nurse practitioner note, dated 10/9/23, at 1:25 p.m. identified Chief Complaint was medication overdose incident; R1 was administered another resident's medications. R1's heart rate recorded 36 bpm (beats per minute) and she was getting symptomatic. Nursing is sending R1 in for immediate evaluation and intervention. EMS has been called and is currently at the facility. R1's ambulance report dated 10/9/23, at 1:45	F 760		

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 10/24/2023

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 760	Continued From page 13 p.m. indicated upon arrival R1 was slumped over in her wheelchair and alert to painful stimuli. Staff reported shortly before arrival, R1 reported not feeling well with more sluggish behavior and weak pulses. Staff reported pulses between 30's -40's. R1 was not able to answer questions well, unknown if this was due to dementia or shock. R1's skin was pale and dry; speech was slurred and not able to follow commands appropriately and had noted hypotension and bradycardia. R1 transferred patient care to receiving team at Saint Mary's Hospital. R1's ED to hospital note, dated 10/9/23, indicated reason for visit was a drug overdose with a primary diagnosis as bradycardia. Hospital course: R1 presented with bradycardia and hypotension in the setting of iatrogenic (illness caused by medical treatment) medication administration, generally takes amlodipine 10 mg and lisinopril 20 mg daily while at Rochester West. R1 received diltiazem XL and metoprolol instead of her usual medications. R1 was then transferred to intensive care unit (ICU) where R1 weaned off of the vasopressor (a group of medicines that constrict (tighten) blood vessels and raise blood pressure) medications within hours. During an observation and interview on 10/24/23 at 8:40 a.m., R1 was seated in a wheelchair up to the table in the dining room. R1 stated "I did have to go to the hospital recently, that's why I have bruises all over my arms from where they shot me up." R1 indicated not remembering why she was hospitalized. During a phone interview on 10/24/23 at 4:13 p.m., registered nurse (RN)-A indicated it was her	F 760		

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 10/24/2023

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 760	Continued From page 14 first day of orientation at the facility on 10/10/23, and RN-B was training her in. RN-A indicated she mistakenly gave R1, R2's medications. RN-B told her R1 would be on the toilet. RN-A had asked R1 if she was R2 and R2 indicated she was R1, so she gave R1 the pills. R1's vital signs were checked right away and they were normal. "We tried calling the provider three different times with no call back." We finally called 911 because R1's pulse was in the 30's and R1 was sent out to the hospital. RN-A indicated it was not known when R1's blood pressure and heart rate started to drop because no one was monitoring vital signs and did not identify why monitoring was not in place. RN-A stated R1's vital signs should have been frequently monitored after the error. During a phone interview on 10/24/23 at 10:33 a.m., RN-B stated on 10/9/23, she was mentoring RN-A who was a new nurse to the facility. Around 9:30 a.m. RN-B stated RN-A had dished up R2's medications and went to the bathroom and gave the medications to R1 in error. RN-B indicated R1 had received her morning meds around 7:30 a.m. and then received R2's morning meds around 9:30 am. RN-B stated she took R1's vital signs right away and they were within normal limits, attempted to call the on-call physician, but was unable to get a return call timely. RN-A indicated R1's vital signs had not been monitored after the medication error and before the physician returned the call at 1:15 p.m. RN-A was unable to articulate why there was no monitoring in place. When the provider called back at 1:15 p.m., R1 was lethargic, cool to the touch, and had a pulse of 32. The on-call provider gave the order to send to the hospital. She stayed with R1 trying to keep her awake until the ambulance arrived; they immediately started an IV and gave R1	F 760		

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 10/24/2023

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 760	Continued From page 15 some Atropine (a medication that increases heart rate) and sent to the hospital. During an interview on 10/24/23 at 3:02 p.m., director of nursing (DON), indicated that on 10/9/23, RN-A should not have been passing medications because it was her first day of orientation. RN-A should have just observed, that was the reason access to the electronic health record was not immediately given to new staff. RN-A gave R1, R2's medications in addition to her own mistakenly. DON indicated she informed RN-B to check vital signs and call the provider. DON was not aware there was difficulty with contacting the provider until after lunch time and not aware R1's vital signs were not being monitored or assessed. R1 was transferred from the ER to the ICU for cardiac treatment; her diagnoses were a drug overdose and bradycardia. DON immediately educated RN-A and RN-B on the five rights of medication administration, triple checking medications, cardiac med side effects, the monitoring and assessing of a change in condition, and education on how to contact the on-call medical provider. Additionally she educated all trained medication assistants (TMAs) and licensed staff prior to their next shift. During an interview on 10/25/23, at 11:00 a.m. medical director (MD) indicated he was aware of the medication error had occurred however was not aware of the details that led up to the error, did not realize R1's vital signs were not monitored from 9:09 a.m. until R1 was sent by ambulance at 1:15 p.m., and unsure why their was a delay with the on-call physician services. At a minimum MD expected frequent monitoring of R1's vital signs for changes and when R1's pulse dropped to 32	F 760		

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 10/24/2023

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 760	Continued From page 16 and blood pressure dropped to 55/32 with signs and symptoms of lethargy became an emergent situation requiring emergency services. MD further indicated medications R1 received in the hospital increased and stabilized her blood pressure and heart rate. Facility policy Medication Administration General Guidelines dated 01/21, identified ...10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification include a. check identification band, b. check photograph attached to medical record, C. verifies resident identification with other nursing care center personnel. Note: the residents room number or physical location is not used as an identifier. Facility policy Medication Error Reporting and Adverse Reaction Prevention and Detection dated 9/2010, identified 3. Medication errors and adverse drug reactions are considered significant if they: a. require discontinuing a medication or modifying a dose, b. require hospitalization ...require treatment with a prescription medication ...F. are life threatening 6. In the event of a significant medication error or adverse drug reaction, immediate action is taken, as necessary, to protect the residents safety and welfare. A. The prescriber is notified promptly of any significant error or adverse medication reaction, b. Any new prescriber's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed. Facility policy Change in Condition of the Resident, dated 9/20/22, identified A facility should immediately...consult with the resident's physician...when there is an accident involving	F 760		

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 10/24/2023

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 760	Continued From page 17 the resident which results in injury and has the potential for requiring physician intervention; 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); or a need to alter treatment significantly. Facility policy, Physician Visits, dated 6/17/19, identified a facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. Lacked a procedure. The past noncompliance immediate jeopardy that began on 10/9/23, was removed on 10/9/23, after the facility implemented a systemic plan which included training of all staff responsible for medication administration to include: the right patient, right medication, right dose, right time, right route, and documentation. Assessing for a change in condition and monitoring the residents condition along with provider notification. A plan was made for medication competency checks and audits to ensure compliance, which was verified through interview and document review.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		11/21/23

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 10/24/2023

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 880	Continued From page 18 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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 10/24/2023

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 880	Continued From page 19 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper hand hygiene was performed during a medication pass between 2 of 6 residents (R3 and R4) reviewed for medication administration. Findings include R3's admission Minimum Data Set (MDS) 8/23/23, indicated R3 had severe cognitive impairment with diagnoses that included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia (lack of oxygen), Alzheimer's disease with late onset, and dementia. During an observation and interview on 10/24/23 at 8:39 a.m., licensed practical nurse (LPN)-A prepared R3's -Duo neb inhalation (breathing medication). At 8:45 a.m. LPN-A entered R3's room as he was seated in a wheelchair. LPN-A	F 880	1. R3 and R4 have not demonstrated any signs or symptoms of infection related to the alleged practice. 2. Facility in house residents who receive nebulizers have the potential to be affected by alleged practice. 3. The facility licensed nursing staff were re-educated on nebulizer administration and infection control processes by Director of nursing and or designee starting on 10/25/2023. 4. The facility will audit nebulizer administration including infection control policies starting 10/25/23. Director of Nursing or designee will complete medication competencies by 11/21/2023. Director of Nursing or designee will complete audits. Audit will be completed 3	

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 10/24/2023

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 880	Continued From page 20 administered R3's medications. LPN-A put the Duo neb fluid into the nebulizer reservoir and started the nebulizer machine and placed the mask on R3, stated she set a timer (did not report how long), and left R3 unattended in his room. At 9:07 a.m. R3 remained seated in his wheelchair with the nebulizer mask on his face with the treatment running. At 9:12 a.m. R3 took his mask off and hung it on the nebulizer machine. LPN-A was not observed to use hand hygiene before or after administration. LPN-A was not observed to cleanse R3's nebulizer reservoir before or after treatment. R4's quarterly MDS dated 8/8/23, indicated R4's did not have cognitive impairment and had diagnoses of diabetes and lack of coordination. During an observation on 10/24/23 at 9:08 a.m., LPN-A prepared R4's morning medications without first completing hand hygiene. Medications included: -Amlodipine 2.5 mg (hypertension medication) -Metformin 1000 mg (diabetic medication) -Metoprolol tartrate 25 mg (hypertension medication) -Novolin N 10 units (insulin) subcutaneous injection At 9:14 a.m. LPN-A walked into R4's room as R4 was seated in his wheelchair. LPN-A placed the medication cup that contained the pills and a small cup of applesauce on R4's bedside table. LPN-A then left the room. At 9:21 a.m. LPN-A was not observed to use hand hygiene before or after entering R4's room. LPN-A further indicated she did not cleanse or sanitize R3's nebulizer reservoir before or after treatment. During an interview on 10/24/23 at 2:37 p.m.,	F 880	times per week on varying shift for 8 weeks or until substantial compliance is Maintained. Results of Audits will be brought to QAPI for review and recommendation	

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 10/24/2023

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 880	Continued From page 21 LPN-A indicated she did not perform hand hygiene in between administering resident treatments and medications and further indicated she did not cleanse the nebulizer reservoir before or after administration. During an interview on 10/24/23 at 2:52 p.m., director of nursing (DON) indicated hand hygiene should be performed before after medication administration and between residents and indicated the nebulizer reservoir should be cleansed before and after administration. Facility policy Medication administration dated 1/21, identified ...11. Hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. Hands are washed with soap and water again after administration and with any resident contact. Antimicrobial sanitizer may be used in place of soap and water as allowed per state nursing regulations and facility policy. Facility policy Nebulizer Administration dated 09/2010, identifed 2. Assemble equipment and supplies on the resident's overbed table, with a barrier between supplies/medication and table. 3. Perform hand hygiene. 4. Position resident in semi-fowler's position. 5. Obtain baseline pulse, respiratory rate and lung sounds. 6. Draw up the medication to be nebulized if the medication is not in a unit-dose container. 7. Pour medication into a clean nebulizer cup. 8. Add the diluent, if ordered or required by the manufacturer (see package insert). 9. Assemble nebulizer equipment and attach to nebulizer compressor or gas source per manufacturer's instructions. Adjust the flow rate as ordered or per facility	F 880		

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 10/24/2023

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 880	Continued From page 22 protocol.10. Turn on the nebulizer and check the outflow port for visible mist. 11. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask).12. Instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughout treatment.13. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer.14. Monitor for medication side effects, including rapid pulse, restlessness and nervousness. 15. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits.16. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup.17. Encourage the resident to cough and expectorate as needed.18. Administer therapy until medication is gone (mist has stopped) or until the designated time of treatment has been reached. 19. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. 20. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings on the MAR or in the resident's medical record following facility policy. 21. Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations and facility policy. 22. Wash hands thoroughly. 23. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 24. Change equipment and tubing per nursing facility policy.25. Disinfect outside of the compressor between residents, according to manufacturer's instructions and facility policy.	F 880		

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 _____	C 10/24/2023

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) COMPLETE DATE
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 10/24/23, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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 _____	C 10/24/2023

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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53066530C (MN97607 and MN97604) with a licensing order issued at 1385, 1545 and 1565. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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 _____	C 10/24/2023

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) COMPLETE DATE
2 000	Continued From page 2 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		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper hand hygiene was performed during a medication pass between 2 of 6 residents (R3 and R4) reviewed for medication administration. Findings include: R3's admission Minimum Data Set (MDS) 8/23/23, indicated R3 had severe cognitive impairment with diagnoses that included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia (lack of oxygen), Alzheimer's disease with late onset, and dementia. During an observation and interview on 10/24/23 at 8:39 a.m., licensed practical nurse (LPN)-A prepared R3's -Duo neb inhalation (breathing	21385		11/21/23

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 _____	C 10/24/2023

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) COMPLETE DATE
21385	Continued From page 3 medication). At 8:45 a.m. LPN-A entered R3's room as he was seated in a wheelchair. LPN-A administered R3's medications. LPN-A put the Duo neb fluid into the nebulizer reservoir and started the nebulizer machine and placed the mask on R3, stated she set a timer (did not report how long), and left R3 unattended in his room. At 9:07 a.m. R3 remained seated in his wheelchair with the nebulizer mask on his face with the treatment running. At 9:12 a.m. R3 took his mask off and hung it on the nebulizer machine. LPN-A was not observed to use hand hygiene before or after administration. LPN-A was not observed to cleanse R3's nebulizer reservoir before or after treatment. R4's quarterly MDS dated 8/8/23, indicated R4's did not have cognitive impairment and had diagnoses of diabetes and lack of coordination. During an observation on 10/24/23 at 9:08 a.m., LPN-A prepared R4's morning medications without first completing hand hygiene. Medications included: -Amlodipine 2.5 mg (hypertension medication) -Metformin 1000 mg (diabetic medication) -Metoprolol tartrate 25 mg (hypertension medication) -Novolin N 10 units (insulin) subcutaneous injection At 9:14 a.m. LPN-A walked into R4's room as R4 was seated in his wheelchair. LPN-A placed the medication cup that contained the pills and a small cup of applesauce on R4's bedside table. LPN-A then left the room. At 9:21 a.m. LPN-A was not observed to use hand hygiene before or after entering R4's room. LPN-A further indicated she did not cleanse or sanitize R3's nebulizer reservoir before or after treatment.	21385		

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 _____	C 10/24/2023

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) COMPLETE DATE
21385	Continued From page 4 During an interview on 10/24/23 at 2:37 p.m., LPN-A indicated she did not perform hand hygiene in between administering resident treatments and medications and further indicated she did not cleanse the nebulizer reservoir before or after administration. During an interview on 10/24/23 at 2:52 p.m., director of nursing (DON) indicated hand hygiene should be performed before after medication administration and between residents and indicated the nebulizer reservoir should be cleansed before and after administration. Facility policy Medication administration dated 1/21, identified ...11. Hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. Hands are washed with soap and water again after administration and with any resident contact. Antimicrobial sanitizer may be used in place of soap and water as allowed per state nursing regulations and facility policy. Facility policy Nebulizer Administration,dated 09/2010, identifed 2. Assemble equipment and supplies on the resident's overbed table, with a barrier between supplies/medication and table. 3. Perform hand hygiene. 4. Position resident in semi-fowler's position. 5. Obtain baseline pulse, respiratory rate and lung sounds. 6. Draw up the medication to be nebulized if the medication is not in a unit-dose container. 7. Pour medication into a clean nebulizer cup. 8. Add the diluent, if ordered or required by the manufacturer (see package insert). 9. Assemble nebulizer equipment and attach to nebulizer compressor or gas source per manufacturer's instructions. Adjust the flow rate as ordered or per facility	21385		

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 _____	C 10/24/2023

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) COMPLETE DATE
21385	Continued From page 5 protocol.10. Turn on the nebulizer and check the outflow port for visible mist. 11. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask).12. Instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughout treatment.13. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer.14. Monitor for medication side effects, including rapid pulse, restlessness and nervousness. 15. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits.16. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup.17. Encourage the resident to cough and expectorate as needed.18. Administer therapy until medication is gone (mist has stopped) or until the designated time of treatment has been reached. 19. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. 20. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings on the MAR or in the resident's medical record following facility policy. 21. Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations and facility policy. 22. Wash hands thoroughly. 23. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 24. Change equipment and tubing per nursing facility policy.25. Disinfect outside of the compressor between residents, according to manufacturer's instructions and facility policy. SUGGESTED METHOD OF CORRECTION: The	21385		

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 _____	C 10/24/2023

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) COMPLETE DATE
21385	Continued From page 6 DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single	21545		11/21/23

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 _____	C 10/24/2023

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) COMPLETE DATE
21545	Continued From page 7 medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: F755 Based on observation, interview and record review, the facility failed to ensure insulin was administered in accordance with manufacturer recommendations for 1 of 1 resident (R4) reviewed for insulin administration. Findings include: R4's quarterly Minimum Data Set (MDS) dated 8/8/23, indicated R4's did not have cognitive impairment and had diagnoses of diabetes and lack of coordination. MDS further identified R4 received daily insulin injections.	21545	na	

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 _____	C 10/24/2023

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) COMPLETE DATE
21545	Continued From page 8 R4's medication administration record (MAR) dated 10/9/223, included the physicians order to inject NPH (Human) (Isophane) insulin 10 units subcutaneously at 8:00 a.m. During an observation on 10/24/23 at 9:08 a.m., licensed practical nurse (LPN)-A prepared R4's insulin. During preparation LPN-A did not clean the rubber seal of the insulin flex pen with an alcohol wipe, put the disposable needle on, pulled off the inner needle cap and dialed up 8 units of insulin without priming the needle. At 9:14 a.m. LPN-A administered the insulin to R4 in the abdomen. LPN-A informed R4 she needed to get 2 more units of insulin. LPN-A walked to the medication room, obtained a new insulin pen, did not clean the rubber seal of the insulin flex pen with alcohol, and did not prime the needle, and dialed up 2 units. At 9:21 a.m. LPN-A returned to R4's room and administered the remaining 2 units of insulin without first priming the insulin. During an interview on 10/24/23, at 2:37 p.m. LPN-A confirmed she did not prime the insulin pen with 2 units to ensure the correct dose of insulin was delivered when she administered R4's insulin. During an interview on 10/24/23, at 2:52 p.m. director of nursing (DON) confirmed staff should be priming insulin pens with 2 units prior to dialing up the ordered dose of insulin. Facility policy, Subcutaneous Insulin, dated 01/22, identified to administer subcutaneous insulin as ordered in a safe, accurate and effective manner. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen	21545		

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 _____	C 10/24/2023

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) COMPLETE DATE
21545	Continued From page 9 and needle work properly and removing air bubbles. A. Select the dose of units by turning the dosage selector. You can set the dose in steps of 1 unit, from a minimum of 1 unit to a maximum of 80 units. If you need a dose greater than 80 units, you should give it as two or more injections. Check that the dose window shows "0" following the safety test. Select your required dose (in the example below, the selected dose is 30 units). If you turn past your dose, you can turn back down. C. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. D. Hold the pen with the needle pointing upwards. E. Tap the insulin reservoir so that any air bubbles rise up towards the needle. F. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. If no insulin comes out, check for air bubbles, and repeat the safety test two more times to remove them. If still no insulin comes out, the needle may be blocked. Change the needle and try again. If no insulin comes out after changing the needle, the pen may be damaged. Do not use this pen. Do not push the injection button while turning, as insulin will come out. You cannot turn the dosage selector past the number of units left in the pen. Do not force the dosage selector to turn. Manufacturer Recommendations, Humulin N KwikPen (insulin isophane human) injectable solution for subcutaneous use, revised June 2022, identified preparing your pen; Step 1 Pull the Pen Cap straight off. Do not remove the Pen Label. Wipe the Rubber Seal with an alcohol swab. Do not attach the Needle before mixing. Step 2: Gently roll the Pen between your hands 10 times. Step 3: Move the Pen up and down (invert) 10 times. Mixing by rolling and inverting	21545		

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 _____	C 10/24/2023

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) COMPLETE DATE
21545	Continued From page 10 the Pen is important to make sure you get the right dose. Step 4: check the liquid in the Pen. HUMULIN N should look white and cloudy after mixing. Do not use if it looks clear or has any lumps or particles in it. Step 5: Select a new Needle. Pull off the Paper Tab from the Outer Needle Shield. Step 6: Push the capped Needle straight onto the Pen and twist the Needle on until it is tight. Step 7: Pull off the Outer Needle Shield. Do not throw it away. Pull off the Inner Needle Shield and throw it away. Priming your pen; Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 8: To prime your Pen, turn the Dose Knob to select 2 units. Step 9: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Keep Outer Needle Shield Throw Away Inner shield. Step 10: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 8 to 10, no more than 4 times. If you still do not see insulin, change the Needle, and repeat priming steps 8 to 10. Small air bubbles are normal and will not affect your dose. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these	21545		

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 _____	C 10/24/2023

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) COMPLETE DATE
21545	Continued From page 11 measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and determine safety for self-administration of medications (SAM) for 2 of 6 residents (R3 and R4) reviewed for medication administration. Findings include: R3's admission Minimum Data Set (MDS) 8/23/23, indicated R3 had severely impaired cognition, and diagnoses of chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia (lack of oxygen), Alzheimer's disease with late onset, and dementia. During an observation on 10/24/23, at 8:39 a.m., licensed practical nurse (LPN)-A prepared R3's -Duo neb inhalation (breathing medication). At 8:45 a.m. LPN-A entered R3's room as he was seated in a wheelchair. LPN-A put the Duo neb fluid into the nebulizer reservoir and started the	21565	corrected	11/21/23

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 _____	C 10/24/2023

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) COMPLETE DATE
21565	Continued From page 12 nebulizer machine and placed the mask on R3, stated she set a timer (did not report how long), and left R3 unattended in his room. At 9:07 a.m. R3 remained seated in his wheelchair with the nebulizer mask on his face with the treatment running. At 9:12 a.m. R3 took his mask off and hung it on the nebulizer machine. R4's quarterly MDS dated 8/8/23, indicated R4's cognition was intact and had diagnoses of diabetes and lack of coordination. During an observation on 10/24/23, at 9:08 a.m. LPN-A prepared R4's morning medications. Medications included: -Amlodipine 2.5 mg (hypertension medication) -Metformin 1000 mg (diabetic medication) -Metoprolol tartrate 25 mg (hypertension medication) -Novolin N 10 units (insulin) subcutaneous injection At 9:14 a.m. LPN-A walked into R4's room as R4 was seated in his wheelchair. LPN-A placed the medication cup that contained the pills and a small cup of applesauce on R4's bedside table. LPN-A then left the room without watching R4 take the medications. At 9:21 a.m. LPN-A returned to R4's room the pills on the bedside table were no longer there. LPN-A asked R4 if the medications went down ok, R4 indicated, yes. During an interview on 10/24/23, at 2:37 p.m. LPN-A indicated she left R3 unattended with his nebulizer and R4 unattended with his medications and verified they did not have self-administration assessments completed to determine if they were safe to take medications safely themselves. During an interview on 10/24/23, at 2:52 p.m. DON indicated the only time a self-administration	21565		

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 _____	C 10/24/2023

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) COMPLETE DATE
21565	Continued From page 13 assessment was completed on a resident to determine if they were able to safely self-administer their own medications was upon request. DON indicated R3 and R4 have not been assessed to safely to self-administer their own medications. Facility policy, Self-Administration by Resident, dated, 11/17, identified residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, and the medications are appropriate and safe for self-administration. 2. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted as part of the care plan process. The nursing care center may use the following as a guideline or establish an alternate procedure: The resident is instructed in the use of the package, purpose of the medication, reading of the label, and scheduling of medication doses. The resident is then requested to read the label on each package and indicate at what time the medication should be taken and any other special instructions for use and know what conditions they are taken for. Resident is able to tell time to know when medications need to be taken. Resident comprehends instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff. The resident is asked to demonstrate the removal of the medication from the package and, in the case of nonsolid dosage forms such as an inhaler, to verbalize the steps involved in administration. The resident's physical capacity to swallow without difficulty and to open medication bottles. The resident is asked to complete a bedside record indicating the	21565		

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 _____	C 10/24/2023

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) COMPLETE DATE
21565	Continued From page 14 administration of the medication. Resident understands what refusal of medication is, and appropriate steps taken by staff to educate when this occurs. 3. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is placed in the resident's medical record. Facility policy, Nebulizer Administration, dated 09/10, identified 2. Assemble equipment and supplies on the resident ' s overbed table, with a barrier between supplies/medication and table. 3. Perform hand hygiene. 4. Position resident in semi-fowler ' s position. 5. Obtain baseline pulse, respiratory rate and lung sounds. 6. Draw up the medication to be nebulizer if the medication is not in a unit-dose container. 7. Pour medication into a clean nebulizer cup. 8. Add the diluent, if ordered or required by the manufacturer (see package insert). 9. Assemble nebulizer equipment and attach to nebulizer compressor or gas source per manufacturer ' s instructions. Adjust the flow rate as ordered or per facility protocol.10. Turn on the nebulizer and check the outflow port for visible mist. 11. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask).12. Instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughout treatment.13. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer. 14. Monitor for medication side effects, including rapid pulse, restlessness and nervousness. 15. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits. 16. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup. 17. Encourage the resident to cough and expectorate as needed. 18.	21565		

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 _____	C 10/24/2023

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) COMPLETE DATE
21565	Continued From page 15 Administer therapy until medication is gone (mist has stopped) or until the designated time of treatment has been reached. 19. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. 20. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings on the MAR or in the resident ' s medical record following facility policy. 21. Rinse and disinfect the nebulizer equipment according to manufacturer ' s recommendations and facility policy. 22. Wash hands thoroughly. 23. When equipment is completely dry, store in a plastic bag with the resident ' s name and the date on it. 24. Change equipment and tubing per nursing facility policy. 25. Disinfect outside of the compressor between residents, according to manufacturer ' s instructions and facility policy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one	21565		

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 _____	C 10/24/2023

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) COMPLETE DATE
21565	Continued From page 16 (21) days.	21565		