

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered May 6, 2021

Administrator Rochester Rehabilitation And Living Center 1900 Ballington Boulevard Nw Rochester, MN 55901

RE: CCN: 245626

Cycle Start Date: February 18, 2021

Dear Administrator:

On April 23, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mighing

P.O. Box 64970

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 April 29, 2021

Administrator
Rochester Rehabilitation And Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626

Cycle Start Date: February 18, 2021

Dear Administrator:

On March 9, 2021, we informed you that we may impose enforcement remedies.

Compliance with the health deficiencies cited on February 18, 2021 has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 18, 2021. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Adminstrative Contractor (MAC) that the denial of payment for new admissions is effective May 18, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 18, 2021. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Rochester Rehabilitation And Living Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 18, 2021. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

Rochester Rehabilitation And Living Center April 29, 2021 Page 2

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900 Rochester Rehabilitation And Living Center April 29, 2021 Page 3

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, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 9, 2021

Administrator Rochester Rehabilitation And Living Center 1900 Ballington Boulevard NW Rochester, MN 55901

RE: CCN: 245626

Cycle Start Date: February 18, 2021

Dear Administrator:

On February 18, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

Rochester Rehabilitation And Living Center March 9, 2021 Page 2

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by May 18, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

Rochester Rehabilitation And Living Center March 9, 2021

Page 3

In addition, if substantial compliance with the regulations is not verified by August 18, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 03/30/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--------------------|-----|---|---|----------------------------|
| | | 245626 | B. WING | | | C 02/18/2021 | |
| _ | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | , <u>, , , , , , , , , , , , , , , , , , </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 000 | On 2/16/2021 to 2/ survey was comple a complaint investion NOT to be in comp | TS /18/2021, an abbreviated ted at your facility to conduct gation. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities. | FC | 000 | | | |
| | SUBSTANTIATED: H5626019C (MN00 | | | | | | |
| | of investigation a de H5626017C (MN00 cited at F761 | plaints were found ED however, during the course eficiency was identified: 1064741), a deficiency was 1069637), a deficiency was | | | | | |
| | The following comp UNSUBSTANTIATE deficiencies. H5626014C (MN00 H5626016C (MN00 H5626012C (MN00 | ED without associated 0069655) 0061235) 0067429) | | | | | |
| | as your allegation of Department's accelenrolled in ePOC, y | f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 | | | | | |
| I ABOBATOR | an on-site revisit of | acceptable electronic POC, your facility may be DER/SUPPLIER REPRESENTATIVE'S SIGN | IATLIDE | | TITLE | | (X6) DATE |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/18/2021

Electronically Signed

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.

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | (X3) DATE COMP | LETED |
|--------------------------|---|--|---------------------|--|--|----------------------------|
| | | 245626 | B. WING | | 02/18 | 8/2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | , , , | |
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| F 000 | with the regulations accordance with yo | te that substantial compliance has been attained in | F 0 | | , | 3/19/21 |
| | CFR(s): 483.12(b)(§483.12(b) The fac implement written p §483.12(b)(1) Proh neglect, and exploit misappropriation of §483.12(b)(2) Estal to investigate any s §483.12(b)(3) Inclu paragraph §483.95 | lity must develop and colicies and procedures that: bit and prevent abuse, ation of residents and resident property, blish policies and procedures uch allegations, and de training as required at | F 0 | | | 5/19/21 |
| | facility failed to ensign Policy and Procedure Regulations. Findings include: The facility Resider Protection/Freedom Misappropriation Policy 12020 was inconsigned reporting requirement of the facility Resider Protection of | r From Abuse, Neglect and blicy and Procedures revised stent with the Federal ents for abuse and did not abuse within the two-hour included that "If there is e occurred, it will be reported ng Agency in accordance with | | F000-Allegation of Compliance: plan of correction is prepared and submitted as required by the law. submitting this plan of correction, does not admit that the deficiencion CMS-2567 form exist nor does admit to any statements, findings conclusions that are for the basis alleged deficiencies. RRLC reserright to challenge in legal proceed deficiencies, statements, findings and conclusions that form the basis deficiencies. Corrective actions taken for residing found to be affected by this deficiencies Addendum was added to facility president/Client/Participant | By RRLC es listed s RRLC , facts or for all rves the dings all , facts sis of the ents ency? | |

PRINTED: 03/30/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF F | -NOVIDEN ON SUFFEIEN | | | | | | |
| ROCHES | TER REHABILITATIO | N AND LIVING CENTER | | | 900 BALLINGTON BOULEVARD NW COCHESTER, MN 55901 | | |
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| F 607 | executive director (It of abuse should be twenty-four hours, of The ED-A verified the Policy and Procedurallegations of abuse hours of the incider | on 2/18/2021, at 12:51 p.m. ED)-A stated that allegations reported within two hours or depending on the incident. The facility Abuse Prevention are did not indicate that the should be reported within 2 at. | F 6 | | Protection/Freedom From Abuse, Nand Misappropriation Policy and Procedures to reflect the Federal reporting requirement. How the facility will identify other residents that have the potential to affected by the same deficient pracand what corrective action was take All residents have the potential to affected by this practice. In-service to staff regarding the Federal reporting requirement and Vulneral Adult Reporting was held on March 10 and 11, 2021. Systemic changes to be made to enthe deficient practice does not recurred the deficient practice does not recurred to resident/Client/Participant Protection/Freedom From Abuse, Nand Misappropriation Policy and Procedures to reflect the Federal reporting requirement. Quality monitor implemented to revocompliance with timeliness of reporting requirements weekly x 4 weeks, max 3 months then quarterly x 2 quart Measures that will be implemented monitor the continued effectiveness correction action taken to ensure compliance is achieved and sustain Results of the quality review monitor be reviewed monthly through the Corrocess to identify need for further education and/or need for future monitoring. | be etice en: be deral ble in 4, 9, insure ir: Neglect view riting onthly ters. to so of the ined: brs will DAPI | 0/40/04 |
| F 609 | Reporting of Allege | a violations | F 6 | 809 | | | 3/19/21 |

Facility ID: 29822

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | ' IDENTIFICATION NUMBER: ' | | TIPLE CONSTRUCTION ING | COM | (X3) DATE SURVEY COMPLETED | |
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| | | 245626 | B. WING | | | C 18/2021 | |
| | PROVIDER OR SUPPLIER | ON AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 1900 BALLINGTON BOULEVARD N ROCHESTER, MN 55901 | CODE | | |
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| F 609 SS=D | CFR(s): 483.12(c) §483.12(c) In resp neglect, exploitation must: §483.12(c)(1) Ens involving abuse, not involving abuse, not involve and misapp are reported immed hours after the alled that cause the alled in serious bodily in if the events that convolve abuse and injury, to the admit other officials (incl.) Agency and adult law provides for jutter facilities) in accorded established process §483.12(c)(4) Reprinvestigations to the designated repressuccordance with Survey Agency, with incident, and if the appropriate correct This REQUIREME by: Based on interviet facility failed to represent the State Agency of the State Agency in the Sta | onse to allegations of abuse, on, or mistreatment, the facility are that all alleged violations eglect, exploitation or uding injuries of unknown propriation of resident property, diately, but not later than 2 egation is made, if the events gation involve abuse or result jury, or not later than 24 hours ause the allegation do not do not result in serious bodily histrator of the facility and to uding to the State Survey protective services where state risdiction in long-term care lance with State law through | F6 | Corrective actions taken for found to be affected by this R6 currently residing at the and NA-A received education emotional or mental abuse reporting. | deficiency? facility. LPN-A on regarding | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| F 609 | Findings include A Facility Reported the State Agency or alleged emotional of member that had or 10:00 p.m. According 10:00 p.m. the nursurde to R6 and the suspended pending. During an interview licensed practical in worked the evening stated at around 9:10 concerns of how Napassed the concerns of how N | Incident (FRI) submitted to n 2/1/2021, at 3:00 p.m., or mental abuse by a staff occurred on 1/31/2021, at ng to the report on 1/31/21, at se was reported to be verbally staff member had been g investigation. If on 2/19/2021, at 10:27 a.m. urse (LPN)-A stated he g shift on 1/31/2021. LPN- A 200 p.m. R6 ad reported A-A had treated her and a along to the overnight nurse. nawareness the allegation eported to the State Agency. If on 2/17/2021, at 1:15 p.m. on 2/17/2021, at 1:15 | F 609 | R4 no longer resides at the facility. LPN-A received education regardir respecting residents wishes. LPN-following physician orders for the rinjection. How the facility will identify other residents that have the potential to affected by the same deficient pracand what corrective action was tak All residents have the potential to affected by this practice. In-service to staff regarding the Fe reporting requirement and Vulnera Adult Reporting was held on March 10 and 11, 2021. Systemic changes to be made to e the deficient practice does not recurred to the deficient practice does not recurred to the resident/Client/Participant Protection/Freedom From Abuse, I and Misappropriation Policy and Procedures to reflect the Federal reporting requirement. Quality monitor implemented to recompliance with timeliness of reporequirements weekly x 4 weeks, m x 3 months then quarterly x 2 quare Measures that will be implemented monitor the continued effectivenes correction action taken to ensure compliance is achieved and sustain Results of the quality review monit be reviewed monthly through the Coprocess to identify need for further education and/or need for future monitoring. | deral ble n 4, 9, ensure ur: Neglect View rting onthly ters. I to s of the ned: ors will QAPI | |

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| F 609 | During an interview social worker (SW)-submitted to the state allegation was not a Agency and should two hours of the incomplete two hours of the security of abuse should be reported to the security of the facility Resident (Client/Par From Abuse, Negle and Procedure did abuse should be reincident. The facility Resident Protection/Freedom Misappropriation Postation of the facility Resident (Client/Par From Abuse) was inconsing reporting requirement of the facility Resident (Client/Par From Abuse) and procedure did abuse should be reincident. | told R4 that he needed to cedures around here. on 2/18/2021, 9:35 a.m. A reviewed the report ate agency, verified the submitted timely to the State have been submitted within cident. on 2/18/2021, at 12:51 p.m. ED)-A stated that allegations reported within two hours or depending on the incident. at allegations of abuse should cate within two hours and cort was not submitted within a ED-A verified the ticipant Protection/Freedom ct and Misappropriation Policy not indicate that allegations of ported within 2 hours of the at/Client/Participant a From Abuse, Neglect and olicy and Procedures revised stent with the Federal ents for abuse and did not a abuse within the two-hour an included that "If there is e occurred, it will be reported and Agency in accordance with | F 60 | 09 | | |
| F 684 SS=D | state law immediate Quality of Care CFR(s): 483.25 § 483.25 Quality of | | F 68 | 34 | | 3/19/21 |
| | 3 +00.20 Quality Of | GaiG | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245626 | B. WING | | C 02/18/ 2 | 2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE CC | (X5) DMPLETION DATE |
| F 684 | Quality of care is a applies to all treatm facility residents. Be assessment of a rethat residents received accordance with propractice, the compression of the compression of the control | fundamental principle that hent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of behensive person-centered residents' choices. NT is not met as evidenced stion, interview, and document ailed to provide bowel cility protocol and/or physician revent constipation for 3 of 3 and R3) who were reviewed hent. cord, included diagnosis of the weakness, dementia without nice. The report indicated R5 to the facility on 8/13/2020, 8/21/2020 to a hospital. the plan, indicated R5 was inent of bowel. ers included: adder Data Collection in the of chart and fill out and lock | F 684 | Corrective actions taken for reside found to be affected by this deficien R5 no longer resides in the facility. R8 and R3 currently reside in the facility. R8 and R3 currently reside in the facility resident standing orders for box protocol has been updated. How the facility will identify other residents that have the potential to affected by the same deficient practice and what corrective action was take All residents have the potential to affected by this practice. The Bowel Protocol was updated in facility standing orders. BM record spreadsheets were developed and implemented for all residents. Instead to clinical staff will be conducted regarding updated standing order of Bowel protocol. Systemic changes to be made to each the deficient practice does not recurred the deficient practice does not rec | be etice en: be the ervice on ensure ur: n the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245626 | B. WING _ | | 02 | C / 18/2021 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | | 710/2021 |
| ROCHES | STER REHABILITATION | ON AND LIVING CENTER | | 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 684 | facility bowel care evidence of a bow -Prune Juice 4 our bran/applesauce/ptablespoons twice constipationMiralax 17 grams constipationMiralax 17 grams constipationSennosides 2 tab for constipationGlycerin or bisacc rectum daily as ne-Tap water enema medications attem. The standing orde order to administe suppository or if the given all at the R5's Nursing Data Collection-Admiss assessment dated Gastrointestinal Sybowel movement of frequently incontin pattern however the what the pattern were orded answer find with an "X" with no R5's bowel movement of bowel movements 8/13/2020 to 8/21/bowel movements 8/18 and 8/21/202 | protocol (facility lacked el care protocol) noes daily and/or orune mixture/equivalent to 2 a day as needed for daily as needed for lets twice per day as needed ontact provider if taking an odyl 10 mg suppository one per eded for constipation after above as needed pted and unsuccessful. It is did not identify a specific or Miralax, Sennosides, or elemedications could/or should same time. Ion/Readmission Day 8/14/2020, included a section of seem that identified R5's last was on 8/12/2020, was ent, R5 had a regular bowel he assessment did not identify as. The area that prompted a for bowel sounds was noted to other description. Inent record identified between 2020, R5 had one medium on 8/17/2020. No recorded between 8/12 and 8/16, and | F 68 | regarding updated standing of Bowel protocol. Quality monitor implemented residents without BM for 3 da Clinical meeting and assure bowel protocol executed-week weeks, monthly x 3 months tix 2 quarters. Measures that will be implemented to the continued effective correction action taken to ensure the compliance is achieved and a Results of the quality review be reviewed monthly through process to identify need for full monitoring. | to review ays at Daily appropriate ekly x 4 hen quarterly nented to veness of the sure sustained: monitors will a the QAPI urther | 9 |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 245626 | B. WING | | | | C 18/2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP COI 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD | BE | (X5) COMPLETION DATE |
| F 684 | monitoring, assessi interventions according orders. R5's progress note indicated Tylenol with abdominal pain. R5's progress note included, "At 730 [stresident's overnight reporting abdominates resident was bladdered and Tylenol was off relieving resident's resident still complation pain; pain noted up and center quadrar last bowel moveme 8/17. Bowel sounds sennat and a supposent belation of the second or the second of the second or the second o | ment and implementation of ding to the facility's standing dated 8/20/2020 at 8:15 p.m., as administered for left sided dated 8/21/2020, at 9:23 a.m. sic], author was notified by a nurse that resident was all pain. As interventions are scanned and catheterized, fered. None were effective in pain. Upon assessment, ained of right-sided abdominal on palpation of right-sided ats of abdomen. Resident's and noted to be a medium on a sluggish. Resident was given sitory, neither of which were aporting nausea, declining all dated 8/21/2020, at 9:26 a.m. c/o [complained of] abdominal stated it was across his whole sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider communication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider communication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider sommunication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider sommunication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider sommunication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider sommunication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider communication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider communication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider communication form] and the sident has not had a bowel 17/2020. Rectal suppository his morning at 0730, no provider communication form] and 11/2020. | F 6 | 84 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245626 | B. WING _ | | | C / 18/2021 | |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 684 | be sent to the ER. R5's August 2020 M Record identified R on 8/21/2020, at 11 identify any other b administered betwee indicated in the pro R5's physician visit one of the reasons The note indicated R5 was "complainin pain and nausea th scan/catheterization or Tums. The note a medium bowel m 8/17/2020. R8 R8's Admission Reconstipation and m Physician orders in -Monitor resident for two times a day if rethree days start BM 2/4/2021)Miralax (laxative) oneeded for bowels -Senna Plus 8.6-50 for bowels (start day Facility Standing O | Medication Administration 5 was given a Fleet Enema :15 a.m The MAR did not owel medication was een 8/13/2020 to 8/21/2020 as gress notes. dated 8/21/2020, identified for the visit was constipation. a nurse at the facility reported ng of right-sided abdominal at was not relieved by bladder n, Tylenol, Senna, suppository further indicated R5's last had ovement four days prior on cord, included diagnosis of uscle weakness. cluded: or bowel movement and size esident does not have a BM in 1 protocol (start date give one packet by mouth as (start date 2/4/2021) or milligrams (mg) as needed te 2/4/2021) reders signed by a physician on to implemented for R8 orders | F 6 | 34 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | 190 | REET ADDRESS, CITY, STATE, ZIP CODE 00 BALLINGTON BOULEVARD NW OCHESTER, MN 55901 | , <u> </u> | 10/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 684 | R8's care plan inclured to decrease constipation]." R8's instructed staff to deevery shift and admineded/ordered. R8's Nursing Data Collection-Admission assessment dated 2 Gastrointestinal Systowel movement with abdomen was soft of four quadrants, was pattern of daily bown R8's bowel movements with and a bowel movement of daily bown and 2/10/2021. R8's record lacked monitoring and assinterventions for book R8's progress note indicated as needed administered; "Last day with no BM". A medication administial a.m. indicated the complete Miralax was adminible BM". EMAR note a Miralax dose was not a sintervential to the complete state of the complete state | aided "At risk for constipation d mobility, h/o [history of associated interventions ocument bowel movements ninister bowel medications as on/Readmission Day 2/4/2021, included a section stem that identified R8's last as on 2/4/2021, R8's with bowel sounds active in all a always continent and had a rel movements. The entrecord identified that R8 nents on 2/5, 2/6, 2/11, Nowere recorded between 2/7 evidence of ongoing essment and prescribed wel management. Idated 2/10/2021, at 7:56 a.m. of Senna Plus was BM was on 2/6/2021. Fourth of Sena Plus was BM was on 2/6/2021. Fourth of Sena Plus was anot effective and stered for "Fourth day with not to 2:27 p.m. indicated the | F6 | 844 | | | |
| | indicated Bisacodyl | | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH C | /IDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUI EFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| F 684 | 2/11/2021, at 8:09 a suppository was ined. R8's record was revassessment of bow appropriate interver after medications grays progress note included, Patients lathe charting but patimultiple BM yesters on 2/10/2021 shern plus. As per the nur 2/10/2021, stated the suppository and night orders tab show suppository on 2/11 tomorrow. Active both She did complain of along with pain all confused at times of manager was award. R8's progress note included, "Author for brought forth by restregarding confusion aches/pain, gastric assigned nurse admitted that the completely relieved stated she had felt currently feeling and suppository and suppository on 2/11 tomorrow. Active both She did complain of along with pain all confused at times of manager was award. | a.m. noted that the effective. Viewed and did not include an els to determine the ntions for further bowel care iven were ineffective. dated 2/12/2021 at 3:41 p.m., ast BM as on 2/6/2021 as per ient insisted that she had day and Refused suppository. eceived Miralax and senna rese from evening shift on the patient refused bisacodyl that shift was informed about it. we that she had bisacodyl /2021 at 2 AM I will follow up owel sounds in all quadrants. If nausea and gastric upset over her body today received TUMS and Zofran omiting] along with Tylenol. It within normal limits. She was luring my shift. Nurse the e. SBAR has been done. dated 2/12/2021, at 5:10 p.m. followed up on concerns sident's assigned nurse. | | 84 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION NG | COM | TE SURVEY MPLETED |
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| | | 245626 | B. WING _ | | | C / 18/2021 |
| | PROVIDER OR SUPPLIER STER REHABILITATIO | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
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| F 684 | Bowel sounds were quadrants. Resider bloated but abdome time of examination the resident's last E multiple staff membeowel movement yeadditional medicatic confirm actually obclose attention to e occurs and possibly suppository if need conversation but shencephalopathy [dabrain], altered membeometric always been so interactions with the change subjects dure-directable and weauthor's questions. Physician was continue to monitor on-call physician shence 6:21 p.m. indicated 6:00 p.m. R8's progress note included "moaning; abdominal pain] bo [quadrants]. R8's eindicated Senna Plustated that she feel bisacodyl supposition edium BM. There | nontender to the touch. e actively gurgling in all 4 at stated she sometimes felt en was not distended at the a. It is debatable as to when BM was; resident reported to bers that she had a very large esterday so she wanted no ons but no staff member can serving it, so staff will pay insure bowel movement by reproach resident about ed. She was confused during | F 68 | 34 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP 1900 BALLINGTON BOULEVARD ROCHESTER, MN 55901 | | 02. | 10,2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | ON SHOULD HE APPROPR | BE | (X5) COMPLETION DATE |
| F 684 | four quadrants." During an interview R8 stated she sat in was able to articula constipation. When bowel movement stated she went to took any medication reiterated her historiand off topic. R3 R3's Admission Reconstipation, muscl communication defibehavioral disturba R3's care plan ider constipation related administration of op Corresponding interpowel movements abowel medications R3's Bowel and Blate assessment dated a occasionally inconting a bowel program to The area that prominical pattern had the reconstinent and at the R3's physician orders. | on 2/16/2021, at 12:00 p.m. In her chair in her room. R8 te a history of problems with asked when she had her last the spoke out of order and the library. When asked if she ins for her constipation, R5 ry, again spoke out of order order order. The cord is included diagnoses of the weakness, cognitive incit, and dementia without ince. Intified R3 was "At risk for it to decreased mobility and bioloid pain medications. The revertions included document the every shift and administer as needed/ordered. Induced Data Collection 2/11/2021, identified R3 was inent of bowel and was not on manage the incontinence. In part of the product | F 6 | 684 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 1900 BALLINGTON BOULEVARD NO ROCHESTER, MN 55901 | | 02/10/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD B | | |
| F 684 | 12/29/2020) -Bisacodyl Supposi constipation daily (s-Monitor resident for twice daily; if reside three days start BM 12/29/2020). Facility Standing Or 11/16/2012 was als listed above) R3's bowel movement large bowel movement and assinterventions and on R8's progress notes included, "Patient warm prune juice for BM that appeared to ordered Miralax dail During an interview nursing assistant (N supposed to record computer (electronishe would only doot the EHR and would stated it was up to the bowel movement for resident reported fellet the nurse know. | tory as needed for start date 12/29/2020) or bowel movement and size ent does not have a BM in 1 protocol (start date orders signed by a physician on to implemented for R3 (details ent record identified R3 had a | F 6 | 584 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | COM | E SURVEY IPLETED |
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| | PROVIDER OR SUPPLIER STER REHABILITATIO | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 684 | documents BM's. During an interview registered nurse (R not had a bowel mosupposed to give be RN-B stated he wonthe same day and the same day and the stated that the physical three days. By the bowel protocol. Unawareness if the certain time between and/or if one should RN-B stated he woor observe/palpate administration of as unless the resident effectively communed to the bowel making sure resident three days. During an interview director of nursing (was not administered according to physical lacked comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protocol did not director of nursing (was not administered comprehensistated the physician facility bowel protoc | on 2/16/2021, at 12:37 p.m. N)-B stated if a resident has evement for 3 days we are even medication on day three. all give Miralax and Senna on hen go to the suppository, en use the Enema. RN-B sician's standing orders was | F 68 | 34 | | |

PRINTED: 03/30/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 690 SS=D | assessment be con a bowel medication administer. DON ex administer as need three without a bow follow-up for medic medication was not interventions or ale A bowel managemer requested and not | s expected a complete bowel inpleted in order to determine if it is warranted and safe to expected nursing staff to ed bowel medications on day wel movement, complete a action effectiveness, and if the effective to continue it the provider. The policy/protocol was received. | F 6 | | | 3/19/21 | |
| | resident who is con admission receives maintain continence condition is or beconot possible to main §483.25(e)(2)For a incontinence, base comprehensive assensure that (i) A resident who e | facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical omes such that continence is ntain. resident with urinary d on the resident's sessment, the facility must | | | | | |
| | resident's clinical or catheterization was (ii) A resident who e indwelling catheter is assessed for rem as possible unless demonstrates that of and | is not catheterized unless the condition demonstrates that a necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | (X3) DATE SU COMPLE | |
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| | | 245626 | B. WING _ | | 02/18/ | /2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | , | - |
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| F 690 | receives appropriate prevent urinary trace continence to the endinger of the end of the endinger of the end of the e | the treatment and services to be infections and to restore extent possible. The resident with fecal door the resident's resident, the facility must ent who is incontinent of bowel the treatment and services to formal bowel function as the interest of th | F 69 | F690 Bowel and Bladder Incontine Corrective actions taken for reside found to be affected by this deficine R5 no longer resides in the facility. Procompleted virtual visit on 2/18 with and updated orders to discontinually bladder scans, discontinually catheterizations and monitor urine output. How the facility will identify other residents that have the potential that affected by the same deficient proceed and what corrective action was to all residents have the potential to affected by this practice. An audit was conducted to review residents with bladder scan order appropriateness. Education was nurses regarding the importance following provider directives on blace scanning and documentation of refusals/re-approaches and notifi provider where warranted. Systemic changes to be made to | to be actice aken: o be given to of ladder cation to | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | E CONSTRUCTION | | SURVEY PLETED |
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| | | 245626 | B. WING | | | 1 | 18/2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | 19 | TREET ADDRESS, CITY, STATE, ZIP CODE 900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 690 | needed. R3's Bowel and Bla 2/11/2021, identifie incontinent of urine problems with urina of toileting program assistance from on assessment also id urinary retention ar six hours, I/O cather R3's TAR (Treatmer identified times of the for 12:00 a.m. 5:45 p.m. The TAR inclusion when completed for including the amount amount. R3's progress note reviewed from 2/10 to identify physician of 12:00 a.m. R3's progress note and lacked evidency TAR for scheduled blank; R3's progress the procedure had | adder Data Collection dated d R3 was frequently, sometimes leaked urine, had ary urgency, was not on a trial a, and required extensive e staff for toileting. The lentified R3 had problems with a drequired bladder scan every eterization as needed. Int Administration Record) bladder scan were scheduled a.m., 12:00 p.m. and 6:00 ded boxes to be checked off or the post void residual scans and the catheterization Is and February (TAR) was 1/2021 to 2/17/2021 and failed a orders were followed. TAR indicated for the R3 had or scan for the scheduled time did not address the refusal, are R3 was re-approached. The 5:45 a.m. boxes were left as notes did not address why not been completed. TAR for 12:00 p.m. was ser time per progress note at 6:00 p.m. scheduled time was | F | 690 | the deficient practice does not recule ducation was given to nurses regithe importance of following provided directives on bladder scanning and documentation of refusals/re-approand notification to provider where warranted. Quality monitor implemented to revesidents with bladder scan orders monitor weekly at Daily Clinical meand assure appropriate completion bladder scan or refusal outcome documented-weekly x 4 weeks, most monitor the quarterly x 2 quarted Measures that will be implemented monitor the continued effectiveness correction action taken to ensure compliance is achieved and sustain Results of the quality review monitor be reviewed monthly through the Coprocess to identify need for further education and/or need for future monitoring. | arding er l baches view and eeting n of onthly x rs. to s of the ned: ors will | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | FIPLE CONSTRUCTION NG | COM | TE SURVEY MPLETED |
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| | | 245626 | B. WING | | | C / 18/2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 690 | not completed. Alti 11:07 p.m. included "Resident refused to many outputs at bather record lacked or re-approached. -On 2/15/2021, the 12:00 a.m. and 5:40 were not performed address why the procompleted. -On 2/16/2021, the 12:00 a.m. had "X" of "9" (the TAR did meant). R3's progres address what had oscheduled time of scans were not perdid not address who completed. R5 R5's Admission Reference admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 R5's physician order admitted to the facing discharged on 8/21 | nough a progress note at the order with a note, or go to bed at this time. Had throom tonight. Did not scan." evidence of R3 was TAR for scheduled times of 5 a.m. indicated the scans of R3's progress notes did not occedure had not been TAR for scheduled time of in the boxes with a chart code not identify what the "9" ess notes did not clarify and/or occurred. The TAR for 5:45 a.m. indicated bladder formed R8's progress notes by the procedure was not cord, included diagnosis of pecific antigen, testicular or incontinence, muscle mentia without behavioral export indicated R5 had been lity on 8/13/2020, and /2020. ers included: ladder Data Collection date 8/15/2020) void. If retention is greater | F 6 | 90 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | COM | E SURVEY IPLETED |
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| | | 245626 | B. WING | | | C 18/2021 |
| | PROVIDER OR SUPPLIER TER REHABILITATIO | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 690 | signs or symptoms void/discomfort ever 8/14/2020). R5's record lacked Bladder Data Collecompleted on 8/15/was requested and R5's August 2020 Record (TAR), iden R5's Nursing Data Collection-Admission assessment dated Genitourinary Systemicontinent of urine for toileting. R5's progress notes with documentation administration recomplysician order for on 8/13 to 8/21/202 evidence the bladdiphysician order, and refusing the treatment R5's TAR identified as 2:00 a.m., 8:00 and -On 8/16/2020, the scheduled time of 1 were not performed R5's progress notes 8/15's progress | evidence that the Bowel and ction assessment was not '2020 (the blank assessment not received). Treatment Administration tified it was not completed on/Readmission Day 8/14/2020, in section H. em identified R5 was always and required staff assistance is was reviewed in conjunction in on the treatment rd (TAR) that identified the bladder scans from admission to The record lacked er scans were completed per difference in on record of R5 | F 6 | 90 | | |
| | | | | | | |

PRINTED: 03/30/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245626 | B. WING | | | C | |
| NAME OF | PROVIDER OR SUPPLIER | 243020 | B. WING | STREET ADDRESS, CITY, STATE, ZIP COL | | 2/18/2021 | |
| | | N AND LIVING CENTER | | 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BE | (X5) COMPLETION DATE | |
| F 690 | -On /17/2020, the Tacheduled time of 2 were not performed R5's progress note procedure was not During an interview director of nursing and confirmed the bladder scans worders. DON indicanursing should readocument all refusal During an interview nurse practitioner (with residents and follow physician orders and O catheterizati re-approach if residents and follow physician orders and Comment refusals Label/Store Drugs CFR(s): 483.45(g) Labelin Drugs and biological labeled in accordar professional principal propriate accessinstructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In accederal laws, the face of the provider of the properties of the provider of the properties of the | TAR indicated for the 2:00 a.m. indicated the scans devidenced by blank boxes. Is did not address why the completed or R5 had refused. You on 2/16/2020, at 2:14 p.m. (DON) reviewed the records record lacked evidence that were completed per physician atted if the resident had refused approach the resident and als. You on 2/18/2021, at 2:58 p.m. NP)-A stated she was familiar said the expectation was to ders for bladder scans and I on for urinary retention, dent refused, notify the ry, monitor for symptoms, and and assessments. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nee with currently accepted oles, and include the | F 6 | | | 3/19/21 | |

| | ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM | | COMF | E SURVEY PLETED | | |
|--------------------------|--|--|---------------------|---|---|----------------------------|
| | | 245626 | B. WING | | 02/1 | 18/2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 761 | §483.45(h)(2) The separately locked, compartments for slisted in Schedule I Abuse Prevention a other drugs subject facility uses single systems in which the and a missing dose This REQUIREMEI by: Based on observative review the facility famedications for 5 or R12, and R8) whose observed to be unlocked to | Is, and permit only authorized access to the keys. facility must provide permanently affixed storage of controlled drugs. I of the Comprehensive Drug and Control Act of 1976 and it to abuse, except when the unit package drug distribution he quantity stored is minimal ecan be readily detected. NT is not met as evidenced ation, interview, and document ailed to ensure safe storage of f 5 residents (R9, R10, R11, see medication cupboards were bocked. ion on 2/17/2021, at 3:00 p.m. upboard in their room was ed. Medications in the one bottle of Nasonex to treat allergies), one tube of 1% (used to treat fungal uterol inhaler (used to treat and wheezing), and one er (used to prevent symptoms | F 761 | Corrective actions taken for reside found to be affected by this deficien R9 is currently out of the facility. R10, R11 and R12 currently reside facility. All medication/treatment cabinets is resident rooms were immediately checked and locked. How the facility will identify other residents that have the potential to affected by the same deficient practand what corrective action was taken and the properly secured/locked. Educating given to nurses and TMAs regarding requirement of locking medication/treatment cabinets. Fathas initiated installation of auto lock room medication cabinets. | ncy? R8, e in the | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | ` ´COMI | |
|--------------------------|--|--|---------------------|--|--|----------------------------|
| | | 245626 | B. WING _ | | I | C 18/2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | - | 10,2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 761 | R8's medication cur found to be unlocked cupboard included to treat shortness of the confirmed that and the aforementic cupboards are supposed are s | ion on 2/17/2021, at 3:10 p.m. pboard in their room was ed. Medications in the two boxes of Duo Nebs (used if breath and wheezing). tions of the resident's red nurse RN-C was present; the cupboards were unlocked oned medications in those resent. RN-C stated the roosed to remain locked if res in them. ion on 2/17/21, at 3:21 p.m. pboard in their room was red. Medications in cupboard idocaine patches (pain of fluticasone nasal spray by symptoms), 1 tube of reat fungal/yeast infections), 2 rebulizers, 2 tubes of rel (topical pain medication), 2 resulting to decrease/prevent, 1 bottle Refresh eye drops, 1 red to clean the skin to 1 container omnipaque refore imaging tests), 1 tube of treat skin infections), 4 tubes of treat skin infections of rel tube of hydrocortisone at inflammatory skin ribe of lodasorb (used to clean the healing). | F 76 | Systemic changes to be made the deficient practice does not Education was given to nurses regarding the requirement of long medication/treatment cabinets initiated installation of auto lock medication cabinets. Quality monitor implemented to that facility room medication/trecabinets are lockedweekly a monthly x 3 months then quart quarters. Measures that will be implemented monitor the continued effective correction action taken to ensure compliance is achieved and sure Results of the quality review made reviewed monthly through the process to identify need for further education and/or need for future monitoring. | recur: and TMAs beking Facility ks to room continued to the stained: continued to the stained | |
| | | ion on 2/17/21, at 3:10 p.m. upboard in their room was | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245626 | B. WING | | | C 02/18/2021 | | |
| NAME OF PROVIDER OR SUPPLIER ROCHESTER REHABILITATION AND LIVING CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP (1900 BALLINGTON BOULEVARD N ROCHESTER, MN 55901 | | V 2. | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | N SHOULD E APPROPF | HOULD BE COMPLÉTION | | |
| F 761 | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | F 7 | 61 | | | | |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 9, 2021

Administrator Rochester Rehabilitation And Living Center 1900 Ballington Boulevard NW Rochester, MN 55901

Re: State Nursing Home Licensing Orders

Event ID: MZZ111

Dear Administrator:

The above facility was surveyed on February 16, 2021 through February 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

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.

Rochester Rehabilitation And Living Center March 9, 2021 Page 2

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:

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 03/30/2021 FORM APPROVED

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
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| | 20022 | | B. WING | | | C 02/18/2021 | | |
| NAME OF | | 29822 | OTDEET AD | | 274TE 7ID 00DE | 02/ | 18/2021 | |
| | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE OULEVARD NW | | | |
| ROCHESTER REHABILITATION AND LIVING CI 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 | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | 'S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATE | | |
| 2 000 Initial Comments | | | 2 000 | | | | | |
| | ****ATTENTION***** | | | | | | | |
| | NH LICENSING CORRECTION ORDER | | | | | | | |
| | 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall | Minnesota Statute, section order has been y. If, upon reinspect iency or deficiencies ected, a fine for each be assessed in accofines promulgated by artment of Health. | issued ion, it is cited violation rdance | | | | | |
| | corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has compliance with all rule provided at the alle number indicated as several items, faill the items will be con- Lack of compliance any item of multi-part ment of a fine even i uring the initial inspec | tag below. ure to sidered upon rule will f the item | | | | | |
| | that may result from orders provided tha the Department with | hearing on any assent non-compliance with a written request is thin 15 days of receipont for non-compliance. | th these made to t of a | | | | | |
| | survey was conduct with State Licensure be NOT in compliar Licensure. Please if of correction that you | rs: Igh 2/18/2021, an abouted to determine conce. Your facility was fouce with the MN State and the concentration of the date when they are the date. | npliance ound to e onic plan | | | | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/18/21

STATE FORM 6899 MZZ111 If continuation sheet 1 of 20

TITLE

(X6) DATE

PRINTED: 03/30/2021 FORM APPROVED

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | | |
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| 29822 | | 29822 | B. WING | | C 02/18/2021 | | | | |
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| ROCHESTER, MN 55901 | | | | | | | | | |
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| | completed. | | | | | | | | |
| | The following complaint was found to be SUBSTANTIATED with correction orders issued: H5626013C (MN00064413 & MN00064496) The following complaint was found to be UNSUBSTANTIATED, however a correction order was issued: H5626017C (MN00064741) 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 surveyors findings are the Suggested Method of Correction and Time period for Correction. | | | | | | | | |
| | receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for State enter the word "CO available for text. Y electronic State lice | tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are | | | | | | | |

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

| | OF CORRECTION | (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM | | | | | SURVEY LETED |
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| | | 29822 | | B. WING | | 0 2/1 | ; 8/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | <u> </u> | |
| ROCHES | TER REHABILITATIO | N AND LIVING CI | | LINGTON BOTER, MN 559 | OULEVARD NW 901 | | |
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| 2 830 | to the Minnesota Defacility is enrolled in signature is not requage of state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLAAPPLIES TO FEDETHIS WILL APPEA | N OF CORRECTION RAL DEFICIENCIES R ON EACH PAGE. O Subp. 1 Adequate a | The a a f the first OF THE I." THIS ONLY. | 2 830 | | | 3/19/21 |
| | receive nursing can custodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. At be out of bed as muis a written order from the custodial care. | general. A resident re and treatment, pers supervision based or d preferences as ider resident assessment scribed in parts 4658. nursing home resident as possible unles om the attending physust remain in bed or the remain in bed. | sonal and n ntified in and 0400 nt must s there | | | | |
| | by: Based on observati review the facility fa medications per fac orders in order to p residents (R5, R8, a for bowel managem Findings include: | ent is not met as evident, and do on, interview, and do siled to provide bowel cility protocol and/or prevent constipation for and R3) who were revient. | cument hysician or 3 of 3 viewed | | Corrective actions taken for reside found to be affected by this deficie R5 no longer resides in the facility R8 and R3 currently reside in the fall resident standing orders for borprotocol has been updated. How the facility will identify other residents | ncy? acility. wel | |

Minnesota Department of Health

STATE FORM 6899 MZZ111 If continuation sheet 3 of 20

| Minnesc | <u>ota Department of He</u> | alth | | | | |
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| 2 830 | Continued From pa | ge 3 | 2 830 | | | |
| | constipation, muscle behavioral disturbation had been admitted and discharged on R5's admission car occasionally incont R5's physician order -DUE Bowel and Blassessments divide one time (start daterate -Fleet Oil Enema repain (8/21/2020) Facility Standing O 11/16/2012, includer -If no BM (bowel material for a bowel -Prune Juice 4 oun bran/applesauce/proposition begiven all at the standing order to administer suppository or if the begiven all at the standing order order to administer suppository or if the begiven all at the standing order constipation. Collection-Admission assessment dated Gastrointestinal Sy | e weakness, dementia wance. The report indicated to the facility on 8/13/20/8/21/2020 to a hospital. e plan, indicated R5 was inent of bowel. ers included: adder Data Collection in er of chart and fill out and 8/15/2020) ectally one time for abdorded the following for bowel over entry in 3 days followers signed by a physic ed the following for bowel over entry in 3 days followers adaly and/or entry in a day as needed for daily as needed for eats twice per day as needed in the following and the following and the following if taking a day in the following if taking a day in the following suppository or entry in the following suppository in the following s | vithout d R5 20, d lock minal dian on d care, w to 2 ded in he per fic hould | that have the potential to be the same deficient practice corrective action was taken All residents have the potential fected by this practice. The Bowel Protocol was upfacility standing orders. Buspreadsheets were develop implemented for all resident to clinical staff will be condupdated standing order on protocol. Systemic changes to be mathe deficient practice does. The Bowel Protocol was upfacility standing orders. Buspreadsheets were develop implemented for all resident to clinical staff will be condupdated standing order on protocol. Quality monitor implementer residents without BM for 3 Clinical meeting and assurbowel protocol executed-wweeks, monthly x 3 months x 2 quarters. Measures that will be implemented for the compliance is achieved and Results of the quality review be reviewed monthly through process to identify need for education and/or need for formonitoring. | and what in: Intial to be intia | |

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Minnesota Department of Health

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| ROCHES | STER REHABILITATIO | IN AND LIVING CL | LINGTON BOTER, MN 55 | OULEVARD NW 901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | frequently incontine pattern however the what the pattern was recorded answer for with an "X" with no R5's bowel movement obowel movement obowel movements 8/18 and 8/21/2020 R5's record lacked monitoring, assess interventions accorders. R5's progress note indicated Tylenol was abdominal pain. R5's progress note included, "At 730 [s resident's overnigh reporting abdominaresident was bladd and Tylenol was off relieving resident's resident still complapain; pain noted up and center quadrar last bowel movement \$/17. Bowel sounds senna and a suppose helpful. Resident refoods and fluids" R5's progress note included "Resident refoods and fluids" R5's progress note included "Resident refoods and fluids" R5's progress note included "Resident pain this morning. So lower stomach. Removement since 8/ was administered to | ent, R5 had a regular bowel e assessment did not identify as. The area that prompted a or bowel sounds was noted other description. ent record identified between 2020, R5 had one medium n 8/17/2020. No recorded between 8/12 and 8/16, and 0. evidence of ongoing bowel ment and implementation of ding to the facility's standing dated 8/20/2020 at 8:15 p.m., as administered for left sided dated 8/21/2020, at 9:23 a.m. sic], author was notified by the nurse that resident was all pain. As interventions er scanned and catheterized, fered. None were effective in pain. Upon assessment, ained of right-sided abdominal for palpation of right-sided abdominal for palpation of right-sided and on palpation of right-sided abdomen. Resident's ent noted to be a medium on as sluggish. Resident was given esitory, neither of which were exporting nausea, declining all | 2 830 | | | |

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Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | SURVEY PLETED |
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| ANDELAN | OF CONNECTION | IDENTIFICATION NOWIDER. | A. BUILDING | : | COM | LLILD |
| | | 29822 | B. WING | | | C 18/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | |
| ROCHES | STER REHABILITATIO | IN AND LIVING CI | ALLINGTON B STER, MN 55 | OULEVARD NW 901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| 2 830 | sent to the provider the situation. R5's progress note a.m. indicated the proom. Progress not had very small resube sent to the ER. R5's August 2020 MRecord identified Ron 8/21/2020, at 11 identify any other badministered between indicated in the prorection of the reasons. The note indicated R5 was "complaining pain and nausea the scan/catheterization or Tums. The note a medium bowel material mat | dated 8/21/2020, at 11:06 provider gave an order to try results send to the emergence at 12:10 p.m. indicated R5 alts from the enema and would discount and size at 13:10 p.m. indicated R5 alts from the enema and would discount a Fleet Enema and a size a | d derrydd | | | |
| | | d above) uded "At risk for constipation | | | | |

Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|--|-------------------|--------------------------|
| | | | B. WING | | | |
| | | 29822 | | | 02/1 | 8/2021 |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| ROCHES | STER REHABILITATIO | N AND I IVING CI | TER, MN 55 | OULEVARD NW 901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | related to decrease constipation]." R8's instructed staff to devery shift and admineeded/ordered. R8's Nursing Data Collection-Admission assessment dated Gastrointestinal Sybowel movement was abdomen was soft four quadrants, was pattern of daily bow R8's bowel movement and a bowel movement and 2/10/2021. R8's record lacked monitoring and assinterventions for book R8's progress note indicated as needed administered; "Last day with no BM". A medication administion a.m. indicated the of Miralax was adminibed by many medication administicated as note as Miralax dose was many R8's Emar note data indicated Bisacody administered to R8 2/11/2021, at 8:09 a suppository was incompressioned interversioned and suppropriate interversions grants. | ed mobility, h/o [history of associated interventions ocument bowel movements ininister bowel medications as on/Readmission Day 2/4/2021, included a section stem that identified R8's last was on 2/4/2021, R8's with bowel sounds active in all a law and a la | 2 830 | | | |

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Minnesota Department of Health

| Millinesc | ota Department of He | ī | | | | | |
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| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPL | | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION N | OMBEK: | A. BUILDING: | | COMP | LETED |
| | | | | | | | |
| | | 29822 | | B. WING | | | 8/2021 |
| | | ZJOZZ | | | | 02/1 | 0/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BOCHE | TED DELIABILITATIO | AND LIVING CL | 1900 BAL | LINGTON BO | OULEVARD NW | | |
| ROCHES | STER REHABILITATIO | IN AND LIVING CI | ROCHES | ΓER, MN 559 | 901 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENC | ES | ID | PROVIDER'S PLAN OF CORRECTI | ON | (X5) |
| PREFIX | _ | / MUST BE PRECEDED B | | PREFIX | (EACH CORRECTIVE ACTION SHOU | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORM | MATION) | TAG | CROSS-REFERENCED TO THE APPRO | PRIATE | DATE |
| | | | | | DEFICIENCY) | | |
| 2 830 | Continued From pa | ige 7 | | 2 830 | | | |
| | - | | 001 | | | | |
| | included, Patients I | | | | | | |
| | the charting but pat | | | | | | |
| | multiple BM yester | | | | | | |
| | On 2/10/2021 she i | | | | | | |
| | plus. As per the nu | | | | | | |
| | 2/10/2021, stated the | | | | | | |
| | suppository and nig The orders tab sho | | | | | | |
| | suppository on 2/11 | | | | | | |
| | tomorrow. Active be | | | | | | |
| | She did complain o | | | | | | |
| | along with pain all | | | | | | |
| | (02/12/2021). She | | | | | | |
| | [used for nausea/vo | | | | | | |
| | Her vital signs were | | | | | | |
| | confused at times of | | | | | | |
| | manager was awar | | | | | | |
| | R8's progress note | | | | | | |
| | included, "Author fo | | | | | | |
| | brought forth by res | | | | | | |
| | regarding confusion | | | | | | |
| | aches/pain, gastric | | | | | | |
| | assigned nurse adr | | | | | | |
| | Zofran during the d | | | | | | |
| | resident did feel be | | | | | | |
| | completely relieved | I. Upon evaluation, | resident | | | | |
| | stated she had felt | gastric upset but w | asn't | | | | |
| | currently feeling an | y symptoms at the | time. An | | | | |
| | abdominal examina | ation was performed | d and her | | | | |
| | abdomen was soft, | nontender to the to | ouch. | | | | |
| | Bowel sounds were | | | | | | |
| | quadrants. Resider | | | | | | |
| | bloated but abdome | | | | | | |
| | time of examination | | | | | | |
| | the resident's last E | | | | | | |
| | multiple staff memb | | , , | | | | |
| | bowel movement y | | | | | | |
| | additional medication | | | | | | |
| | confirm actually ob | serving it, so staff v | ∕ill pay | | | | |

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| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIDENTIFICATION N | | | E CONSTRUCTION | | SURVEY PLETED | |
| 7.1101 27.11 | TOT CONTINUE THOR | IDENTIFICATION TO | JIVIDEI (. | A. BUILDING: | | | | |
| | | 29822 | | B. WING | | C 02/18/2021 | | |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| | | | | , , | OULEVARD NW | | | |
| ROCHES | STER REHABILITATIO | | | HESTER, MN 55901 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED B' SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE | |
| 2 830 | Continued From pa | ige 8 | | 2 830 | | | | |
| | occurs and possibly suppository if need conversation but she encephalopathy [da brain], altered men has always been so interactions with the change subjects dure-directable and wauthor's questions. physician was controus to monitor on-call physician she R8's eMAR progres 6:21 p.m. indicated 6:00 p.m. R8's progress note included "moaning; abdominal pain] bo [quadrants]. R8's e indicated Senna Pl stated that she feel bisacodyl supposite medium BM. There administered. Bowe four quadrants." During an interview R8 stated she sat it was able to articular constipation. When bowel movement stated she went to took any medicatio reiterated her historand off topic. | nsure bowel movemy reproach resident ed. She was confuse has a history of amage or malfunction tal status and COVI omewhat confused de author. She was nuring conversation, by a sable to answer as "The note indicated acted with return or the resident and canould the need arises note dated 2/12/2 a suppository was a dated 2/13/2021, at C/O [complained or owel sounds all 4 qual Mar note at 8:25 a.r. us was administered so constipated. She fore, senna plus was also sounds were present a history of problem asked when she has he spoke out of ord the library. When a ns for her constipation, again spoke out | about sed during on in the D-19 and during all soted to out was all of the ders to all the der | | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | SURVEY PLETED |
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| AND I ENVIOL COLUMN | IDENTIFICATION NOMBER. | A. BUILDING: | | | |
| | 29822 | B. WING | | | C 1 8/2021 |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | 1900 BAI | | OULEVARD NW | | |
| ROCHESTER REHABILITATION | ROCHES | TER, MN 55 | 901 | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TON SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 830 Continued From pa | age 9 | 2 830 | | | |
| constipation, musc communication del behavioral disturba R3's care plan ide constipation relater administration of of Corresponding into bowel movements bowel medications R3's Bowel and Bla assessment dated occasionally income a bowel program to The area that prome pattern had the receincontinent and at R3's physician ordersenna Plus Tablet bowels (start date -Miralax packet by 12/29/2020) -Bisacodyl Suppos constipation daily (-Monitor resident for twice daily; if resident three days start BN 12/29/2020). Facility Standing CO 11/16/2012 was also listed above) R3's bowel movem large bowel movem R8's record lacked monitoring and assessinterventions and constituted, "Patient warm prune juice for the second start of the | le weakness, cognitive ficit, and dementia without ance. Intified R3 was "At risk for d to decreased mobility and pioid pain medications. erventions included document every shift and administer as needed/ordered. Indided and Collection 2/11/2021, identified R3 was sinent of bowel and was not on a manage the incontinence. Instead an answer for R3's bowel corded answer of "at times times constipation". It is 8.6-50 mg as needed for 12/29/2020) mouth for bowels (start date itory as needed for start date 12/29/2020) or bowel movement and size ent does not have a BM in M protocol (start date itory as regional by a physician on so implemented for R3 (details tent record identified R3 had a | | | | |

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Minnesota Department of Health

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|-------------------|-----------------------|-----------------------|--------------|----------------|--|-----------|------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPL | | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION N | UMBEK: | A. BUILDING: | | COMP | LETED |
| | | | | | | | ` |
| | | 29822 | | B. WING | | | 8/2021 |
| | | 23022 | | | | 02/1 | 0/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | | 1900 BAL | LINGTON BO | OULEVARD NW | | |
| ROCHES | TER REHABILITATIO | N AND LIVING CI | ROCHES. | ΓER, MN 559 | 901 | | |
| 0(4) 15 | CHMMADY CTA | TEMENT OF DEFICIENC | | | | ON | ()(5) |
| (X4) ID PREFIX | | / MUST BE PRECEDED B | | ID PREFIX | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE |
| TAG | | SC IDENTIFYING INFORM | | TAG | CROSS-REFERENCED TO THE APPRO | | DATE |
| | | | | | DEFICIENCY) | | |
| 2 020 | Ozutinosal Fuzus uz | 10 | | 2 830 | | | |
| 2 830 | Continued From pa | ige 10 | | 2 030 | | | |
| | ordered Miralax dai | ilv. Encourage fluid | s." | | | | |
| | During an interview | | | | | | |
| | nursing assistant (N | | | | | | |
| | supposed to record | | | | | | |
| | computer (electroni | | | | | | |
| | she would only doc | | | | | | |
| | the EHR and would | | | | | | |
| | stated it was up to | | | | | | |
| | bowel movement fr | | | | | | |
| | resident reported fe | | | | | | |
| | let the nurse know. | • | ono would | | | | |
| | During an interview | | 2·19 n m | | | | |
| | NA-C stated that N | | | | | | |
| | supposed to tell the | | | | | | |
| | documents BM's. | | 1100 0100 | | | | |
| | During an interview | on 2/16/2021 at 1 | 2:37 n m | | | | |
| | registered nurse (R | | | | | | |
| | not had a bowel mo | | | | | | |
| | supposed to give b | | | | | | |
| | RN-B stated he wo | | | | | | |
| | the same day and t | | | | | | |
| | and if no results the | | | | | | |
| | stated that the phys | | | | | | |
| | the bowel protocol. | | | | | | |
| | unawareness if the | | | | | | |
| | certain time betwee | | | | | | |
| | and/or if one should | | | | | | |
| | RN-B stated he wo | | | | | | |
| | or observe/palpate | | | | | | |
| | administration of as | • | | | | | |
| | unless the resident | | | | | | |
| | effectively commun | | | | | | |
| | - | | | | | | |
| | document BM's in t | | | | | | |
| | look up the bowel n | • | • | | | | |
| | RN-B stated that al | | | | | | |
| | making sure reside | nis nau at least one | e bivi every | | | | |
| | three days. | . am 0/46/0004 4.0 | .11 | | | | |
| | During an interview | | | | | | |
| | director of nursing (| (אטטן) verified the i | esiaents | | | | |

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Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | |
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| | | | | | C | |
| | | 29822 | B. WING | | 02/1 | 8/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | | |
| ROCHES | TER REHABILITATIO | N AND I IVING CI | | DULEVARD NW | | |
| | | ROCHEST | TER, MN 559 | 901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | остания и тот ра | ge 11 ed PRN bowel medication | 2 830 | | | |
| | | sian orders, and R5's record | | | | |
| | lacked comprehens | sive bowel assessments. DON | | | | |
| | | n's standing orders was the | | | | |
| | | col. The DON stated the ect which medication to give | | | | |
| | first and/or duration | between medications. DON | | | | |
| | | es of each unit were supposed | | | | |
| | • | e frequency of bowel ay three a bowel medication | | | | |
| | was required, it was | s expected a complete bowel | | | | |
| | | npleted in order to determine if | | | | |
| | | is warranted and safe to spected nursing staff to | | | | |
| | | ed bowel medications on day | | | | |
| | | vel movement, complete a | | | | |
| | | ation effectiveness, and if the teffective to continue | | | | |
| | interventions or ale | | | | | |
| | A bowel manageme | ent policy/protocol was | | | | |
| | requested and not | received. THOD OF CORRECTION: The | | | | |
| | | (DON) or designee could | | | | |
| | review bowel mana | gement program | | | | |
| | | and or develop appropriate | | | | |
| | | rel management. The ld then provide staff | | | | |
| | | ning to comprehensive bowel | | | | |
| | | relation to administration of as | | | | |
| | | el medications. The ds to develop and implement | | | | |
| | | not rely on computer alerts as | | | | |
| | | prevent the deficient practice | | | | |
| | | e DON/designee could then rehensive auditing as part of | | | | |
| | | es assurance actives to | | | | |
| | maintain compliance | | | | | |
| | | | | | | |

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Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | | OATE SURVEY OMPLETED |
|--------------------------|--|---|--|--|--------------------------|
| | | 29822 | B. WING | | C 02/18/2021 |
| | PROVIDER OR SUPPLIER | N AND LIVING CI | ET ADDRESS, CITY, BALLINGTON B HESTER, MN 55 | OULEVARD NW | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| 2 830 | • | ge 12 R CORRECTION: Twenty-o | 2 830 one | | |
| 2 910 | Subp. 5. Incontined have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident with receives appropriate prevent urinary trace | nce. A nursing home must program of bowel and blad luce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ag catheter is not catheterized catheter is clinical condition indicated was necessary; and no is incontinent of bladder the treatment and services to the infections and to restore er function as possible. | der g ged es | | 3/19/21 |
| | by: Based on interview facility failed to comurinary catheterizat orders for 2 of 2 resfor urinary retention Findings include: R3 R3's Admission Reoveractive bladder, | cord, included diagnoses o chronic kidney disease sta s, and dementia without | d ed f | F690 Bowel and Bladder Incontinence Corrective actions taken for residents found to be affected by this deficiency? R5 no longer resides in the facility. R3 still resides at the facility. Provider completed virtual visit on 2/18 with R3 updated orders to discontinue bladder scans, discontinue i/o catheterizations and monitor urinary output. How the facility will identify other reside that have the potential to be affected by the same deficient practice and what corrective action was taken: | and ents |

Minnesota Department of Health

STATE FORM 6899 MZZ111 If continuation sheet 13 of 20

Minnesota Department of Health

| 29822 B. WING C 02/18/2021 | AND PLAN OF CORRECTION |
|--|---|
| | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | NAME OF PROVIDER OR SUPPLIE |
| ROCHESTER REHABILITATION AND LIVING CI 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901 | ROCHESTER REHABILITAT |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ONLY ONL | PREFIX (EACH DEFICIEN |
| R3's physician orders included, bladder scan every six hours and as needed. Intake/output catheterization if patient unable to void or if residuals greater than 300 milliliters (ml), (order start date 12/29/2020). R3's care plan indicated R3 had an overactive bladder and alteration in continence related to requiring assistance with mobility and weakness. Associated interventions included, assist R3 to the toilet, change incontinent brief as needed, and provide frequent toileting and cares as needed. R3's Bowel and Bladder Data Collection dated 2/11/2021, identified R3 was frequently incontinent of urine, sometimes leaked urine, had problems with urinary urgency, was not on a trial of toileting program, and required extensive assistance from one staff for toileting. The assessment also identified R3 had problems with urinary retention and required bladder scan every six hours, I/O catheterization as needed. R3's TAR (Treatment Administration Record) identified times of bladder scan were scheduled for 12:00 a.m. 5:45 a.m., 12:00 p.m. and 6:00 p.m. The TAR included boxes to be checked off when completed for the post void residual scans including the amount and the catheterization amount. R3's progress notes and February (TAR) was reviewed from 2/10/2021 to 2/17/2021 and failed to identify physician orders were followed. -on 2/12/2021, the TAR indicated for the R3 had refused the bladder scan for the scheduled time | R3's physician or every six hours a catheterization if residuals greater start date 12/29/2 R3's care plan in bladder and alter requiring assistar Associated intervithe toilet, change and provide frequineeded. R3's Bowel and E 2/11/2021, identification incontinent of urity problems with urity of toileting programs assistance from assessment also urinary retention six hours, I/O cates R3's TAR (Treatmost identified times of for 12:00 a.m. 5:4 p.m. The TAR incompleted including the amount. R3's progress no reviewed from 2/to identify physicians. |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|------------------------------|---------------------------|--|-------------------------------|--------------------------|
| | | A. BUILDING: | | | C | | |
| | | 29822 | | B. WING | | | 18/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STR | REET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| ROCHES | TER REHABILITATIO | IN AND I IVING CI | | LINGTON BO TER, MN 559 | OULEVARD NW 901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 910 | Continued From pa | ige 14 | | 2 910 | | | |
| | of 12:00 a.m. | | | | | | |
| | and lacked evidence TAR for scheduled blank; R3's progress the procedure had -On 2/14/2021, the completed at anoth 4:36 p.m. and the 6 not completed. Alth 11:07 p.m. included "Resident refused to many outputs at ba | did not address the refuse R3 was re-approached 5:45 a.m. boxes were left is notes did not address who to been completed. TAR for 12:00 p.m. was ler time per progress notes in the color p.m. scheduled time though a progress note at the order with a note, so go to bed at this time. If throom tonight. Did not sevidence of R3 was | d. The ft why e at was | | | | |
| | -On 2/15/2021, the TAR for scheduled times of 12:00 a.m. and 5:45 a.m. indicated the scans were not performed R3's progress notes did not address why the procedure had not been completed. | | IS | | | | |
| | 12:00 a.m. had "X" of "9" (the TAR did meant). R3's progre address what had c scheduled time of 5 scans were not per | TAR for scheduled time of in the boxes with a chart not identify what the "9" less notes did not clarify a poccurred. The TAR for 5:45 a.m. indicated bladd formed R8's progress not the procedure was not | code and/or er otes | | | | |
| | elevated prostate s dysfunction, urinary | cord, included diagnosis pecific antigen, testicular / incontinence, muscle nentia without behavioral | - | | | | |

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Minnesota Department of Health

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|--|---------|-------------------------------|--|
| | | A. BUILDING: | · <u> </u> | | , | | |
| | | 29822 | B. WING | | | C 1 8/2021 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | STATE, ZIP CODE | | | |
| ROCHES | STER REHABILITATIO | IN AND LIVING CI | LLINGTON BOSTER, MN 55 | OULEVARD NW 901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | |
| 2 910 | Continued From pa | nge 15 | 2 910 | | | | |
| | disturbance. The re | eport indicated R5 had been lity on 8/13/2020, and | | | | | |
| | assessment. (start -Bladder scan post than 300 mls, perfo (intake/output-inter also in and out cath signs or symptoms | ladder Data Collection date 8/15/2020) void. If retention is greater | | | | | |
| | Bladder Data Colle completed on 8/15/ was requested and R5's August 2020 | evidence that the Bowel and ction assessment was not /2020 (the blank assessment not received). Treatment Administration tiffied it was not completed | | | | | |
| | assessment dated Genitourinary Syste | on/Readmission Day 8/14/2020, in section H. em identified R5 was always and required staff assistance | | | | | |
| | with documentation administration reco physician order for on 8/13 to 8/21/202 evidence the bladd | rd (TAR) that identified the bladder scans from admission 20. The record lacked er scans were completed per d there was no record of R5 | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|--|--|-------------------------------|--------------------------|
| | | | | | | С | |
| | | 29822 | B. WING | | | | 02/18/2021 |
| NAME OF | PROVIDER OR SUPPLIER | | | | ATE, ZIP CODE | | |
| ROCHES | STER REHABILITATIO | N AND LIVING C | BALLINGTO IESTER, MN | | JLEVARD NW 11 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIAT | (X5) COMPLETE DATE |
| 2 910 | Continued From pa | ge 16 | 2 910 | | | | |
| | | the scheduled bladder sca a.m., 1:45 p.m., and 8:00 p | | | | | |
| | scheduled time of 1 were not performed R5's progress notes | TAR indicated for the :45 p.m. indicated the scar evidenced by blank boxes did not address why the completed or R5 had refus | | | | | |
| | scheduled time of 2 were not performed R5's progress notes | AR indicated for the 1:00 a.m. indicated the scar 1:00 evidenced by blank boxes a did not address why the 1:00 completed or R5 had refus | | | | | |
| | director of nursing (and confirmed the r the bladder scans v orders. DON indica | on 2/16/2020, at 2:14 p.m (DON) reviewed the record record lacked evidence that were completed per physicited if the resident had refus pproach the resident and alls. | an | | | | |
| | nurse practitioner (I with residents and s follow physician ord and O catheterization re-approach if residents | on 2/18/2021, at 2:58 p.m NP)-A stated she was fam said the expectation was to lers for bladder scans and on for urinary retention, ent refused, notify the ry, monitor for symptoms, a and assessments. | iar | | | | |
| | director of nursing (review the facility's provide re-educatio orders for residents specifically pertaining | HOD OF CORRECTION: DON) or designee could policies/procedures, and n to nursing staff on follow with urinary retention, ng to assessment, care pla ving physician orders, and | ng | | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---|---|--|--------------------------|--|
| | | B. WING | | С | | | |
| 29822 | | | D. WING | | 02/1 | 8/2021 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| ROCHES | TER REHABILITATIO | N AND LIVING CI | LINGTON BO FER, MN 559 | OULEVARD NW 901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | D BE | (X5) COMPLETE DATE | |
| 2 910 | documentation star then develop an au facility's quality ass compliance. | ge 17 Indards. DON/designee could diting system as part of the urance activities to maintain | 2 910 | | | | |
| 21610 | 0 MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area; Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. | | 21610 | | | 3/19/21 | |
| | by: Based on observation review the facility far medications for 5 or R12, and R8) whose observed to be unlocked. Findings include: During an observation of found to be unlocked cupboard included. Suspension (used to clotrimazole cream infections), one alb shortness of breath | ion on 2/17/2021, at 3:00 p.m. upboard in their room was ed. Medications in the one bottle of Nasonex to treat allergies), one tube of 1% (used to treat fungal uterol inhaler (used to treat and wheezing), and one er (used to prevent symptoms | | Corrective actions taken for reside found to be affected by this deficience. R9 is currently out of the facility. R11 and R12 currently reside in the facility. All medication/treatment cabinets resident rooms were immediately and locked. How the facility will identify other in that have the potential to be affect the same deficient practice and will corrective action was taken: All residents have the potential to affected by this practice. An audit was conducted to check a medication cabinets in facility for the properly secured/locked. Educating given to nurses and TMAs regarding | ency? R8, R10, le in checked residents led by hat be all being ion was | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|--|---|--|
| | | | 7. BOILDING. | | С | |
| 29822 | | B. WING | | 02/18/2021 | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ROCHES | STER REHABILITATIO | N AND I IVING CI | LINGTON BOTER, MN 559 | OULEVARD NW 901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | D BE COMPLETE | |
| 21610 | Continued From pa | ge 18 | 21610 | | | |
| | During an observation on 2/17/2021, at 3:05 p.m. R12's medication cupboard in their room was found to be unlocked. Medication in the cupboard included one bottle of refresh tears (used to treat dry eyes). | | | requirement of locking medication/treatment cabinets. Fainitiated installation of auto locks to medication cabinets. Systemic changes to be made to the state of | o room | |
| | R8's medication cu found to be unlocked cupboard included to treat shortness of During the observad cupboards, register she confirmed that and the aforementic | ion on 2/17/2021, at 3:10 p.m. pboard in their room was ed. Medications in the two boxes of Duo Nebs (used f breath and wheezing). tions of the resident's red nurse RN-C was present; the cupboards were unlocked oned medications in those | | the deficient practice does not rec Education was given to nurses an regarding the requirement of locki medication/treatment cabinets. Fainitiated to installation of auto lock room medication cabinets. Quality monitor implemented to en that facility room medication/treatmedicationets are lockedweekly x 4 monthly x 3 months then quarterly | ur: d TMAs ng acility s to nsure ment weeks, | |
| | cupboards were procupboards are supposed there are medication. During an observat R9's medication curiound to be unlocked included 1 box of Lipatches), 2 bottles (used to treat allerg Nystatin (used to treat allerg Nystatin (used to treat allerg Systatin (used to the Indian Symptoms) bottle of Hibiclens (prevent infections), (medication used be mupirocin (used to of Premarin (used to treat allerg Systation systation), 1 experies (used to treat allerg Systation). | esent. RN-C stated the bosed to remain locked if | | quarters. Measures that will be implemented monitor the continued effectiveness correction action taken to ensure compliance is achieved and sustan Results of the quality review monitor the reviewed monthly through the process to identify need for furthe education and/or need for future monitoring. | d to ss of the ined: tors will QAPI | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ١ | ` ' | E CONSTRUCTION | | E SURVEY PLETED | |
|---|---|---|-------------------------------------|-----------------------|--|------------------------------|--------------------------|
| | | A. BUILDING: | | | | | |
| | | 29822 | | B. WING | | 02 | C 18/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STRE | ETADE | DRESS, CITY, S | STATE, ZIP CODE | | |
| ROCHES | STER REHABILITATIO | IN AND LIVING CI | | LINGTON BOTER, MN 559 | OULEVARD NW 901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| 21610 | Continued From pa | ige 19 | | 21610 | | | |
| | wounds and promo | te healing). | | | | | |
| | During an observate R10's medication of found to be unlocked included 1 bottle of bottle of Latanopro. During an interview registered nurse (R R10's med cupboards be locked at all time. During an interview director of nursing cupboards should be the nurse is in there. The Storage and E Biologicals, Syringe 2013 indicated in sensure that all med including treatment a locked cabinet/cathat is inaccessible SUGGESTED MET administrator, directorsulting pharmac policies and proced medications. Nursing necessary to the immedications. The D the pharmacist, coubasis to ensure corrections. | ion on 2/17/21, at 3:10 p.n upboard in their room was ed. Medications in cupboar Refresh eye drops and 1 st eye drops. on 2/17/21, at 3:39 p.m. (N)-A verified that R9 and rds were unlocked and shores. on 2/18/21, at 1:24 p.m. (DON) stated that all med be locked at all times unless a using them. expirations of Medications, as and Needles policy date ection the facility should lications and biologicals, attems, are securely stored att or locked medication roof by residents and visitors. THOD OF CORRECTION: attor of nursing (DON) and control of the proper storage of the staff could be educated aportance of properly securing the conduct and the staff | ould ss ed in om The ering th gular | | | | |

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