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
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
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.

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

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

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:

- 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).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	**1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/16/2021 to 2/18/2021, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5626019C (MN00059189) at F609, H5626013C (MN00064413 & MN00064496) at F684 and F690 The following complaints were found UNSUBSTANTIATED however, during the course of investigation a deficiency was identified: H5626017C (MN00064741), a deficiency was cited at F761 H5626015C (MN00069637), a deficiency was cited at F609 The following complaints were found UNSUBSTANTIATED without associated deficiencies. H5626014C (MN00069655) H5626018C (MN00061235) H5626016C (MN00067429) H5626012C (MN00069814) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be	F 000		

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

Electronically Signed | 03/18/2021

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

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F 000	Continued From page 1 conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Abuse Prevention Policy and Procedure identified appropriate reporting procedures according to Federal Regulations. Findings include: The facility Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedures revised 5/2020 was inconsistent with the Federal reporting requirements for abuse and did not direct staff to report abuse within the two-hour timeframe. The plan included that "If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law immediately."	F 607	F000-Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to any statements, findings, facts or conclusions that are for the basis for all alleged deficiencies. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiencies. Corrective actions taken for residents found to be affected by this deficiency? Addendum was added to facility policy on Resident/Client/Participant	3/19/21

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F 607	Continued From page 2 During an interview on 2/18/2021, at 12:51 p.m. executive director (ED)-A stated that allegations of abuse should be reported within two hours or twenty-four hours, depending on the incident. The ED-A verified the facility Abuse Prevention Policy and Procedure did not indicate that allegations of abuse should be reported within 2 hours of the incident.	F 607	Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedures to reflect the Federal reporting requirement. How the facility will identify other residents that have the potential to be affected by the same deficient practice and what corrective action was taken: All residents have the potential to be affected by this practice. In-service to staff regarding the Federal reporting requirement and Vulnerable Adult Reporting was held on March 4, 9, 10 and 11, 2021. Systemic changes to be made to ensure the deficient practice does not recur: Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedures to reflect the Federal reporting requirement. Quality monitor implemented to review compliance with timeliness of reporting requirements weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	
F 609	Reporting of Alleged Violations	F 609		3/19/21

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F 609 SS=D	Continued From page 3 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document reivew the facility failed to report allegations of abuse timely to the State Agency for 2 of 2 residents (R6 and R4) reviewed for allegations of mental/emotional abuse	F 609	Corrective actions taken for residents found to be affected by this deficiency? R6 currently residing at the facility. LPN-A and NA-A received education regarding emotional or mental abuse and timely reporting.	

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F 609	Continued From page 4 Findings include A Facility Reported Incident (FRI) submitted to the State Agency on 2/1/2021, at 3:00 p.m., alleged emotional or mental abuse by a staff member that had occurred on 1/31/2021, at 10:00 p.m. According to the report on 1/31/21, at 10:00 p.m. the nurse was reported to be verbally rude to R6 and the staff member had been suspended pending investigation. During an interview on 2/19/2021, at 10:27 a.m. licensed practical nurse (LPN)-A stated he worked the evening shift on 1/31/2021. LPN- A stated at around 9:00 p.m. R6 ad reported concerns of how NA-A had treated her and passed the concern along to the overnight nurse. LPN- A stated an unawareness the allegation should have been reported to the State Agency. During an interview on 2/17/2021, at 1:15 p.m. social worked (SW)-A reviewed the report submitted to the state agency, verified the allegation was not submitted timely to the State Agency and should have been submitted within two hours of the incident. A Facility Reported Incident (FRI) submitted to the State Agency on 3/11/2020, at 4:23 p.m., alleged emotional or mental abuse by staff member that had occurred on 3/8/2020, at 11:00 p.m. According to the report on 3/8/2020, at 11:00 p.m. the nurse was reported to have entered R4's room and turned the big bright light on waking R4 up. R4 asked what was happening and the nurse stated they were giving him his shot. R4 stated family had put a sign on the door to not wake him before 7:00 a.m. The report	F 609	R4 no longer resides at the facility. LPN-A received education regarding respecting residents wishes. LPN-A was following physician orders for the resident injection. How the facility will identify other residents that have the potential to be affected by the same deficient practice and what corrective action was taken: All residents have the potential to be affected by this practice. In-service to staff regarding the Federal reporting requirement and Vulnerable Adult Reporting was held on March 4, 9, 10 and 11, 2021. Systemic changes to be made to ensure the deficient practice does not recur: Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedures to reflect the Federal reporting requirement. Quality monitor implemented to review compliance with timeliness of reporting requirements weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	

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F 609	Continued From page 5 indicated the nurse told R4 that he needed to wake up for the procedures around here. During an interview on 2/18/2021, 9:35 a.m. social worker (SW)-A reviewed the report submitted to the state agency, verified the allegation was not submitted timely to the State Agency and should have been submitted within two hours of the incident. During an interview on 2/18/2021, at 12:51 p.m. executive director (ED)-A stated that allegations of abuse should be reported within two hours or twenty-four hours, depending on the incident. ED-A then stated that allegations of abuse should be reported to the state within two hours and verified that this report was not submitted within that timeframe. The ED-A verified the Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure did not indicate that allegations of abuse should be reported within 2 hours of the incident. The facility Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedures revised 5/2020 was inconsistent with the Federal reporting requirements for abuse and did not direct staff to report abuse within the two-hour timeframe. The plan included that "If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law immediately."	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		3/19/21

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F 684	Continued From page 6 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide bowel medications per facility protocol and/or physician orders in order to prevent constipation for 3 of 3 residents (R5, R8, and R3) who were reviewed for bowel management. Findings include: R5's Admission Record, included diagnosis of constipation, muscle weakness, dementia without behavioral disturbance. The report indicated R5 had been admitted to the facility on 8/13/2020, and discharged on 8/21/2020 to a hospital. R5's admission care plan, indicated R5 was occasionally incontinent of bowel. R5's physician orders included: -DUE Bowel and Bladder Data Collection in assessments divider of chart and fill out and lock one time (start date 8/15/2020) -Fleet Oil Enema rectally one time for abdominal pain (8/21/2020) Facility Standing Orders signed by a physician on 11/16/2012, included the following for bowel care, -If no BM (bowel movement) in 3 days follow	F 684	Corrective actions taken for residents found to be affected by this deficiency? R5 no longer resides in the facility. R8 and R3 currently reside in the facility. All resident standing orders for bowel protocol has been updated. How the facility will identify other residents that have the potential to be affected by the same deficient practice and what corrective action was taken: All residents have the potential to be affected by this practice. The Bowel Protocol was updated in the facility standing orders. BM record spreadsheets were developed and implemented for all residents. In-service to clinical staff will be conducted regarding updated standing order on Bowel protocol. Systemic changes to be made to ensure the deficient practice does not recur: The Bowel Protocol was updated in the facility standing orders. BM record spreadsheets were developed and implemented for all residents. In-service to clinical staff will be conducted	

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F 684	Continued From page 7 facility bowel care protocol (facility lacked evidence of a bowel care protocol) -Prune Juice 4 ounces daily and/or bran/applesauce/prune mixture/equivalent to 2 tablespoons twice a day as needed for constipation. -Miralax 17 grams daily as needed for constipation. -Sennosides 2 tablets twice per day as needed for constipation. Contact provider if taking an opioid. -Glycerin or bisacodyl 10 mg suppository one per rectum daily as needed for constipation -Tap water enema after above as needed medications attempted and unsuccessful. The standing orders did not identify a specific order to administer Miralax, Sennosides, or suppository or if the medications could/or should be given all at the same time. R5's Nursing Data Collection-Admission/Readmission Day assessment dated 8/14/2020, included a section Gastrointestinal System that identified R5's last bowel movement was on 8/12/2020, was frequently incontinent, R5 had a regular bowel pattern however the assessment did not identify what the pattern was. The area that prompted a recorded answer for bowel sounds was noted with an "X" with no other description. R5's bowel movement record identified between 8/13/2020 to 8/21/2020, R5 had one medium bowel movement on 8/17/2020. No recorded bowel movements between 8/12 and 8/16, and 8/18 and 8/21/2020. R5's record lacked evidence of ongoing bowel	F 684	regarding updated standing order on Bowel protocol. Quality monitor implemented to review residents without BM for 3 days at Daily Clinical meeting and assure appropriate bowel protocol executed-weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	

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monitoring, assessment and implementation of interventions according to the facility's standing orders.

R5's progress note dated 8/20/2020 at 8:15 p.m., indicated Tylenol was administered for left sided abdominal pain.

R5's progress note dated 8/21/2020, at 9:23 a.m. included, "At 730 [sic], author was notified by resident's overnight nurse that resident was reporting abdominal pain. As interventions resident was bladder scanned and catheterized, and Tylenol was offered. None were effective in relieving resident's pain. Upon assessment, resident still complained of right-sided abdominal pain; pain noted upon palpation of right-sided and center quadrants of abdomen. Resident's last bowel movement noted to be a medium on 8/17. Bowel sounds sluggish. Resident was given senna and a suppository, neither of which were helpful. Resident reporting nausea, declining all foods and fluids ..."

R5's progress note dated 8/21/2020, at 9:26 a.m. included "Resident c/o [complained of] abdominal pain this morning. Stated it was across his whole lower stomach. Resident has not had a bowel movement since 8/17/2020. Rectal suppository was administered this morning at 0730, no results yet. SBAR [provider communication form] sent to the provider. Nursing manager aware of the situation.

R5's progress note dated 8/21/2020, at 11:06 a.m. indicated the provider gave an order to try Fleet enema, if no results send to the emergency room. Progress note at 12:10 p.m. indicated R5

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F 684	Continued From page 9 had very small results from the enema and would be sent to the ER. R5's August 2020 Medication Administration Record identified R5 was given a Fleet Enema on 8/21/2020, at 11:15 a.m. . The MAR did not identify any other bowel medication was administered between 8/13/2020 to 8/21/2020 as indicated in the progress notes. R5's physician visit dated 8/21/2020, identified one of the reasons for the visit was constipation. The note indicated a nurse at the facility reported R5 was "complaining of right-sided abdominal pain and nausea that was not relieved by bladder scan/catheterization, Tylenol, Senna, suppository or Tums. The note further indicated R5's last had a medium bowel movement four days prior on 8/17/2020. R8 R8's Admission Record, included diagnosis of constipation and muscle weakness. Physician orders included: -Monitor resident for bowel movement and size two times a day if resident does not have a BM in three days start BM protocol (start date 2/4/2021). -Miralax (laxative) give one packet by mouth as needed for bowels (start date 2/4/2021) -Senna Plus 8.6-50 milligrams (mg) as needed for bowels (start date 2/4/2021) Facility Standing Orders signed by a physician on 11/16/2012 was also implemented for R8 orders (see details as listed above)	F 684		

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R8's care plan included "At risk for constipation related to decreased mobility, h/o [history of constipation]." R8's associated interventions instructed staff to document bowel movements every shift and administer bowel medications as needed/ordered.

R8's Nursing Data Collection-Admission/Readmission Day assessment dated 2/4/2021, included a section Gastrointestinal System that identified R8's last bowel movement was on 2/4/2021, R8's abdomen was soft with bowel sounds active in all four quadrants, was always continent and had a pattern of daily bowel movements.

R8's bowel movement record identified that R8 had a bowel movements on 2/5, 2/6, 2/11, No bowel movements were recorded between 2/7 and 2/10/2021.
R8's record lacked evidence of ongoing monitoring and assessment and prescribed interventions for bowel management.

R8's progress note dated 2/10/2021, at 7:56 a.m. indicated as needed Senna Plus was administered; "Last BM was on 2/6/2021. Fourth day with no BM". A follow-up EMAR [electronic medication administration record] note at 11:57 a.m. indicated the dose was not effective and Miralax was administered for "Fourth day with no BM". EMAR note at 2:27 p.m. indicated the Miralax dose was not effective.

R8's Emar note dated 2/11/2021 at 2:41 a.m. indicated Bisacodyl Suppository was administered to R8, A follow-up eMar note on

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2/11/2021, at 8:09 a.m. noted that the suppository was ineffective.

R8's record was reviewed and did not include an assessment of bowels to determine the appropriate interventions for further bowel care after medications given were ineffective.
R8's progress note dated 2/12/2021 at 3:41 p.m., included, Patients last BM as on 2/6/2021 as per the charting but patient insisted that she had multiple BM yesterday and Refused suppository. On 2/10/2021 she received Miralax and senna plus. As per the nurse from evening shift on 2/10/2021, stated the patient refused bisacodyl suppository and night shift was informed about it. The orders tab shows that she had bisacodyl suppository on 2/11/2021 at 2 AM I will follow up tomorrow. Active bowel sounds in all quadrants. She did complain of nausea and gastric upset along with pain all over her body today (02/12/2021). She received TUMS and Zofran [used for nausea/vomiting] along with Tylenol. Her vital signs were within normal limits. She was confused at times during my shift. Nurse manager was aware. SBAR has been done.

R8's progress note dated 2/12/2021, at 5:10 p.m. included, "Author followed up on concerns brought forth by resident's assigned nurse regarding confusion, generalized body aches/pain, gastric upset and nausea. Resident's assigned nurse administered Tylenol, TUMS, and Zofran during the day. Per assigned nurse, resident did feel better but that symptoms weren't completely relieved. Upon evaluation, resident stated she had felt gastric upset but wasn't currently feeling any symptoms at the time. An abdominal examination was performed and her

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abdomen was soft, nontender to the touch. Bowel sounds were actively gurgling in all 4 quadrants. Resident stated she sometimes felt bloated but abdomen was not distended at the time of examination. It is debatable as to when the resident's last BM was; resident reported to multiple staff members that she had a very large bowel movement yesterday so she wanted no additional medications but no staff member can confirm actually observing it, so staff will pay close attention to ensure bowel movement occurs and possibly reproach resident about suppository if needed. She was confused during conversation but she has a history of encephalopathy [damage or malfunction in the brain], altered mental status and COVID-19 and has always been somewhat confused during all interactions with the author. She was noted to change subjects during conversation, but was re-directable and was able to answer all of the author's questions." The note indicated the physician was contacted with return orders to continue to monitor the resident and call the on-call physician should the need arise.

R8's eMAR progress note dated 2/12/2021, at 6:21 p.m. indicated a suppository was given at 6:00 p.m.

R8's progress note dated 2/13/2021, at 4:22 a.m. included "moaning; C/O [complained of abdominal pain] bowel sounds all 4 quads [quadrants]. R8's eMar note at 8:25 a.m. indicated Senna Plus was administered; "Patient stated that she feels constipated. She received bisacodyl suppository yesterday and had a medium BM. Therefore, senna plus was administered. Bowel sounds were present in all

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F 684	Continued From page 13 four quadrants." During an interview on 2/16/2021, at 12:00 p.m. R8 stated she sat in her chair in her room. R8 was able to articulate a history of problems with constipation. When asked when she had her last bowel movement she spoke out of order and stated she went to the library. When asked if she took any medications for her constipation, R5 reiterated her history, again spoke out of order and off topic. R3 R3's Admission Record , included diagnoses of constipation, muscle weakness, cognitive communication deficit, and dementia without behavioral disturbance. R3's care plan identified R3 was "At risk for constipation related to decreased mobility and administration of opioid pain medications. Corresponding interventions included document bowel movements every shift and administer bowel medications as needed/ordered. R3's Bowel and Bladder Data Collection assessment dated 2/11/2021, identified R3 was occasionally incontinent of bowel and was not on a bowel program to manage the incontinence. The area that prompted an answer for R3's bowel pattern had the recorded answer of "at times incontinent and at times constipation". R3's physician orders included: -Senna Plus Tablet 8.6-50 mg as needed for bowels (start date 12/29/2020) -Miralax packet by mouth for bowels (start date	F 684		

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F 684	Continued From page 14 12/29/2020) -Bisacodyl Suppository as needed for constipation daily (start date 12/29/2020) -Monitor resident for bowel movement and size twice daily; if resident does not have a BM in three days start BM protocol (start date 12/29/2020). Facility Standing Orders signed by a physician on 11/16/2012 was also implemented for R3 (details listed above) R3's bowel movement record identified R3 had a large bowel movement on 2/10/2021. R8's record lacked evidence of ongoing monitoring and assessment or prescribed interventions and or medications for bowel care. R8's progress notes dated 2/16/2021 at 7:22 p.m. included, "Patient was given 6oz [ounces] of warm prune juice for supper. Just had a medium BM that appeared to be hard. Patient has ordered Miralax daily. Encourage fluids." During an interview 2/16/2021, at 12:17 p.m. nursing assistant (NA)-B stated NA's are supposed to record bowel movements in the computer (electronic health record]. NA-B stated she would only document bowel movements in the EHR and would not tell the nurse. NA-B stated it was up to the nurse to check resident bowel movement frequency. NA-B stated if a resident reported feeling constipation she would let the nurse know. During an interview on 2/16/2021, at 12:19 p.m. NA-C stated that NA's document BM's, they are	F 684		

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supposed to tell the nurse, then the nurse also documents BM's.

During an interview on 2/16/2021, at 12:37 p.m. registered nurse (RN)-B stated if a resident has not had a bowel movement for 3 days we are supposed to give bowel medication on day three. RN-B stated he would give Miralax and Senna on the same day and then go to the suppository, and if no results then use the Enema. RN-B stated that the physician's standing orders was the bowel protocol. RN-B indicated an unawareness if there was supposed to be a certain time between the bowel medications and/or if one should be given before the other. RN-B stated he would not listen for bowel sounds or observe/palpate the abdomen prior to administration of as needed bowel medications unless the resident had dementia and could not effectively communicate. RN-B stated NA's document BM's in the EHR, the nurses would look up the bowel movement frequency and RN-B stated that all nurses were responsible for making sure residents had at least one BM every three days.

During an interview on 2/16/2021, at 2:14 p.m. director of nursing (DON) verified the residents was not administered PRN bowel medication according to physician orders, and R5's record lacked comprehensive bowel assessments. DON stated the physician's standing orders was the facility bowel protocol. The DON stated the protocol did not direct which medication to give first and/or duration between medications. DON stated charge nurses of each unit were supposed to be monitoring the frequency of bowel movements, if on day three a bowel medication

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F 684	Continued From page 16 was required, it was expected a complete bowel assessment be completed in order to determine if a bowel medication is warranted and safe to administer. DON expected nursing staff to administer as needed bowel medications on day three without a bowel movement, complete a follow-up for medication effectiveness, and if the medication was not effective to continue interventions or alert the provider. A bowel management policy/protocol was requested and not received.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		3/19/21

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F 690	Continued From page 17 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete bladder scanning and urinary catheterization according to physician orders for 2 of 2 residents (R3 and R5) reviewed for urinary retention management. Findings include: R3 R3's Admission Record, included diagnoses of overactive bladder, chronic kidney disease stage 3, muscle weakness, and dementia without behavioral disturbance. 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,	F 690	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 and updated orders to discontinue bladder scans, discontinue i/o catheterizations and monitor urinary output. How the facility will identify other residents that have the potential to be affected by the same deficient practice and what corrective action was taken: All residents have the potential to be affected by this practice. An audit was conducted to review all residents with bladder scan orders for appropriateness. Education was given to nurses regarding the importance of following provider directives on bladder scanning and documentation of refusals/re-approaches and notification to provider where warranted. Systemic changes to be made to ensure	

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F 690	Continued From page 18 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 of 12:00 a.m. R3's progress note did not address the refusal, and lacked evidence R3 was re-approached. The TAR for scheduled 5:45 a.m. boxes were left blank; R3's progress notes did not address why the procedure had not been completed. -On 2/14/2021, the TAR for 12:00 p.m. was completed at another time per progress note at 4:36 p.m. and the 6:00 p.m. scheduled time was	F 690	the deficient practice does not recur: Education was given to nurses regarding the importance of following provider directives on bladder scanning and documentation of refusals/re-approaches and notification to provider where warranted. Quality monitor implemented to review residents with bladder scan orders and monitor weekly at Daily Clinical meeting and assure appropriate completion of bladder scan or refusal outcome documented-weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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F 690	Continued From page 19	F 690		

not completed. Although a progress note at 11:07 p.m. included the order with a note, "Resident refused to go to bed at this time. Had many outputs at bathroom tonight. Did not scan." The record lacked evidence of R3 was re-approached.

-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.

-On 2/16/2021, the TAR for scheduled time of 12:00 a.m. had "X" in the boxes with a chart code of "9" (the TAR did not identify what the "9" meant). R3's progress notes did not clarify and/or address what had occurred. The TAR for scheduled time of 5:45 a.m. indicated bladder scans were not performed.. R8's progress notes did not address why the procedure was not completed.

R5
R5's Admission Record, included diagnosis of elevated prostate specific antigen, testicular dysfunction, urinary incontinence, muscle weakness, and dementia without behavioral disturbance. The report indicated R5 had been admitted to the facility on 8/13/2020, and discharged on 8/21/2020.

R5's physician orders included:
-DUE Bowel and Bladder Data Collection assessment. (start date 8/15/2020)
-Bladder scan post void. If retention is greater than 300 mls, perform I&O (intake/output-intermittent catheterization). May

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F 690	Continued From page 20 also in and out catheterization if patient has any signs or symptoms of retention or inability to void/discomfort every 6 hours (start date 8/14/2020). R5's record lacked evidence that the Bowel and Bladder Data Collection assessment was not completed on 8/15/2020 (the blank assessment was requested and not received). R5's August 2020 Treatment Administration Record (TAR), identified it was not completed.. R5's Nursing Data Collection-Admission/Readmission Day assessment dated 8/14/2020, in section H. Genitourinary System identified R5 was always incontinent of urine and required staff assistance for toileting. R5's progress notes was reviewed in conjunction with documentation on the treatment administration record (TAR) that identified the physician order for bladder scans from admission on 8/13 to 8/21/2020. The record lacked evidence the bladder scans were completed per physician order, and there was no record of R5 refusing the treatments. R5's TAR identified the scheduled bladder scans as 2:00 a.m., 8:00 a.m., 1:45 p.m., and 8:00 p.m. -On 8 /16/2020, the TAR indicated for the scheduled time of 1:45 p.m. indicated the scans were not performed evidenced by blank boxes. R5's progress notes did not address why the procedure was not completed or R5 had refused.	F 690		

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F 690	Continued From page 21 -On /17/2020, the TAR indicated for the scheduled time of 2:00 a.m. indicated the scans were not performed evidenced by blank boxes. R5's progress notes did not address why the procedure was not completed or R5 had refused. During an interview on 2/16/2020, at 2:14 p.m. director of nursing (DON) reviewed the records and confirmed the record lacked evidence that the bladder scans were completed per physician orders. DON indicated if the resident had refused nursing should re-approach the resident and document all refusals. During an interview on 2/18/2021, at 2:58 p.m. nurse practitioner (NP)-A stated she was familiar with residents and said the expectation was to follow physician orders for bladder scans and I and O catheterization for urinary retention, re-approach if resident refused, notify the provider if necessary, monitor for symptoms, and document refusals and assessments.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		3/19/21

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F 761	Continued From page 22 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview , and document review the facility failed to ensure safe storage of medications for 5 of 5 residents (R9, R10, R11, R12, and R8) whose medication cupboards were observed to be unlocked. Findings include: During an observation on 2/17/2021, at 3:00 p.m. R11's medication cupboard in their room was found to be unlocked. Medications in the cupboard included one bottle of Nasonex Suspension (used to treat allergies), one tube of clotrimazole cream 1% (used to treat fungal infections), one albuterol inhaler (used to treat shortness of breath and wheezing), and one Wixela Inhub inhaler (used to prevent symptoms caused by asthma). 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).	F 761	Corrective actions taken for residents found to be affected by this deficiency? R9 is currently out of the facility. R8, R10, R11 and R12 currently reside in the facility. All medication/treatment cabinets in resident rooms were immediately checked and locked. How the facility will identify other residents that have the potential to be affected by the same deficient practice and what corrective action was taken: All residents have the potential to be affected by this practice. An audit was conducted to check all medication cabinets in facility for being properly secured/locked . Education was given to nurses and TMAs regarding the requirement of locking medication/treatment cabinets. Facility has initiated installation of auto locks to room medication cabinets.	

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F 761	Continued From page 23 During an observation on 2/17/2021, at 3:10 p.m. R8's medication cupboard in their room was found to be unlocked. Medications in the cupboard included two boxes of Duo Nebs (used to treat shortness of breath and wheezing). During the observations of the resident's cupboards, registered nurse RN-C was present; she confirmed that the cupboards were unlocked and the aforementioned medications in those cupboards were present. RN-C stated the cupboards are supposed to remain locked if there are medications in them. During an observation on 2/17/21, at 3:21 p.m. R9's medication cupboard in their room was found to be unlocked. Medications in cupboard included 1 box of Lidocaine patches (pain patches), 2 bottles of fluticasone nasal spray (used to treat allergy symptoms), 1 tube of Nystatin (used to treat fungal/yeast infections), 2 boxes of Albuterol nebulizers, 2 tubes of diflofenac sodium gel (topical pain medication), 2 Breo Ellipta inhalers (used to decrease/prevent asthma symptoms), 1 bottle Refresh eye drops, 1 bottle of Hibiclens (used to clean the skin to prevent infections), 1 container omnipaque (medication used before imaging tests), 1 tube of mupirocin (used to treat skin infections), 4 tubes of Premarin (used to treat symptoms of menopause), 1 expired tube of hydrocortisone cream (used to treat inflammatory skin conditions) and 1 tube of Iodasorb (used to clean wounds and promote healing). During an observation on 2/17/21, at 3:10 p.m. R10's medication cupboard in their room was	F 761	Systemic changes to be made to ensure the deficient practice does not recur: Education was given to nurses and TMAs regarding the requirement of locking medication/treatment cabinets. Facility initiated installation of auto locks to room medication cabinets. Quality monitor implemented to ensure that facility room medication/treatment cabinets are locked. -weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	

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F 761	Continued From page 24 found to be unlocked. Medications in cupboard included 1 bottle of Refresh eye drops and 1 bottle of Latanoprost eye drops. During an interview on 2/17/21, at 3:39 p.m. registered nurse (RN)-A verified that R9 and R10's med cupboards were unlocked and should be locked at all times. During an interview on 2/18/21, at 1:24 p.m. director of nursing (DON) stated that all med cupboards should be locked at all times unless the nurse is in there using them. The Storage and Expirations of Medications, Biologicals, Syringes and Needles policy dated 2013 indicated in section the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.	F 761		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 02/18/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/16/2021 through 2/18/2021, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be	2 000		

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2 000	Continued From page 1 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. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders	2 000		

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2 000	Continued From page 2 will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide bowel medications per facility protocol and/or physician orders in order to prevent constipation for 3 of 3 residents (R5, R8, and R3) who were reviewed for bowel management. Findings include: R5's Admission Record, included diagnosis of	2 830	Corrective actions taken for residents found to be affected by this deficiency? R5 no longer resides in the facility. R8 and R3 currently reside in the facility. All resident standing orders for bowel protocol has been updated. How the facility will identify other residents	3/19/21

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2 830	Continued From page 3 constipation, muscle weakness, dementia without behavioral disturbance. The report indicated R5 had been admitted to the facility on 8/13/2020, and discharged on 8/21/2020 to a hospital. R5's admission care plan, indicated R5 was occasionally incontinent of bowel. R5's physician orders included: -DUE Bowel and Bladder Data Collection in assessments divider of chart and fill out and lock one time (start date 8/15/2020) -Fleet Oil Enema rectally one time for abdominal pain (8/21/2020) Facility Standing Orders signed by a physician on 11/16/2012, included the following for bowel care, -If no BM (bowel movement) in 3 days follow facility bowel care protocol (facility lacked evidence of a bowel care protocol) -Prune Juice 4 ounces daily and/or bran/applesauce/prune mixture/equivalent to 2 tablespoons twice a day as needed for constipation. -Miralax 17 grams daily as needed for constipation. -Sennosides 2 tablets twice per day as needed for constipation. Contact provider if taking an opioid. -Glycerin or bisacodyl 10 mg suppository one per rectum daily as needed for constipation -Tap water enema after above as needed medications attempted and unsuccessful. The standing orders did not identify a specific order to administer Miralax, Sennosides, or suppository or if the medications could/or should be given all at the same time. R5's Nursing Data Collection-Admission/Readmission Day assessment dated 8/14/2020, included a section Gastrointestinal System that identified R5's last bowel movement was on 8/12/2020, was	2 830	that have the potential to be affected by the same deficient practice and what corrective action was taken: All residents have the potential to be affected by this practice. The Bowel Protocol was updated in the facility standing orders. BM record spreadsheets were developed and implemented for all residents. In-service to clinical staff will be conducted regarding updated standing order on Bowel protocol. Systemic changes to be made to ensure the deficient practice does not recur: The Bowel Protocol was updated in the facility standing orders. BM record spreadsheets were developed and implemented for all residents. In-service to clinical staff will be conducted regarding updated standing order on Bowel protocol. Quality monitor implemented to review residents without BM for 3 days at Daily Clinical meeting and assure appropriate bowel protocol executed-weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	

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2 830	Continued From page 4 frequently incontinent, R5 had a regular bowel pattern however the assessment did not identify what the pattern was. The area that prompted a recorded answer for bowel sounds was noted with an "X" with no other description. R5's bowel movement record identified between 8/13/2020 to 8/21/2020, R5 had one medium bowel movement on 8/17/2020. No recorded bowel movements between 8/12 and 8/16, and 8/18 and 8/21/2020. R5's record lacked evidence of ongoing bowel monitoring, assessment and implementation of interventions according to the facility's standing orders. R5's progress note dated 8/20/2020 at 8:15 p.m., indicated Tylenol was administered for left sided abdominal pain. R5's progress note dated 8/21/2020, at 9:23 a.m. included, "At 730 [sic], author was notified by resident's overnight nurse that resident was reporting abdominal pain. As interventions resident was bladder scanned and catheterized, and Tylenol was offered. None were effective in relieving resident's pain. Upon assessment, resident still complained of right-sided abdominal pain; pain noted upon palpation of right-sided and center quadrants of abdomen. Resident's last bowel movement noted to be a medium on 8/17. Bowel sounds sluggish. Resident was given senna and a suppository, neither of which were helpful. Resident reporting nausea, declining all foods and fluids ..." R5's progress note dated 8/21/2020, at 9:26 a.m. included "Resident c/o [complained of] abdominal pain this morning. Stated it was across his whole lower stomach. Resident has not had a bowel movement since 8/17/2020. Rectal suppository was administered this morning at 0730, no results yet. SBAR [provider communication form]	2 830		

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2 830	Continued From page 5	2 830		

sent to the provider. Nursing manager aware of the situation.
R5's progress note dated 8/21/2020, at 11:06 a.m. indicated the provider gave an order to try Fleet enema, if no results send to the emergency room. Progress note at 12:10 p.m. indicated R5 had very small results from the enema and would be sent to the ER.
R5's August 2020 Medication Administration Record identified R5 was given a Fleet Enema on 8/21/2020, at 11:15 a.m. . The MAR did not identify any other bowel medication was administered between 8/13/2020 to 8/21/2020 as indicated in the progress notes.
R5's physician visit dated 8/21/2020, identified one of the reasons for the visit was constipation. The note indicated a nurse at the facility reported R5 was "complaining of right-sided abdominal pain and nausea that was not relieved by bladder scan/catheterization, Tylenol, Senna, suppository or Tums. The note further indicated R5's last had a medium bowel movement four days prior on 8/17/2020.
R8
R8's Admission Record, included diagnosis of constipation and muscle weakness.
Physician orders included:
-Monitor resident for bowel movement and size two times a day if resident does not have a BM in three days start BM protocol (start date 2/4/2021).
-Miralax (laxative) give one packet by mouth as needed for bowels (start date 2/4/2021)
-Senna Plus 8.6-50 milligrams (mg) as needed for bowels (start date 2/4/2021)
Facility Standing Orders signed by a physician on 11/16/2012 was also implemented for R8 orders (see details as listed above)
R8's care plan included "At risk for constipation

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2 830	Continued From page 6 related to decreased mobility, h/o [history of constipation]." R8's associated interventions instructed staff to document bowel movements every shift and administer bowel medications as needed/ordered. R8's Nursing Data Collection-Admission/Readmission Day assessment dated 2/4/2021, included a section Gastrointestinal System that identified R8's last bowel movement was on 2/4/2021, R8's abdomen was soft with bowel sounds active in all four quadrants, was always continent and had a pattern of daily bowel movements. R8's bowel movement record identified that R8 had a bowel movements on 2/5, 2/6, 2/11, No bowel movements were recorded between 2/7 and 2/10/2021. R8's record lacked evidence of ongoing monitoring and assessment and prescribed interventions for bowel management. R8's progress note dated 2/10/2021, at 7:56 a.m. indicated as needed Senna Plus was administered; "Last BM was on 2/6/2021. Fourth day with no BM". A follow-up EMAR [electronic medication administration record] note at 11:57 a.m. indicated the dose was not effective and Miralax was administered for "Fourth day with no BM". EMAR note at 2:27 p.m. indicated the Miralax dose was not effective. R8's Emar note dated 2/11/2021 at 2:41 a.m. indicated Bisacodyl Suppository was administered to R8, A follow-up eMar note on 2/11/2021, at 8:09 a.m. noted that the suppository was ineffective. R8's record was reviewed and did not include an assessment of bowels to determine the appropriate interventions for further bowel care after medications given were ineffective. R8's progress note dated 2/12/2021 at 3:41 p.m.,	2 830		

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2 830	Continued From page 7 included, Patients last BM as on 2/6/2021 as per the charting but patient insisted that she had multiple BM yesterday and Refused suppository. On 2/10/2021 she received Miralax and senna plus. As per the nurse from evening shift on 2/10/2021, stated the patient refused bisacodyl suppository and night shift was informed about it. The orders tab shows that she had bisacodyl suppository on 2/11/2021 at 2 AM I will follow up tomorrow. Active bowel sounds in all quadrants. She did complain of nausea and gastric upset along with pain all over her body today (02/12/2021). She received TUMS and Zofran [used for nausea/vomiting] along with Tylenol. Her vital signs were within normal limits. She was confused at times during my shift. Nurse manager was aware. SBAR has been done. R8's progress note dated 2/12/2021, at 5:10 p.m. included, "Author followed up on concerns brought forth by resident's assigned nurse regarding confusion, generalized body aches/pain, gastric upset and nausea. Resident's assigned nurse administered Tylenol, TUMS, and Zofran during the day. Per assigned nurse, resident did feel better but that symptoms weren't completely relieved. Upon evaluation, resident stated she had felt gastric upset but wasn't currently feeling any symptoms at the time. An abdominal examination was performed and her abdomen was soft, nontender to the touch. Bowel sounds were actively gurgling in all 4 quadrants. Resident stated she sometimes felt bloated but abdomen was not distended at the time of examination. It is debatable as to when the resident's last BM was; resident reported to multiple staff members that she had a very large bowel movement yesterday so she wanted no additional medications but no staff member can confirm actually observing it, so staff will pay	2 830		

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2 830	Continued From page 8 close attention to ensure bowel movement occurs and possibly reproach resident about suppository if needed. She was confused during conversation but she has a history of encephalopathy [damage or malfunction in the brain], altered mental status and COVID-19 and has always been somewhat confused during all interactions with the author. She was noted to change subjects during conversation, but was re-directable and was able to answer all of the author's questions." The note indicated the physician was contacted with return orders to continue to monitor the resident and call the on-call physician should the need arise. R8's eMAR progress note dated 2/12/2021, at 6:21 p.m. indicated a suppository was given at 6:00 p.m. R8's progress note dated 2/13/2021, at 4:22 a.m. included "moaning; C/O [complained of abdominal pain] bowel sounds all 4 quads [quadrants]. R8's eMar note at 8:25 a.m. indicated Senna Plus was administered; "Patient stated that she feels constipated. She received bisacodyl suppository yesterday and had a medium BM. Therefore, senna plus was administered. Bowel sounds were present in all four quadrants." During an interview on 2/16/2021, at 12:00 p.m. R8 stated she sat in her chair in her room. R8 was able to articulate a history of problems with constipation. When asked when she had her last bowel movement she spoke out of order and stated she went to the library. When asked if she took any medications for her constipation, R5 reiterated her history, again spoke out of order and off topic. R3 R3's Admission Record , included diagnoses of	2 830		

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2 830	Continued From page 9 constipation, muscle weakness, cognitive communication deficit, and dementia without behavioral disturbance. R3's care plan identified R3 was "At risk for constipation related to decreased mobility and administration of opioid pain medications. Corresponding interventions included document bowel movements every shift and administer bowel medications as needed/ordered. R3's Bowel and Bladder Data Collection assessment dated 2/11/2021, identified R3 was occasionally incontinent of bowel and was not on a bowel program to manage the incontinence. The area that prompted an answer for R3's bowel pattern had the recorded answer of "at times incontinent and at times constipation". R3's physician orders included: -Senna Plus Tablet 8.6-50 mg as needed for bowels (start date 12/29/2020) -Miralax packet by mouth for bowels (start date 12/29/2020) -Bisacodyl Suppository as needed for constipation daily (start date 12/29/2020) -Monitor resident for bowel movement and size twice daily; if resident does not have a BM in three days start BM protocol (start date 12/29/2020). Facility Standing Orders signed by a physician on 11/16/2012 was also implemented for R3 (details listed above) R3's bowel movement record identified R3 had a large bowel movement on 2/10/2021. R8's record lacked evidence of ongoing monitoring and assessment or prescribed interventions and or medications for bowel care. R8's progress notes dated 2/16/2021 at 7:22 p.m. included, "Patient was given 6oz [ounces] of warm prune juice for supper. Just had a medium BM that appeared to be hard. Patient has	2 830		

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2 830	Continued From page 10 ordered Miralax daily. Encourage fluids." During an interview 2/16/2021, at 12:17 p.m. nursing assistant (NA)-B stated NA's are supposed to record bowel movements in the computer (electronic health record]. NA-B stated she would only document bowel movements in the EHR and would not tell the nurse. NA-B stated it was up to the nurse to check resident bowel movement frequency. NA-B stated if a resident reported feeling constipation she would let the nurse know. During an interview on 2/16/2021, at 12:19 p.m. NA-C stated that NA's document BM's, they are supposed to tell the nurse, then the nurse also documents BM's. During an interview on 2/16/2021, at 12:37 p.m. registered nurse (RN)-B stated if a resident has not had a bowel movement for 3 days we are supposed to give bowel medication on day three. RN-B stated he would give Miralax and Senna on the same day and then go to the suppository, and if no results then use the Enema. RN-B stated that the physician's standing orders was the bowel protocol. RN-B indicated an unawareness if there was supposed to be a certain time between the bowel medications and/or if one should be given before the other. RN-B stated he would not listen for bowel sounds or observe/palpate the abdomen prior to administration of as needed bowel medications unless the resident had dementia and could not effectively communicate. RN-B stated NA's document BM's in the EHR, the nurses would look up the bowel movement frequency and RN-B stated that all nurses were responsible for making sure residents had at least one BM every three days. During an interview on 2/16/2021, at 2:14 p.m. director of nursing (DON) verified the residents	2 830		

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2 830	Continued From page 11 was not administered PRN bowel medication according to physician orders, and R5's record lacked comprehensive bowel assessments. DON stated the physician's standing orders was the facility bowel protocol. The DON stated the protocol did not direct which medication to give first and/or duration between medications. DON stated charge nurses of each unit were supposed to be monitoring the frequency of bowel movements, if on day three a bowel medication was required, it was expected a complete bowel assessment be completed in order to determine if a bowel medication is warranted and safe to administer. DON expected nursing staff to administer as needed bowel medications on day three without a bowel movement, complete a follow-up for medication effectiveness, and if the medication was not effective to continue interventions or alert the provider. A bowel management policy/protocol was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review bowel management program policy/procedures and or develop appropriate procedures for bowel management. The DON/designee could then provide staff re-education pertaining to comprehensive bowel assessments in correlation to administration of as needed (PRN) bowel medications. The DON/designee needs to develop and implement a system that does not rely on computer alerts as that system did not prevent the deficient practice from occurring. The DON/designee could then implement a comprehensive auditing as part of the facility's qualities assurance actives to maintain compliance.	2 830		

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2 830	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete bladder scanning and urinary catheterization according to physician orders for 2 of 2 residents (R3 and R5) reviewed for urinary retention management. Findings include: R3 R3's Admission Record, included diagnoses of overactive bladder, chronic kidney disease stage 3, muscle weakness, and dementia without behavioral disturbance.	2 910	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 and updated orders to discontinue bladder scans, discontinue i/o catheterizations and monitor urinary output. How the facility will identify other residents that have the potential to be affected by the same deficient practice and what corrective action was taken:	3/19/21

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2 910	Continued From page 13 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	2 910	All residents have the potential to be affected by this practice. An audit was conducted to review all residents with bladder scan orders for appropriateness. Education was given to nurses regarding the importance of following provider directives on bladder scanning and documentation of refusals/re-approaches and notification to provider where warranted. Systemic changes to be made to ensure the deficient practice does not recur: Education was given to nurses regarding the importance of following provider directives on bladder scanning and documentation of refusals/re-approaches and notification to provider where warranted. Quality monitor implemented to review residents with bladder scan orders and monitor weekly at Daily Clinical meeting and assure appropriate completion of bladder scan or refusal outcome documented-weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	

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2 910	Continued From page 14 of 12:00 a.m. R3's progress note did not address the refusal, and lacked evidence R3 was re-approached. The TAR for scheduled 5:45 a.m. boxes were left blank; R3's progress notes did not address why the procedure had not been completed. -On 2/14/2021, the TAR for 12:00 p.m. was completed at another time per progress note at 4:36 p.m. and the 6:00 p.m. scheduled time was not completed. Although a progress note at 11:07 p.m. included the order with a note, "Resident refused to go to bed at this time. Had many outputs at bathroom tonight. Did not scan." The record lacked evidence of R3 was re-approached. -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. -On 2/16/2021, the TAR for scheduled time of 12:00 a.m. had "X" in the boxes with a chart code of "9" (the TAR did not identify what the "9" meant). R3's progress notes did not clarify and/or address what had occurred. The TAR for scheduled time of 5:45 a.m. indicated bladder scans were not performed.. R8's progress notes did not address why the procedure was not completed. R5 R5's Admission Record, included diagnosis of elevated prostate specific antigen, testicular dysfunction, urinary incontinence, muscle weakness, and dementia without behavioral	2 910		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 15 disturbance. The report indicated R5 had been admitted to the facility on 8/13/2020, and discharged on 8/21/2020. R5's physician orders included: -DUE Bowel and Bladder Data Collection assessment. (start date 8/15/2020) -Bladder scan post void. If retention is greater than 300 mls, perform I&O (intake/output-intermittent catheterization). May also in and out catheterization if patient has any signs or symptoms of retention or inability to void/discomfort every 6 hours (start date 8/14/2020). R5's record lacked evidence that the Bowel and Bladder Data Collection assessment was not completed on 8/15/2020 (the blank assessment was requested and not received). R5's August 2020 Treatment Administration Record (TAR), identified it was not completed.. R5's Nursing Data Collection-Admission/Readmission Day assessment dated 8/14/2020, in section H. Genitourinary System identified R5 was always incontinent of urine and required staff assistance for toileting. R5's progress notes was reviewed in conjunction with documentation on the treatment administration record (TAR) that identified the physician order for bladder scans from admission on 8/13 to 8/21/2020. The record lacked evidence the bladder scans were completed per physician order, and there was no record of R5 refusing the treatments.	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 02/18/2021

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2 910	Continued From page 16 R5's TAR identified the scheduled bladder scans as 2:00 a.m., 8:00 a.m., 1:45 p.m., and 8:00 p.m. -On 8 /16/2020, the TAR indicated for the scheduled time of 1:45 p.m. indicated the scans were not performed evidenced by blank boxes. R5's progress notes did not address why the procedure was not completed or R5 had refused. -On /17/2020, the TAR indicated for the scheduled time of 2:00 a.m. indicated the scans were not performed evidenced by blank boxes. R5's progress notes did not address why the procedure was not completed or R5 had refused. During an interview on 2/16/2020, at 2:14 p.m. director of nursing (DON) reviewed the records and confirmed the record lacked evidence that the bladder scans were completed per physician orders. DON indicated if the resident had refused nursing should re-approach the resident and document all refusals. During an interview on 2/18/2021, at 2:58 p.m. nurse practitioner (NP)-A stated she was familiar with residents and said the expectation was to follow physician orders for bladder scans and I and O catheterization for urinary retention, re-approach if resident refused, notify the provider if necessary, monitor for symptoms, and document refusals and assessments. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the facility's policies/procedures, and provide re-education to nursing staff on following orders for residents with urinary retention, specifically pertaining to assessment, care plan requirements, following physician orders, and	2 910		

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2 910	Continued From page 17 documentation standards. DON/designee could then develop an auditing system as part of the facility's quality assurance activities to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21610	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. This MN Requirement is not met as evidenced by: Based on observation, interview , and document review the facility failed to ensure safe storage of medications for 5 of 5 residents (R9, R10, R11, R12, and R8) whose medication cupboards were observed to be unlocked. Findings include: During an observation on 2/17/2021, at 3:00 p.m. R11's medication cupboard in their room was found to be unlocked. Medications in the cupboard included one bottle of Nasonex Suspension (used to treat allergies), one tube of clotrimazole cream 1% (used to treat fungal infections), one albuterol inhaler (used to treat shortness of breath and wheezing), and one Wixela Inhub inhaler (used to prevent symptoms caused by asthma).	21610	Corrective actions taken for residents found to be affected by this deficiency? R9 is currently out of the facility. R8, R10, R11 and R12 currently reside in the facility. All medication/treatment cabinets in resident rooms were immediately checked and locked. How the facility will identify other residents that have the potential to be affected by the same deficient practice and what corrective action was taken: All residents have the potential to be affected by this practice. An audit was conducted to check all medication cabinets in facility for being properly secured/locked . Education was given to nurses and TMAs regarding the	3/19/21

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21610	Continued From page 18 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). During an observation on 2/17/2021, at 3:10 p.m. R8's medication cupboard in their room was found to be unlocked. Medications in the cupboard included two boxes of Duo Nebs (used to treat shortness of breath and wheezing). During the observations of the resident's cupboards, registered nurse RN-C was present; she confirmed that the cupboards were unlocked and the aforementioned medications in those cupboards were present. RN-C stated the cupboards are supposed to remain locked if there are medications in them. During an observation on 2/17/21, at 3:21 p.m. R9's medication cupboard in their room was found to be unlocked. Medications in cupboard included 1 box of Lidocaine patches (pain patches), 2 bottles of fluticasone nasal spray (used to treat allergy symptoms), 1 tube of Nystatin (used to treat fungal/yeast infections), 2 boxes of Albuterol nebulizers, 2 tubes of diflofenac sodium gel (topical pain medication), 2 Breo Ellipta inhalers (used to decrease/prevent asthma symptoms), 1 bottle Refresh eye drops, 1 bottle of Hibiclens (used to clean the skin to prevent infections), 1 container omnipaque (medication used before imaging tests), 1 tube of mupirocin (used to treat skin infections), 4 tubes of Premarin (used to treat symptoms of menopause), 1 expired tube of hydrocortisone cream (used to treat inflammatory skin conditions) and 1 tube of Iodasorb (used to clean	21610	requirement of locking medication/treatment cabinets. Facility initiated installation of auto locks to room medication cabinets. Systemic changes to be made to ensure the deficient practice does not recur: Education was given to nurses and TMAs regarding the requirement of locking medication/treatment cabinets. Facility initiated to installation of auto locks to room medication cabinets. Quality monitor implemented to ensure that facility room medication/treatment cabinets are locked. -weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters. Measures that will be implemented to monitor the continued effectiveness of the correction action taken to ensure compliance is achieved and sustained: Results of the quality review monitors will be reviewed monthly through the QAPI process to identify need for further education and/or need for future monitoring.	

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21610	Continued From page 19 wounds and promote healing). During an observation on 2/17/21, at 3:10 p.m. R10's medication cupboard in their room was found to be unlocked. Medications in cupboard included 1 bottle of Refresh eye drops and 1 bottle of Latanoprost eye drops. During an interview on 2/17/21, at 3:39 p.m. registered nurse (RN)-A verified that R9 and R10's med cupboards were unlocked and should be locked at all times. During an interview on 2/18/21, at 1:24 p.m. director of nursing (DON) stated that all med cupboards should be locked at all times unless the nurse is in there using them. The Storage and Expirations of Medications, Biologicals, Syringes and Needles policy dated 2013 indicated in section the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		