

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 29, 2021

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

RE: CCN: 245626

Cycle Start Date: February 18, 2021

Dear Administrator:

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

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

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

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

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

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Rochester Rehabilitation And Living Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 18, 2021. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Rochester Rehabilitation And Living Center April 29, 2021 Page 2

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mistan

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 9, 2021

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

RE: CCN: 245626

Cycle Start Date: February 18, 2021

Dear Administrator:

On February 18, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

Rochester Rehabilitation And Living Center March 9, 2021 Page 2

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

DEPARTMENT CONTACT

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

Rochester Rehabilitation And Living Center March 9, 2021

Page 3

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245626	B. WING			C 02/18/2021	
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
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LADODATON	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Upon receipt of an an on-site revisit of	0061235) 0067429)	IATURE	TITLE		(X6) DATE	

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

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.

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 607	executive director (of abuse should be twenty-four hours, or the ED-A verified to the Policy and Procedurallegations of abuse thours of the incider	c on 2/18/2021, at 12:51 p.m. ED)-A stated that allegations reported within two hours or depending on the incident. The facility Abuse Prevention are did not indicate that e should be reported within 2 at.		607	Protection/Freedom From Abuse, Nand Misappropriation Policy and Procedures to reflect the Federal reporting requirement. How the facility will identify other residents that have the potential to affected by the same deficient praction and what corrective action was take All residents have the potential to affected by this practice. In-service to staff regarding the Federal reporting requirement and Vulneral Adult Reporting was held on March 10 and 11, 2021. Systemic changes to be made to enthe deficient practice does not reconcern the federal reporting requirement. Quality monitor implemented to revolution to the continued effectiveness of reporting requirements weekly x 4 weeks, max 3 months then quarterly x 2 quart deficient practice.	be etice en: be deral ole of 4, 9, on sure ar: Neglect riew rting onthly ters. to sof the ors will paper.	0,40,04
F 609	Reporting of Allege	d violations	F 6	809			3/19/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 684 SS=D	reporting requirement direct staff to report timeframe. The plan suspicion that abust to the State Report state law immediate Quality of Care CFR(s): 483.25	ents for abuse and did not abuse within the two-hour in included that "If there is se occurred, it will be reported ing Agency in accordance with ely."	F 6	84			3/19/21
	§ 483.25 Quality of	care					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 684	Quality of care is a applies to all treatm facility residents. B assessment of a re that residents recei accordance with proportion of the care plan, and the state of the care plan of the care is a possible to all the care i	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, interview, and document ailed to provide bowel cility protocol and/or physician revent constipation for 3 of 3 and R3) who were reviewed nent. cord, included diagnosis of the weakness, dementia without nce. The report indicated R5 to the facility on 8/13/2020, 8/21/2020 to a hospital. the plan, indicated R5 was inent of bowel. ers included: ladder Data Collection in the of chart and fill out and lock	F 684	Corrective actions taken for reside found to be affected by this deficien R5 no longer resides in the facility. R8 and R3 currently reside in the facility. R8 and R3 currently reside in the facility resident standing orders for box protocol has been updated. How the facility will identify other residents that have the potential to affected by the same deficient practice and what corrective action was take All residents have the potential to affected by this practice. The Bowel Protocol was updated in facility standing orders. BM record spreadsheets were developed and implemented for all residents. Instead to clinical staff will be conducted regarding updated standing order of Bowel protocol. Systemic changes to be made to each the deficient practice does not recurrence. The Bowel Protocol was updated in facility standing orders. BM record spreadsheets were developed and implemented for all residents. Instead to clinical staff will be conducted.	ncy? acility. wel be ctice en: be in the lifervice on ensure ur: n the	

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		245626	B. WING				C 18/2021
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ROCHES	TER REHABILITATIO	N AND LIVING CENTER		R	OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	evidence of a bower-Prune Juice 4 ourself bran/applesauce/protablespoons twice a constipation. -Miralax 17 grams of constipation. -Sennosides 2 tables for constipation. -Glycerin or bisaccorrectum daily as needed and the sent standing orders order to administer suppository or if the be given all at the sent sent sent sent sent sent sent sen	protocol (facility lacked I care protocol) ces daily and/or une mixture/equivalent to 2 a day as needed for daily as needed for ets twice per day as needed ntact provider if taking an edded for constipation after above as needed and unsuccessful. Si did not identify a specific Miralax, Sennosides, or emedications could/or should ame time. In/Readmission Day 8/14/2020, included a section estem that identified R5's last as on 8/12/2020, was ent, R5 had a regular bowel exassessment did not identify is. The area that prompted a r bowel sounds was noted other description. Intercord identified between 1020, R5 had one medium 18/17/2020. No recorded between 8/12 and 8/16, and	F 6	84	regarding updated standing order of Bowel protocol. Quality monitor implemented to revresidents without BM for 3 days at Clinical meeting and assure approbowel protocol executed-weekly xaweeks, monthly x 3 months then quax 2 quarters. Measures that will be implemented monitor the continued effectiveness correction action taken to ensure compliance is achieved and sustain Results of the quality review monitobe reviewed monthly through the Coprocess to identify need for further education and/or need for future monitoring.	riew Daily priate 4 uarterly to s of the ned: ors will DAPI	
	R5's record lacked	evidence of ongoing bowel					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
		245626	B. WING _			C / 18/2021
	PROVIDER OR SUPPLIER	ON AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	interventions accorders. R5's progress note indicated Tylenol wabdominal pain. R5's progress note included, "At 730 [stresident's overnighter reporting abdominates and Tylenol was of relieving resident was bladded and Tylenol was of relieving resident's resident still complipain; pain noted upand center quadrallast bowel movemed 8/17. Bowel sound senna and a suppose helpful. Resident refoods and fluids' R5's progress note included "Resident pain this morning." lower stomach. Removement since 8, was administered to results yet. SBAR sent to the provide the situation.	e dated 8/20/2020 at 8:15 p.m., vas administered for left sided dated 8/21/2020, at 9:23 a.m. sic], author was notified by the nurse that resident was all pain. As interventions fered. None were effective in pain. Upon assessment, ained of right-sided abdominal on palpation of right-sided into of abdomen. Resident's ent noted to be a medium on suggish. Resident was given ository, neither of which were exporting nausea, declining all added 8/21/2020, at 9:26 a.m. ac/o [complained of] abdominal Stated it was across his whole sident has not had a bowel (17/2020. Rectal suppository this morning at 0730, no [provider communication form] r. Nursing manager aware of		4		
	a.m. indicated the Fleet enema, if no	e dated 8/21/2020, at 11:06 provider gave an order to try results send to the emergency te at 12:10 p.m. indicated R5				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245626	B. WING				C / 18/2021
	PROVIDER OR SUPPLIER	N AND LIVING CENTER			SS, CITY, STATE, ZIP CODE TON BOULEVARD NW R, MN 55901	021	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHOU REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 684	had very small results be sent to the ER. R5's August 2020 M Record identified R on 8/21/2020, at 11 identify any other bradministered between indicated in the profession of the reasons. The note indicated R5 was "complaining pain and nausea the scan/catheterization or Tums. The note if a medium bowel	Medication Administration 5 was given a Fleet Enema :15 a.m The MAR did not owel medication was een 8/13/2020 to 8/21/2020 as gress notes. dated 8/21/2020, identified for the visit was constipation. a nurse at the facility reported ng of right-sided abdominal at was not relieved by bladder n, Tylenol, Senna, suppository further indicated R5's last had ovement four days prior on cord, included diagnosis of uscle weakness. cluded: or bowel movement and size esident does not have a BM in 1 protocol (start date give one packet by mouth as (start date 2/4/2021) milligrams (mg) as needed te 2/4/2021) rders signed by a physician on to implemented for R8 orders	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245626	B. WING				C 18/2021
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		19	TREET ADDRESS, CITY, STATE, ZIP CODE 900 BALLINGTON BOULEVARD NW COCHESTER, MN 55901	021	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	R8's care plan inclurelated to decrease constipation]." R8's instructed staff to devery shift and admineded/ordered. R8's Nursing Data Collection-Admissic assessment dated? Gastrointestinal Systowel movement with abdomen was soft four quadrants, was pattern of daily bown R8's bowel movements with and a bowel movement of daily bown abdomen was soft four quadrants, was pattern of daily bown R8's bowel movements with and 2/10/2021. R8's record lacked monitoring and assinterventions for book R8's progress note indicated as needed administered; "Last day with no BM". A medication administicated the complete the c	aided "At risk for constipation d mobility, h/o [history of associated interventions ocument bowel movements ninister bowel medications as on/Readmission Day 2/4/2021, included a section stem that identified R8's last as on 2/4/2021, R8's with bowel sounds active in all a salways continent and had a rel movements. The entrecord identified that R8 nents on 2/5, 2/6, 2/11, Nowere recorded between 2/7 evidence of ongoing essment and prescribed wel management. Idated 2/10/2021, at 7:56 a.m. d Senna Plus was BM was on 2/6/2021. Fourth a follow-up EMAR [electronic tration record] note at 11:57 dose was not effective and stered for "Fourth day with not 2:27 p.m. indicated the ot effective.	F	884			
	indicated Bisacodyl	ed 2/11/2021 at 2:41 a.m. Suppository was , A follow-up eMar note on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245626	B. WING _		02/1	8/2021
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 684	assessment of bow appropriate interver after medications g R8's progress note included, Patients Is the charting but pat multiple BM yester On 2/10/2021 she r plus. As per the nur 2/10/2021, stated the suppository and nig The orders tab shor suppository and nig The orders tab shor suppository on 2/11 tomorrow. Active be She did complain or along with pain all of (02/12/2021). She r [used for nausea/ve Her vital signs were confused at times or manager was award. R8's progress note included, "Author for brought forth by res regarding confusion aches/pain, gastric assigned nurse addresident did feel be completely relieved stated she had felt currently feeling and	a.m. noted that the effective. Viewed and did not include an els to determine the ntions for further bowel care iven were ineffective. dated 2/12/2021 at 3:41 p.m., ast BM as on 2/6/2021 as per ient insisted that she had day and Refused suppository. eccived Miralax and sennates from evening shift on the patient refused bisacodyl that shift was informed about it. We that she had bisacodyl /2021 at 2 AM I will follow up owel sounds in all quadrants. If nausea and gastric upset over her body today received TUMS and Zofran omiting] along with Tylenol. It within normal limits. She was during my shift. Nurse the e. SBAR has been done. dated 2/12/2021, at 5:10 p.m. followed up on concerns sident's assigned nurse.	F 68	34		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245626	B. WING		02	C / 18/2021
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	abdomen was soft, Bowel sounds were quadrants. Resider bloated but abdome time of examination the resident's last Emultiple staff membeowel movement yeadditional medicatic confirm actually obclose attention to eoccurs and possibly suppository if need conversation but shencephalopathy [dabrain], altered membeometric and was always been so interactions with the change subjects dure-directable and wauthor's questions. physician was conticulated monitor on-call physician should be monitored. Re's eMAR progres 6:21 p.m. indicated 6:00 p.m. R8's progress note included "moaning; abdominal pain] bo [quadrants]. R8's elindicated Senna Plestated that she feel bisacodyl supposition edium BM. There	nontender to the touch. a actively gurgling in all 4 at stated she sometimes felt an was not distended at the a. It is debatable as to when BM was; resident reported to be restricted to she wanted no be restricted to	F 6	84		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245626	B. WING _	B. WING		C 02/18/2021	
	NAME OF PROVIDER OR SUPPLIER ROCHESTER REHABILITATION AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	R8 stated she sat it was able to articula constipation. When bowel movement stated she went to took any medication reiterated her historand off topic. R3 R3's Admission Reconstipation, muscl communication defibehavioral disturbation related administration of operation of the constipation related administration of the bowel movements of the bowel medications. R3's Bowel and Blates assessment dated to cocasionally incontrated abovel program to the area that prompattern had the reconstinent and at the R3's physician orders.	on 2/16/2021, at 12:00 p.m. In her chair in her room. R8 te a history of problems with asked when she had her last the spoke out of order and the library. When asked if she ins for her constipation, R5 ry, again spoke out of order order order. Cord , included diagnoses of the weakness, cognitive cit, and dementia without ince. Intified R3 was "At risk for it to decreased mobility and bioloid pain medications. In rventions included document the every shift and administer as needed/ordered. Industrial diagnoses of its decreased mobility and bioloid pain medications. In the properties of the propert	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245626	B. WING	B. WING		C 18/2021
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		10,2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	12/29/2020) -Bisacodyl Supposi constipation daily (s-Monitor resident for twice daily; if reside three days start BM 12/29/2020). Facility Standing Or 11/16/2012 was als listed above) R3's bowel movemed large bowel movement from the large l	tory as needed for start date 12/29/2020) or bowel movement and size ent does not have a BM in I protocol (start date orders signed by a physician on o implemented for R3 (details ent record identified R3 had a	F6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ′	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		245626	B. WING			C / 18/2021
	NAME OF PROVIDER OR SUPPLIER ROCHESTER REHABILITATION AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP 1900 BALLINGTON BOULEVARD ROCHESTER, MN 55901	CODE	10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	supposed to tell the documents BM's. During an interview registered nurse (R not had a bowel mosupposed to give be RN-B stated he won the same day and the same day and the stated that the physical three days. By the bowel protocol. Unawareness if the certain time between and/or if one should RN-B stated he wood or observe/palpate administration of as unless the resident effectively commundocument BM's in the look up the bowel in RN-B stated that all making sure resident three days. During an interview director of nursing (was not administered according to physical lacked comprehensistated the physician facility bowel protocol did not directly first and/or duration stated charge nurse to be monitoring the	on 2/16/2021, at 12:37 p.m. N)-B stated if a resident has evement for 3 days we are even medication on day three. all give Miralax and Senna on then go to the suppository, en use the Enema. RN-B sician's standing orders was	F6	684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245626	B. WING			C 1 18/2021	
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	assessment be con a bowel medication administer. DON ex administer as need three without a bow follow-up for medic medication was not interventions or ale A bowel management requested and not Bowel/Bladder Inco	s expected a complete bowel inpleted in order to determine if its warranted and safe to expected nursing staff to ed bowel medications on day wel movement, complete a pation effectiveness, and if the effective to continue it the provider. The policy/protocol was received.	F 6			3/19/21	
35=D	resident who is con admission receives maintain continence	nence. facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical omes such that continence is					
	incontinence, base comprehensive assensure that- (i) A resident who estindwelling catheter resident's clinical continuation was (ii) A resident who estindwelling catheter is assessed for remandary as possible unlessed demonstrates that continuation in the continuation of the continuati	essment, the facility must enters the facility without an is not catheterized unless the condition demonstrates that					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245626		B. WING		02/18/2021		
	PROVIDER OR SUPPLIER	N AND LIVING CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 690	receives appropriate prevent urinary trace continence to the endinger of the end of the endinger of the end of the e	e treatment and services to et infections and to restore extent possible. In resident with fecal do not he resident's resessment, the facility must ent who is incontinent of bowel the treatment and services to extend bowel function as the interest of the interest extended with an according to physician sidents (R3 and R5) reviewed in management. The cord, included diagnoses of chronic kidney disease stage is, and dementia without ince. The stream of the infection is included, bladder scan included	F 690	F690 Bowel and Bladder Incontine Corrective actions taken for residen found to be affected by this deficien R5 no longer resides in the facility. R3 still resides at the facility. Provice completed virtual visit on 2/18 with land 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 affected by the same deficient practionand what corrective action was take All residents have the potential to be affected by this practice. An audit was conducted to review a residents with bladder scan orders appropriateness. Education was ginurses regarding the importance of following provider directives on blact scanning and documentation of refusals/re-approaches and notifical provider where warranted. Systemic changes to be made to en	tts cy? der R3 / be tice en: e Ill for ven to dder tion to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING			COMF	SURVEY PLETED	
		245626	B. WING	B. WING		02/1	C 18/2021
	PROVIDER OR SUPPLIER	ON AND LIVING CENTER		19	TREET ADDRESS, CITY, STATE, ZIP CODE 200 BALLINGTON BOULEVARD NW OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	and provide frequenceded. R3's Bowel and Bl 2/11/2021, identificincontinent of uring problems with uring of toileting programmers assistance from on assessment also is urinary retention as ix hours, I/O cath R3's TAR (Treatment identified times of for 12:00 a.m. 5:45 p.m. The TAR including the amount. R3's progress note reviewed from 2/10 to identify physicial con 2/12/2021, the refused the bladded of 12:00 a.m. R3's progress note and lacked eviden TAR for scheduled blank; R3's progres the procedure had completed at another complete comp	age 18 ent toileting and cares as adder Data Collection dated ed R3 was frequently e, sometimes leaked urine, had ary urgency, was not on a trial m, and required extensive ne staff for toileting. The dentified R3 had problems with nd required bladder scan every eterization as needed. ent Administration Record) bladder scan were scheduled 5 a.m., 12:00 p.m. and 6:00 uded boxes to be checked off or the post void residual scans unt and the catheterization es and February (TAR) was 0/2021 to 2/17/2021 and failed an orders were followed. e TAR indicated for the R3 had er scan for the scheduled time e did not address the refusal, ce R3 was re-approached. The 15:45 a.m. boxes were left ss notes did not address why I not been completed. e TAR for 12:00 p.m. was her time per progress note at 6:00 p.m. scheduled time was	F6	690	the deficient practice does not recule Education was given to nurses regithe importance of following provided directives on bladder scanning and documentation of refusals/re-approand notification to provider where warranted. Quality monitor implemented to review residents with bladder scan orders monitor weekly at Daily Clinical meand assure appropriate completion bladder scan or refusal outcome documented-weekly x 4 weeks, most a months then quarterly x 2 quarter Measures that will be implemented monitor the continued effectiveness correction action taken to ensure compliance is achieved and sustain Results of the quality review monitor be reviewed monthly through the Coprocess to identify need for further education and/or need for future monitoring.	arding er I Daches view and eeting n of onthly x rs. I to s of the ned: ors will QAPI	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245626	B. WING _	B. WING		C 02/18/2021	
	NAME OF PROVIDER OR SUPPLIER ROCHESTER REHABILITATION AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901	.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 690	not completed. Alti 11:07 p.m. included "Resident refused to many outputs at bather record lacked or re-approached. -On 2/15/2021, the 12:00 a.m. and 5:40 were not performed address why the procompleted. -On 2/16/2021, the 12:00 a.m. had "X" of "9" (the TAR did meant). R3's progred address what had one scheduled time of second were not performed address what had one scheduled time of second were not performed address who completed. R5 R5's Admission Refered address, and der disturbance. The refered address who completed address, and der disturbance. The refered address who completed address who completed address, and der disturbance. The refered address who completed address who completed address who completed. R5 R5's physician order address who completed address and der disturbance. The refered address who completed address who completed address who completed address who completed. R5 R5's physician order address who completed address and der disturbance. The refered address who completed address address who completed address address address address addre	nough a progress note at the order with a note, to go to bed at this time. Had throom tonight. Did not scan." evidence of R3 was TAR for scheduled times of 5 a.m. indicated the scans of R3's progress notes did not occedure had not been TAR for scheduled time of in the boxes with a chart code not identify what the "9" ess notes did not clarify and/or occurred. The TAR for 5:45 a.m. indicated bladder formed R8's progress notes by the procedure was not cord, included diagnosis of pecific antigen, testicular or incontinence, muscle mentia without behavioral export indicated R5 had been lity on 8/13/2020, and /2020. ers included: ladder Data Collection date 8/15/2020) void. If retention is greater	F 6:	90			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C	
		245626	B. WING _	B. WING		18/2021
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 690	signs or symptoms void/discomfort ever 8/14/2020). R5's record lacked Bladder Data Colle completed on 8/15/was requested and R5's August 2020 Record (TAR), iden R5's Nursing Data Collection-Admissic assessment dated Genitourinary Systemicontinent of urine for toileting. R5's progress note with documentation administration recophysician order for on 8/13 to 8/21/202 evidence the bladd physician order, an refusing the treatment R5's TAR identified as 2:00 a.m., 8:00 and 16/2020, the	evidence that the Bowel and ction assessment was not (2020 (the blank assessment not received). Treatment Administration tified it was not completed on/Readmission Day (8/14/2020, in section H. em identified R5 was always and required staff assistance as was reviewed in conjunction to on the treatment rd (TAR) that identified the bladder scans from admission (20). The record lacked er scans were completed per d there was no record of R5	F 69	90		
	R5's progress note	d evidenced by blank boxes. s did not address why the completed or R5 had refused.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245626	B. WING			C 02/18/2021	
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901		10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 761 SS=E	scheduled time of 2 were not performed R5's progress note procedure was not During an interview director of nursing and confirmed the the bladder scans vorders. DON indica nursing should readocument all refusal During an interview nurse practitioner (with residents and follow physician orders and O catheterizati re-approach if residents and CFR(s): 483.45(g) Labeling Drugs and biological labeled in accordar professional principappropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In accedaral laws, the face	TAR indicated for the 2:00 a.m. indicated the scans devidenced by blank boxes. Is did not address why the completed or R5 had refused. If on 2/16/2020, at 2:14 p.m. (DON) reviewed the records record lacked evidence that were completed per physician atted if the resident had refused approach the resident and als. If on 2/18/2021, at 2:58 p.m. NP)-A stated she was familiar said the expectation was to ders for bladder scans and I on for urinary retention, dent refused, notify the ry, monitor for symptoms, and and assessments. If and Biologicals h)(1)(2) If of Drugs and Biologicals als used in the facility must be note with currently accepted oles, and include the	F 6			3/19/21	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
245626 B. WING		C 02/18/		C 18/2021		
NAME OF PROVIDER OR SUPPLIER ROCHESTER REHABILITATION AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP 1900 BALLINGTON BOULEVARD ROCHESTER, MN 55901	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 761	§483.45(h)(2) The separately locked, compartments for slisted in Schedule Abuse Prevention other drugs subject facility uses single systems in which the and a missing dose. This REQUIREME by: Based on observation of the facility from the facilit	ols, and permit only authorized access to the keys. facility must provide permanently affixed storage of controlled drugs and Control Act of 1976 and to abuse, except when the unit package drug distribution he quantity stored is minimal ecan be readily detected. NT is not met as evidenced ation, interview, and document ailed to ensure safe storage of a 5 residents (R9, R10, R11, se medication cupboards were ocked. Attion on 2/17/2021, at 3:00 p.m. supboard in their room was and detected at the control of the	F 7	Corrective actions taken found to be affected by the R9 is currently out of the R10, R11 and R12 current facility. All medication/treatment cresident rooms were immore checked and locked. How the facility will identify residents that have the post affected by the same defined and what corrective action. All residents have the post affected by this practice. An audit was conducted to medication cabinets in fact properly secured/locked given to nurses and TMA requirement of locking medication/treatment cabinets in itiated installation or room medication cabinets.	is deficiency? facility. R8, itly reside in the cabinets in ediately fy other otential to be cient practice in was taken: ential to be o check all cility for being Education was s regarding the inets. Facility f auto locks to	

Event ID: MZZ111

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
	245626 B. WING			C 18/2021		
	PROVIDER OR SUPPLIER	N AND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1900 BALLINGTON BOULEVARD NV ROCHESTER, MN 55901	ODE	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	R8's medication cu found to be unlocked cupboard included to treat shortness of the confirmed that and the aforementic cupboards are supposed are su	ion on 2/17/2021, at 3:10 p.m. pboard in their room was ed. Medications in the two boxes of Duo Nebs (used if breath and wheezing). tions of the resident's red nurse RN-C was present; the cupboards were unlocked oned medications in those resent. RN-C stated the roosed to remain locked if res in them. ion on 2/17/21, at 3:21 p.m. pboard in their room was red. Medications in cupboard idocaine patches (pain of fluticasone nasal spray by symptoms), 1 tube of reat fungal/yeast infections), 2 rebulizers, 2 tubes of rel (topical pain medication), 2 resulting to decrease/prevent, 1 bottle Refresh eye drops, 1 used to clean the skin to 1 container omnipaque refore imaging tests), 1 tube of treat skin infections), 4 tubes of treat skin infections), 4 tubes of treat skin infections of iried tube of hydrocortisone at inflammatory skin ube of lodasorb (used to clean te healing).	F 70	Systemic changes to be mathe deficient practice does not be deficient practice does not be deficient practice does not be deficient was given to nurs regarding the requirement of medication/treatment cabine initiated installation of auto I medication cabinets. Quality monitor implemented that facility room medication cabinets are lockedweekl monthly x 3 months then quarters. Measures that will be implemented to correction action taken to endurate the continued effect correction action taken to endurate the compliance is achieved and Results of the quality review be reviewed monthly throug process to identify need for education and/or need for furnonitoring.	mot recur: ses and TMAs of locking ets. Facility locks to room d to ensure n/treatment ly x 4 weeks, larterly x 2 mented to tiveness of the nsure I sustained: w monitors will gh the QAPI further	
		ion on 2/17/21, at 3:10 p.m. upboard in their room was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245626				02	C 02/18/2021	
NAME OF PROVIDER OR SUPPLIER ROCHESTER REHABILITATION AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP 1900 BALLINGTON BOULEVARD ROCHESTER, MN 55901	CODE	10/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 761	found to be unlocked included 1 bottle of bottle of Latanoprose. During an interview registered nurse (R R10's med cupboard be locked at all times. During an interview director of nursing (cupboards should be the nurse is in there. The Storage and Ex Biologicals, Syringe 2013 indicated in seen ensure that all med including treatment a locked cabinet/ca	ed. Medications in cupboard Refresh eye drops and 1 st eye drops. on 2/17/21, at 3:39 p.m. N)-A verified that R9 and ds were unlocked and should es. on 2/18/21, at 1:24 p.m. DON) stated that all med be locked at all times unless	F 7	'61			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 9, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: MZZ111

Dear Administrator:

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

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

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

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

Rochester Rehabilitation And Living Center March 9, 2021 Page 2

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

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

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

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

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mishing

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 03/30/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						С	
		29822		B. WING		02/1	18/2021
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ROCHESTER REHABILITATION AND LIVING CI 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	00 Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING CORRECTION ORDER						
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section order has been y. If, upon reinspectiency or deficiencies ected, a fine for each be assessed in accorines promulgated by artment of Health.	issued on, it is cited violation dance				
	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.						
	that may result from orders provided tha the Department witl	hearing on any asses n non-compliance with it a written request is hin 15 days of receipt nt for non-compliance	h these made to of a				
	survey was conduct with State Licensure be NOT in compliar Licensure. Please in of correction that you	rS: gh 2/18/2021, an abbited to determine come. Your facility was fonce with the MN State and cate in your electrous have reviewed the the date when they was a simple of the date when they was abbited.	pliance und to e onic plan se				

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

Electronically Signed 03/18/21

TITLE

STATE FORM 6899 If continuation sheet 1 of 20 MZZ111

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BUILDING.		C			
29822		B. WING	ıg02		8/2021			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
ROCHES	ROCHESTER REHABILITATION AND LIVING CI							
ROCHESTER, MN 55901								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE		
2 000	Continued From pa	ige 1	2 000					
	completed.							
	SUBSTANTIATED H5626013C (MN00) The following comp UNSUBSTANTIATE order was issued: H5626017C (MN00) Minnesota Departm the State Licensing federal software. To assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stat listed in the "Summ column and replace the correction orde the findings which a statute after the stat as evidence by." Fo	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is nary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state attement, "This Rule is not met following the surveyors findings Method of Correction and						
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for State enter the word "CO available for text. Y electronic State lice	tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are						

6899

Minnesota Department of Health STATE FORM

PRINTED: 03/30/2021 FORM APPROVED

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM					E SURVEY IPLETED	
		29822		B. WING		C 02/18/2021		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>		
ROCHESTER REHABILITATION AND LIVING CI 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 CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	ION SHOULD BE THE APPROPRIATE			
2 000	Continued From page 2			2 000				
2 830	to the Minnesota Defacility is enrolled in signature is not requage of state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLAAPPLIES TO FEDETHIS WILL APPEA	ior to electronically support of the epartment of Health. In ePOC and therefore uired at the bottom of the epartment of the e	The e a f the first OF THE N." THIS S ONLY.	2 830			3/19/21	
2 000	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. At be out of bed as mu is a written order from	general. A resident re and treatment, pers supervision based of d preferences as ide resident assessment acribed in parts 4658. In the properties of the attending physist remain in bed or the assessment of the attending physist remain in bed or the attending physist remain in the attending physical part of the attending physist remain in the attending physical part of the attending physist remain in the attending physical part of the attending physists at the attending physical part of the attending physical physi	must sonal and n ntified in t and .0400 nt must ss there sician	2 000			3,19,21	
	by: Based on observati review the facility fa medications per fac orders in order to p residents (R5, R8, a for bowel managem Findings include:	ent is not met as evident is not met as evident, and do alled to provide bowe cility protocol and/or prevent constipation for and R3) who were renent.	ocument I bhysician or 3 of 3 viewed		Corrective actions taken for reside found to be affected by this deficie R5 no longer resides in the facility R8 and R3 currently reside in the fall resident standing orders for borprotocol has been updated. How the facility will identify other residents	ncy? acility. wel		

Minnesota Department of Health

STATE FORM 6899 MZZ111 If continuation sheet 3 of 20

Minnesc	Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE				
		29822	B. WING		02/18	/2021			
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE					
ROCHES	STER REHABILITATIO	N AND LIVING CI	BALLINGTON E	BOULEVARD NW 5901					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE			
2 830	Continued From pa	ge 3	2 830						
	constipation, muscle behavioral disturbation had been admitted and discharged on R5's admission car occasionally inconted. The same season of time (start dated. Fleet Oil Enema repain (8/21/2020) Facility Standing Oo 11/16/2012, included. If no BM (bowel material for a bowell for constipation. For constipation. Miralax 17 grams of constipation. Sennosides 2 tables for constipation. Sennosides 2 tables for constipation. Copioid. Glycerin or bisacon rectum daily as need. Tap water enema a medications attemp. The standing order order to administer suppository or if the be given all at the sent R5's Nursing Data Collection-Admission assessment dated Gastrointestinal Sy	e weakness, dementia with noce. The report indicated to the facility on 8/13/2020 8/21/2020 to a hospital. The plan, indicated R5 was inent of bowel. The restriction in the restriction of the restriction	R5D, lock inal in on care, 2 ed ed e per	that have the potential to be affect the same deficient practice and w corrective action was taken: All residents have the potential to affected by this practice. The Bowel Protocol was updated facility standing orders. BM recorspreadsheets were developed an implemented for all residents. Into clinical staff will be conducted rupdated standing order on Bowel protocol. Systemic changes to be made to the deficient practice does not recorned to all residents. Into clinical staff will be conducted rupdated standing order on Bowel protocol. Quality monitor implemented to recorned to meeting and assure appropriate to the developed and assure appropriate protocol executed-weekly and assure appropriate to the continued effectiveness and the protocol action taken to ensure compliance is achieved and sustant Results of the quality review monitor the reviewed monthly through the process to identify need for furthe education and/or need for further education and	hat be in the d d service egarding ensure cur: in the d d service egarding eview t Daily opriate 4 quarterly d to ss of the sined: itors will QAPI				

Minnesota Department of Health STATE FORM

6899 If continuation sheet 4 of 20 MZZ111

Minnesota Department of Health

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()	, ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER ROCHESTER REHABILITATION AND LIVING CI (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			A. BUILDING	·		
ROCHESTER REHABILITATION AND LIVING CI (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		29822	B. WING			
ROCHESTER REHABILITATION AND LIVING CI (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	NAME OF PROVIDER OR SUPPLIER	JPPLIER STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
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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	PREFIX (EACH DEFICIENC	FICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE	COMPLETE
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	2 830 Continued From pa	Continued From page 4				
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 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	frequently incontine pattern however the what the pattern was recorded answer for with an "X" with no R5's bowel movement of bowel movements 8/18 and 8/21/2020 R5's record lacked monitoring, assess interventions accorders. R5's progress note indicated Tylenol was abdominal pain. R5's progress note included, "At 730 [s resident's overnight reporting abdominal resident was bladded and Tylenol was of relieving resident's resident still complipain; pain noted up and center quadral last bowel movement 8/17. Bowel sound senna and a suppose helpful. Resident refoods and fluids' R5's progress note included "Resident pain this morning." lower stomach. Removement since 8/10.	accontinent, R5 had a regular bower ever the assessment did not identitern was. The area that prompted swer for bowel sounds was noted with no other description. Innovement record identified between 8/21/2020, R5 had one medium ement on 8/17/2020. No recorded ements between 8/12 and 8/16, are 21/2020. Iacked evidence of ongoing bowers assessment and implementation of a according to the facility's standing as note dated 8/20/2020 at 8:15 per lenol was administered for left side of the standard process. The standard process is bladder scanned and catheterize was offered. None were effective sident's pain. Upon assessment, complained of right-sided abdomnoted upon palpation of right-sided quadrants of abdomen. Resident's novement noted to be a medium of sounds sluggish. Resident was go a suppository, neither of which we ident reporting nausea, declining uids" In ses note dated 8/21/2020, at 9:26 are sident c/o [complained of] abdomentation. Stated it was across his which. Resident has not had a bowe since 8/17/2020. Rectal supposito	en d I of og .m., ed i.m. inal iven re allm. iinal ole			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		29822	B. WING			, 8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND I IVING CI		OULEVARD NW		
			TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
	sent to the provider the situation. R5's progress note a.m. indicated the proof. Fleet enema, if no proof. Progress not had very small results be sent to the ER. R5's August 2020 MRecord identified Ron 8/21/2020, at 11 identify any other badministered between indicated in the prorection of the reasons. The note indicated R5 was "complaining pain and nausea the scan/catheterization or Tums. The note	dated 8/21/2020, at 11:06 crovider gave an order to try results send to the emergency e at 12:10 p.m. indicated R5 alts from the enema and would fedication Administration 5 was given a Fleet Enema :15 a.m The MAR did not owel medication was een 8/13/2020 to 8/21/2020 as				
	R8 R8's Admission Record, included diagnosis of constipation and muscle weakness. Physician orders included: -Monitor resident for bowel movement and size					
	three days start BM 2/4/2021)Miralax (laxative) g	esident does not have a BM in I protocol (start date give one packet by mouth as (start date 2/4/2021)				
	-Senna Plus 8.6-50 for bowels (start da Facility Standing O 11/16/2012 was als (see details as liste	milligrams (mg) as needed te 2/4/2021) rders signed by a physician on o implemented for R8 orders				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I DAY OF CONNECTION	IDEIVIII IO/(IIOIVIVOIMBEIX.	A. BUILDING:			
	29822	B. WING		02/1	; 8/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHESTER REHABILITATION	N AND LIVING CI 1900 BAL	LINGTON BO	OULEVARD NW		
NOONEO LE RENABIENATION	ROCHES	TER, MN 559	901		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830 Continued From page	ge 6	2 830			
related to decreased constipation]." R8's a instructed staff to do every shift and admineeded/ordered. R8's Nursing Data Collection-Admission assessment dated 2 Gastrointestinal Sysbowel movement was abdomen was soft with four quadrants, was pattern of daily bower R8's bowel movement and a bowel movement and a bowel movement was and 2/10/2021. R8's record lacked a monitoring and assessinterventions for bower R8's progress note of indicated as needed administered; "Last day with no BM". A medication administ a.m. indicated the dominal was administed the dominal was administed as more at Miralax was administed and ministered to R8, 2/11/2021, at 8:09 a suppository was incompropriate interven after medications given as the staff of the sta	d mobility, h/o [history of associated interventions ocument bowel movements inister bowel medications as an/Readmission Day 2/4/2021, included a section stem that identified R8's last as on 2/4/2021, R8's with bowel sounds active in all always continent and had a el movements. In trecord identified that R8 nents on 2/5, 2/6, 2/11, No were recorded between 2/7 evidence of ongoing essment and prescribed wel management. Idated 2/10/2021, at 7:56 a.m. Id Senna Plus was BM was on 2/6/2021. Fourth follow-up EMAR [electronic tration record] note at 11:57 ose was not effective and stered for "Fourth day with not 2:27 p.m. indicated the of effective. In the content of the content				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
		71. DOILDING.			
	29822	B. WING		02/1	, 8/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
DOCUECTED DELIABILITATION	1900 BALI	LINGTON BO	DULEVARD NW		
ROCHESTER REHABILITATION	ROCHEST	ER, MN 559	901		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
the charting but patie multiple BM yesterda On 2/10/2021 she reciplus. As per the nurse 2/10/2021, stated the suppository and night. The orders tab shows suppository on 2/11/2 tomorrow. Active bow She did complain of ralong with pain all ov (02/12/2021). She reclused for nausea/vom Her vital signs were we confused at times du manager was aware. R8's progress note dincluded, "Author folle brought forth by residered granding confusion, aches/pain, gastric upassigned nurse admit Zofran during the day resident did feel bette completely relieved. It stated she had felt gas currently feeling any abdominal examination abdomen was soft, not Bowel sounds were a quadrants. Resident bloated but abdomen time of examination. The resident's last BM multiple staff member bowel movement yes	st BM as on 2/6/2021 as per ent insisted that she had ay and Refused suppository. ceived Miralax and senna se from evening shift on e patient refused bisacodyl at shift was informed about it. It is that she had bisacodyl 2021 at 2 AM I will follow up wel sounds in all quadrants. In ausea and gastric upset wer her body today accived TUMS and Zofran miting] along with Tylenol. Within normal limits. She was uring my shift. Nurse . SBAR has been done. Intelled 2/12/2021, at 5:10 p.m. owed up on concerns dent's assigned nurse	2 830			

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Minneso	<u>ota Department of He</u>	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		29822	B. WING		C 02/18/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		1900 BAI		OULEVARD NW			
ROCHES	STER REHABILITATIO	ROCHES	TER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 8	2 830				
	occurs and possibly suppository if need conversation but she encephalopathy [dabrain], altered menthas always been so interactions with the change subjects dure-directable and wauthor's questions. Physician was controus to monitor on-call physician she R8's eMAR progres 6:21 p.m. indicated 6:00 p.m. R8's progress note included "moaning; abdominal pain] bo [quadrants]. R8's elindicated Senna Plustated that she feel bisacodyl supposite medium BM. There administered. Bowe four quadrants." During an interview R8 stated she sat in was able to articular constipation. When bowel movement she stated she went to took any medication reiterated her historiand off topic.	nsure bowel movement of reproach resident about ed. She was confused during the has a history of amage or malfunction in the trail status and COVID-19 and to the mouth of the trail status and coving all the author. She was noted to the action of the trail status and coving all the author. She was noted to train conversation, but was as able to answer all of the trail the mouth the need arise. The note indicated the acted with return orders to the resident and call the mould the need arise. The note dated 2/12/2021, at a suppository was given at a suppository was given at a dated 2/13/2021, at 4:22 a.m. C/O [complained of wel sounds all 4 quads Mar note at 8:25 a.m. as was administered; "Patient is constipated. She received fore, senna plus was all sounds were present in all the con 2/16/2021, at 12:00 p.m. In her chair in her room. R8 the a history of problems with asked when she had her last the spoke out of order and the library. When asked if she as for her constipation, R5 try, again spoke out of order and cord, included diagnoses of cord, included diagnoses of cord, included diagnoses of cord, included diagnoses of cord.					

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Minnesota Department of Health

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
						`	
		29822	B. WING				
		23022	B. WING 02/18/2021				
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
		1900 BAI	LINGTON B	OULEVARD NW			
ROCHES	STER REHABILITATIO	N AND LIVING CI ROCHES	TER, MN 55	901			
0(4) 15	CUMMA DV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON.	(2/5)	
(X4) ID PREFIX	_	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE	
				DEFICIENCY)			
2 830	Continued From pa	ngo 0	2 830				
2 000	Continued From pa	ige 9	2 000				
	constipation, muscl	le weakness, cognitive					
	communication def	icit, and dementia without					
	behavioral disturba	nce.					
	R3's care plan ider	ntified R3 was "At risk for					
		d to decreased mobility and					
		oioid pain medications.					
		rventions included document					
		every shift and administer					
	bowel medications as needed/ordered.						
	R3's Bowel and Bladder Data Collection						
	assessment dated	2/11/2021, identified R3 was					
		inent of bowel and was not on					
		manage the incontinence.					
		pted an answer for R3's bowe					
		orded answer of "at times					
	incontinent and at t						
	R3's physician orde	•					
		8.6-50 mg as needed for					
	bowels (start date 1						
		mouth for bowels (start date					
	12/29/2020)	`					
	-Bisacodyl Supposi	itory as needed for					
		start date 12/29/2020)					
	-Monitor resident for	or bowel movement and size					
	twice daily; if reside	ent does not have a BM in					
	three days start BM	I protocol (start date					
	12/29/2020).	•					
	Facility Standing O	rders signed by a physician on					
	11/16/2012 was als	so implemented for R3 (details					
	listed above)						
	R3's bowel movem	ent record identified R3 had a					
	large bowel movem	nent on 2/10/2021.					
		evidence of ongoing					
		essment or prescribed					
		r medications for bowel care.					
		s dated 2/16/2021 at 7:22 p.m.					
		vas given 6oz [ounces] of					
		or supper. Just had a medium					
		to be hard. Patient has					

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Minnesota Department of Health

WIIIIIICSC	na Department of the	5aiti 1				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
						`
		29822	B. WING			8/2021
		29022			02/1	0/2021
NAME OF I	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY, S	STATE, ZIP CODE		
		1900 E	BALLINGTON B	OULEVARD NW		
ROCHES	STER REHABILITATIO	IN AND I IVING CI	ESTER, MN 55			
040.15	CUMMA DV CTA			T .	ON .	0.45)
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 830	Continued From no	270 10	2 830			
2 030	Continued From pa	ige 10	2 030			
	ordered Miralax dai	ily. Encourage fluids."				
	During an interview	/ 2/16/2021, at 12:17 p.m.				
	nursing assistant (N	NA)-B stated NA's are				
		bowel movements in the				
	computer (electroni	ic health record]. NA-B state	ed			
		cument bowel movements in				
		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		d			
	let the nurse know.					
	During an interview	on 2/16/2021, at 12:19 p.m				
		A's document BM's, they are				
		e nurse, then the nurse also				
	documents BM's.	,				
	During an interview	on 2/16/2021, at 12:37 p.m				
		RN)-B stated if a resident ha				
		ovement for 3 days we are				
		owel medication on day thre	ee.			
		uld give Miralax and Senna				
		then go to the suppository,				
		en use the Enema. RN-B				
	stated that the phys	sician's standing orders was				
	the bowel protocol.					
	unawareness if the	re was supposed to be a				
	certain time betwee	en the bowel medications				
	and/or if one should	d be given before the other.				
	RN-B stated he wo	uld not listen for bowel sour	ds			
	or observe/palpate	the abdomen prior to				
		s needed bowel medications	;			
		had dementia and could no				
		icate. RN-B stated NA's				
		the EHR, the nurses would				
		novement frequency and				
		Il nurses were responsible fo	or			
		ents had at least one BM eve				
	three days.					
		on 2/16/2021, at 2:14 p.m.				
		(DON) verified the residents				

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	T OF PERIODE HOUSE		()(0) 14111 TIDI	E CONOTRUCTION	(VO) DATE	01101/51/
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COIVIP	LETED
						`
		29822	B. WING			, 8/2021
		29022			02/1	0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1900 BAI	LINGTON BO	OULEVARD NW		
ROCHES	STER REHABILITATIO	N AND I IVING CI				
		RUCHES	TER, MN 559	901		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)	TRIAIL	D/((L
				,		
2 830	Continued From pa	ige 11	2 830			
	•					
		ed PRN bowel medication				
		cian orders, and R5's record				
		sive bowel assessments. DON				
		n's standing orders was the				
	facility bowel protoc	col. The DON stated the				
	protocol did not dire	ect which medication to give				
	first and/or duration	between medications. DON				
	stated charge nurse	es of each unit were supposed				
	to be monitoring the	e frequency of bowel				
	movements, if on day three a bowel medication					
		s expected a complete bowel				
		npleted in order to determine if				
		is warranted and safe to				
		xpected nursing staff to				
		ed bowel medications on day				
		vel movement, complete a				
		ation effectiveness, and if the				
	•					
		t effective to continue				
	interventions or ale					
		ent policy/protocol was				
	requested and not					
		THOD OF CORRECTION: The				
		(DON) or designee could				
	review bowel mana					
		and or develop appropriate				
	procedures for bow	el management. The				
	DON/designee cou	ld then provide staff				
		ning to comprehensive bowel				
		relation to administration of as				
		el medications. The				
	,	eds to develop and implement				
		not rely on computer alerts as				
		prevent the deficient practice				
		e DON/designee could then				
		ehensive auditing as part of				
		es assurance actives to				
	maintain compliand	ce.				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLI, IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		29822		B. WING		00/4		
		29822		D. WING		02/1	8/2021	
NAME OF	PROVIDER OR SUPPLIER	STRI	EET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ROCHES	STER REHABILITATIO	N AND I IVING CI		LINGTON BO FER, MN 559	OULEVARD NW 901			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From page 12			2 830				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.							
2 910	0 MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence			2 910			3/19/21	
	have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident with receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and blat luce incontinence and the fatheters. Based on the ident assessment, a nursithat: The enters a nursing home ag catheter is not catheter is clinical condition indicated was necessary; and no is incontinent of bladded treatment and services it infections and to restorer function as possible.	idder e e ing e rized tes er to					
	by: Based on interview facility failed to comurinary catheterizat orders for 2 of 2 resfor urinary retention Findings include: R3 R3's Admission Recoveractive bladder,	cord, included diagnoses chronic kidney disease s s, and dementia without	e nd n wed		F690 Bowel and Bladder Incontine Corrective actions taken for reside found to be affected by this deficiency R5 no longer resides in the facility R3 still resides at the facility. Prove completed virtual visit on 2/18 with updated orders to discontinue blasscans, discontinue i/o catheterization and monitor urinary output. How the facility will identify other in that have the potential to be affect the same deficient practice and will corrective action was taken:	ents ency? vider n R3 and dder cions residents red by		

Minnesota Department of Health STATE FORM

MZZ111 If continuation sheet 13 of 20

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUME	DED:	′	E CONSTRUCTION	(X3) DATE :	
		29822	B. V	WING		02/1	: 8/2021
NAME OF F	PROVIDER OR SUPPLIER	,	STREET ADDRES	SS, CITY, S	TATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND I IVING CI	1900 BALLING ROCHESTER,		DULEVARD NW 01		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFED DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	,			910	All residents have the potential to	be	
	every six hours and catheterization if pa	ers included, bladder s d as needed. Intake/ou atient unable to void or an 300 milliliters (ml), 20).	tput if		affected by this practice. An audit was conducted to review residents with bladder scan orders appropriateness. Education was a nurses regarding the importance of following provider directives on bladen.	s for given to of	
	bladder and alterative requiring assistance. Associated interver the toilet, change in	cated R3 had an overa ion in continence relat- e with mobility and we ntions included, assist acontinent brief as nee nt toileting and cares a	ed to akness. R3 to ded,		scanning and documentation of refusals/re-approaches and notific provider where warranted. Systemic changes to be made to eather deficient practice does not receive Education was given to nurses regardle importance of following provided directives on bladder scanning and	ensure ur: garding er	
	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.		ine, had n a trial ve e ms with		documentation of refusals/re-appr and notification to provider where warranted. Quality monitor implemented to re residents with bladder scan orders monitor weekly at Daily Clinical mand assure appropriate completion bladder scan or refusal outcome documented-weekly x 4 weeks, m 3 months then quarterly x 2 quarter	view s and eeting on of onthly x	
	identified times of b for 12:00 a.m. 5:45 p.m. The TAR inclu when completed fo including the amou amount. R3's progress note reviewed from 2/10	nt Administration Recolladder scan were scholadder scan were scholadder scan were scholadder scan were scholadder to boxes to be checked to the post void residuant and the catheterizates and February (TAR) /2021 to 2/17/2021 and perdors were followed	eduled 6:00 ked off I scans ion was d failed		Measures that will be implemented monitor the continued effectiveness correction action taken to ensure compliance is achieved and susta Results of the quality review monit be reviewed monthly through the oprocess to identify need for further education and/or need for future monitoring.	d to ss of the ined: tors will QAPI	
	-on 2/12/2021, the	n orders were followed TAR indicated for the I r scan for the schedule	R3 had				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7110117111	OF CONTRECTION	BENTI TO/CHON NOWBER.	A. BUILDING:			
		29822	B. WING		02/1	3 8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	ON AND I IVING CI	LINGTON BOTER, MN 55	OULEVARD NW 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	Continued From pa	age 14	2 910			
	of 12:00 a.m.					
	and lacked evidence TAR for scheduled blank; R3's progress the procedure had -On 2/14/2021, the completed at anothe 4:36 p.m. and the 6 not completed. Alti 11:07 p.m. included "Resident refused to many outputs at bather record lacked re-approached. -On 2/15/2021, the 12:00 a.m. and 5:4 were not performed address why the present the progress of the schedule of the process of the schedule of the process of th	did not address the refusal, be R3 was re-approached. The 5:45 a.m. boxes were left as notes did not address why not been completed. TAR for 12:00 p.m. was ner time per progress note at 6:00 p.m. scheduled time was shough a progress note at did the order with a note, to go to bed at this time. Had athroom tonight. Did not scan." evidence of R3 was TAR for scheduled times of 5 a.m. indicated the scans did R3's progress notes did not rocedure had not been				
	12:00 a.m. had "X" of "9" (the TAR did meant). R3's progreaddress what had a scheduled time of 8 scans were not per did not address who completed.	TAR for scheduled time of in the boxes with a chart code not identify what the "9" ess notes did not clarify and/or occurred. The TAR for 5:45 a.m. indicated bladder formed R8's progress notes y the procedure was not				
	elevated prostate s dysfunction, urinary	cord, included diagnosis of specific antigen, testicular y incontinence, muscle mentia without behavioral				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
	THE LEWIS CONTROL OF THE PROPERTY OF THE PROPE		A. BUILDING:			C	
		29822	B. WING			18/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	STATE, ZIP CODE			
ROCHES	STER REHABILITATIO	IN AND LIVING CI	LLINGTON B Ster, MN 55	OULEVARD NW 901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 910	Continued From pa	nge 15	2 910				
	disturbance. The re	eport indicated R5 had been lity on 8/13/2020, and					
	assessment. (start -Bladder scan post than 300 mls, perfo (intake/output-internalso in and out cath signs or symptoms	ladder Data Collection date 8/15/2020) void. If retention is greater					
	Bladder Data Colle completed on 8/15/ was requested and R5's August 2020	evidence that the Bowel and ction assessment was not /2020 (the blank assessment not received). Treatment Administration tified it was not completed					
	assessment dated Genitourinary Syste	on/Readmission Day 8/14/2020, in section H. em identified R5 was always and required staff assistance					
	with documentation administration reco physician order for on 8/13 to 8/21/202 evidence the bladd	ord (TAR) that identified the bladder scans from admissio 20. The record lacked er scans were completed per d there was no record of R5					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING	A. BUILDING:		
		29822	B. WING		02/1	, 8/2021
NAME OF	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE		
ROCHES	STER REHABILITATIO	N AND I IVING CI	BALLINGTON B ESTER, MN 55	OULEVARD NW 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRINCE TO THE APPRINCE DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 16	2 910			
		the scheduled bladder sca a.m., 1:45 p.m., and 8:00 p.				
	scheduled time of 1 were not performed R5's progress note:	e TAR indicated for the 1:45 p.m. indicated the scan d evidenced by blank boxes s did not address why the completed or R5 had refuse				
	scheduled time of 2 were not performed R5's progress note:	TAR indicated for the 2:00 a.m. indicated the scand evidenced by blank boxes sidd not address why the completed or R5 had refuse				
	director of nursing (and confirmed the r the bladder scans v orders. DON indica	on 2/16/2020, at 2:14 p.m. (DON) reviewed the records record lacked evidence that were completed per physiciated if the resident had refusipproach the resident and als.	ın			
	nurse practitioner (I with residents and s follow physician ord and O catheterizations- re-approach if residents	on 2/18/2021, at 2:58 p.m. NP)-A stated she was fami said the expectation was to ders for bladder scans and lon for urinary retention, lent refused, notify the ry, monitor for symptoms, a and assessments.				
	director of nursing (review the facility's provide re-educatio orders for residents specifically pertaini	THOD OF CORRECTION: 1 (DON) or designee could policies/procedures, and on to nursing staff on following with urinary retention, ang to assessment, care plan wing physician orders, and	ng			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
29822		B. WING		C 02/18/2021			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ROCHES	ROCHESTER REHABILITATION AND LIVING CI 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 910	then develop an au facility's quality ass compliance.	nge 17 Indards. DON/designee could diting system as part of the urance activities to maintain	2 910				
21610	MN Rule 4658.1344 and Preparation Are Subpart 1. Storage must store all drugs under proper temper	e of drugs. A nursing home in locked compartments erature controls, and permit ising personnel to have	21610			3/19/21	
	by: Based on observati review the facility fa medications for 5 o R12, and R8) whos observed to be unlo Findings include: During an observat R11's medication of found to be unlocked cupboard included Suspension (used to clotrimazole cream infections), one alb shortness of breath	ion on 2/17/2021, at 3:00 p.m. upboard in their room was ed. Medications in the one bottle of Nasonex to treat allergies), one tube of 1% (used to treat fungal uterol inhaler (used to treat and wheezing), and one er (used to prevent symptoms		Corrective actions taken for reside found to be affected by this deficie R9 is currently out of the facility. R11 and R12 currently reside in the facility. All medication/treatment cabinets is resident rooms were immediately and locked. How the facility will identify other rethat have the potential to be affected the same deficient practice and who corrective action was taken: All residents have the potential to laffected by this practice. An audit was conducted to check a medication cabinets in facility for be properly secured/locked. Educating given to nurses and TMAs regarding	ncy? R8, R10, e in checked esidents ed by nat be		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		С		
		29822	B. WING		02/18/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHESTER REHABILITATION AND LIVING CI 1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE COMPLETE	
21610	Continued From pa	ge 18	21610			
	During an observation on 2/17/2021, at 3:05 p.m. R12's medication cupboard in their room was found to be unlocked. Medication in the cupboard included one bottle of refresh tears (used to treat dry eyes). 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			requirement of locking medication/treatment cabinets. Fainitiated installation of auto locks to medication cabinets. Systemic changes to be made to the state of	o room	
				the deficient practice does not rec Education was given to nurses an regarding the requirement of locki medication/treatment cabinets. From medication cabinets. Quality monitor implemented to en that facility room medication/treatr cabinets are lockedweekly x 4 monthly x 3 months then quarterly quarters.	ur: d TMAs ng acility s to nsure ment weeks,	
	R9's medication cu found to be unlocked included 1 box of L patches), 2 bottles (used to treat allerg Nystatin (used to treoverse of Albuterol redifformac sodium greo Ellipta inhaler asthma symptoms) bottle of Hibiclens (prevent infections), (medication used be mupirocin (used to of Premarin (used to menopause), 1 experience of the symptoms of the	ion on 2/17/21, at 3:21 p.m. pboard in their room was ed. Medications in cupboard idocaine patches (pain of fluticasone nasal spray y symptoms), 1 tube of eat fungal/yeast infections), 2 nebulizers, 2 tubes of jel (topical pain medication), 2 is (used to decrease/prevent , 1 bottle Refresh eye drops, 1 used to clean the skin to 1 container omnipaque efore imaging tests), 1 tube of treat skin infections), 4 tubes o treat symptoms of irred tube of hydrocortisone at inflammatory skin ube of lodasorb (used to clean		Measures that will be implemente monitor the continued effectivenes correction action taken to ensure compliance is achieved and susta Results of the quality review moni be reviewed monthly through the process to identify need for furthe education and/or need for future monitoring.	ined: tors will QAPI	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			DATE SURVEY COMPLETED	
		A. Bolebino.		С			
		29822	B. WING		02/1	8/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ROCHES	STER REHABILITATIO	N AND LIVING CI	LINGTON BO TER, MN 559	OULEVARD NW 901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21610	Continued From pa	ge 19	21610				
	wounds and promo	te healing).					
	During an observate R10's medication of found to be unlocked included 1 bottle of bottle of Latanopro. During an interview registered nurse (R R10's med cupboa be locked at all time. During an interview director of nursing cupboards should be the nurse is in there. The Storage and E Biologicals, Syringe 2013 indicated in sensure that all med including treatment a locked cabinet/cathat is inaccessible SUGGESTED MET administrator, directonsulting pharmac policies and proced medications. Nursing necessary to the immedications. The D the pharmacist, coubasis to ensure corrections.	ion on 2/17/21, at 3:10 p.m. upboard in their room was ed. Medications in cupboard Refresh eye drops and 1 st eye drops. I on 2/17/21, at 3:39 p.m. (N)-A verified that R9 and rds were unlocked and should es. I on 2/18/21, at 1:24 p.m. (DON) stated that all med be locked at all times unless e using them. Expirations of Medications, es and Needles policy dated ection the facility should ications and biologicals, items, are securely stored in art or locked medication room by residents and visitors. THOD OF CORRECTION: The stor of nursing (DON) and coist could review and revise dures for proper storage of any staff could be educated as apportance of properly securing DON or designee, along with all donduct audits on a regular					

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