DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 15, 2022

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

RE: CCN: 245626
Cycle Start Date: August 11, 2022

Dear Administrator:

On September 12, 2022, we notified you a remedy was imposed. On October 21, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 7, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 20, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 5, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 22, 2022.

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

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
August 26, 2022

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

RE: CCN: 245626
Cycle Start Date: August 11, 2022

Dear Administrator:

On August 11, 2022, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 November 11, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 11, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 08/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/10/22, through 8/11/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H56263709C (MN85601), with a deficiency cited at F659. The following complaints were found to be UNSUBSTANTIATED: H56263954C (MN85772 & 85770). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 659		9/2/22

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

Electronically Signed | 09/01/2022

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

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F 659	Continued From page 1 by: Based on interview and document review, the facility failed to ensure services were provided by qualified staff for 1 of 1 resident (R1) reviewed for accidents who received additional services from an outside agency which was contracted by the family. Findings include: R1's admission Minimum Data Set (MDS) dated 6/22/22, included diagnoses of osteoarthritis, spinal fractures of lumbar region, fibromyalgia, osteoarthritis and pain in right shoulder. In addition, the MDS indicated R1 had intact cognition and required extensive assist of with activities of daily living (ADLs) which included transfers, walking in the room and corridor. R1 was receiving occupational and physical therapy. During a review of R1's fall incident report dated 7/24/22, it was revealed R1 had a fall while attempting to go for a walk with the homemaker. The report indicated the homemaker staff had applied a transfer belt around R1's waist and assisted R1 to stand with a walker and as R1 stood up she tipped over to the left and fell on her left arm and hip. Upon interview R1 stated she was tired, and her knees gave out. During a review of R1's facility care plan dated 7/21/22, did not include evidence R1 was receiving home care services or what services were allowed to be provided from the outside agency. During further review R1's medical record lacked a care plan from the agency or progress notes from visits made (services provided) by the agency staff.	F 659	F 689 – Qualified Persons – Comprehensive Care Plans Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction, RRLC does not admit that the deficiencies listed on CMS-2567 form exist nor does RRLC admit to statements, findings, facts or conclusions that are for the basis for all alleged deficiencies. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R1 discharged from facility on August 23, 2022. The DON contacted outside agency (Visiting Angels) on July 26, 2022 and measures were immediately taken to assure that there would be no further ambulation. The DON instructed case manager that the V.A. employees cannot provide hands-on care with mobility (i.e., ambulation, transfers). A copy of the V.A.'s plan of care was obtained on August 11, 2022 and incorporated into resident's medication record. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents or resident representatives that arrange for services with outside agencies	

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F 659	Continued From page 2 During review of R1's medical record, it was revealed R1 had transferred to the hospital related to worsening of back pain since the fall on 7/24/22, to rule out new fracture and evaluate the increased acute pain. R1's hospital emergency room imaging results dated 7/29/22, indicated a computed tomography (CT) scan of the lumbar spine identified R1 had a new acute compression fracture on the L5 vertebral body. During an interview with the director of nursing (DON) on 8/10/22, at 3:33 p.m. the DON stated the facility had not received a care plan from the home care agency and she was unaware of what type of services the agency was being provided to R1. The agency had contracted with the family members to provide additional services for R1. The DON stated the agency staff had access to the agency care plan which the registered nurse (RN) had determined to be R1's needs. The DON stated the agency staff did not have access to the facility care plan, but facility staff are able to provide that information upon request. The DON acknowledged she did not know what services the agency staff provided and added, "I don't know what they can do and can't do, what the scope of practice is." The DON stated since the incident the facility had reached out to the agency and the agency staff was no longer allowed to ambulate R1. In addition, the DON stated the agency was going to provide the care plan and was going to continue with services as this was an arrangement with R1's family. During interview on 8/12/22, at 10:15 a.m. home care agency registered nurse (HCRN)-A nursing supervisor stated according to the information	F 659	(excluding Hospice) have the ability to be affected by this deficient practice. There are no residents in the building that are currently utilizing outside agencies, excluding Hospice agencies. 3. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. Audit was conducted for all residents to see if anyone was utilizing outside agencies. Audits of residents' outside services will be completed by DON or designee weekly X one month and continue ongoing audits as warranted with follow up provided as indicated. Education was provided to interdisciplinary team and management staff on September 1, 2022 If staff see an outside agency (excluding Hospice) providing services to a resident in our facility, they must report to DON and/or Social Services. Policy for facility arranged outside agency usage excluding Hospice agencies was found to be in compliance with the regulation. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of the outside agency audit will be reviewed by the QAPI committee and committee's recommendations for further action will be followed.	

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F 659	Continued From page 3 she had received from the caregiver following the incident, R1 had a transfer belt on around her waist and was using a walker as she wanted to walk. HCRN-A also stated as R1 attempted to stand up with the walker she tipped over to the left and fell. RN stated the agency had a contract with the family, and not the facility. The agency RN stated the homemaker had a care plan from the agency which she used. During a review of the agency care plan dated 7/14/22, directed the homemaker before walking to "Pause before standing" and use "Gait belt" the care plan did not have instructions for ambulating and a line was drawn to the side of "ambulation." During a follow up interview on 8/12/22, at 12:31 p.m. the HCRN-A verified R1's agency care plan did not have ambulation assistance indicated and had a line through the space. HCRN-A stated the line meant "there was nothing to say about it and doesn't refer to patient." HCRN-A added the homecare staff members were not to assist R1 with ambulation. The RN stated the homemaker was supposed to follow the agency care plan and what the nursing home care plan directed. The RN also stated the agency staff were to ask the facility staff, however, there was no way to know if the homemaker had asked the facility staff because she had not completed an investigation or discussed the fall with the homemaker staff member. The facility Quality of Care policy dated 11/28/2016, directed "all clinical services that the resident requires, VOA will either provide the services or provide assistance for arranging appointments, transportation arrangements, and any reasonable required communication needed	F 659		

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F 659	Continued From page 4 for the service. All coordination will be documented in the individual resident's electronic health record..."	F 659		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 26, 2022

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

Re: Event ID: WYKF11

Dear Administrator:

The above facility survey was completed on August 11, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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	29822	A. BUILDING: _____ B. WING _____	C 08/11/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/10/22, through 8/11/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H56263709C (MN85601) however, no licensing order was issued. The following complaint was found to be UNSUBSTANTIATED: H56263954C (MN85772 & 85770). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		