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

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November 15, 2022

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

Re: Reinspection Results
Event ID: MXJV12 and IUZU12

Dear Administrator:

On October 21, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 30, 2022 and September 22, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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Electronically delivered

October 5, 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 26, 2022, we informed you that we may impose enforcement remedies.

On September 22, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On September 22, 2022, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 20, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 20, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 20, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

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

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Rochester Rehabilitation And Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 22, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 11, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 09/22/2022

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 9/20/22 through 9/22/22, 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 was found to be SUBSTANTIATED: H56264676C (MN86783), with a deficiency cited at F684. AND The following complaint was found to be UNSUBSTANTIATED, H56264733C (MN83898), The survey resulted in an Immediate Jeopardy (IJ) at F684 when facility failed to provide adequate nursing assessments in order to determine appropriate interventions/cares when a change of condition was reported. The administrator and director of nursing were notified of the IJ on 9/21/22, 1:06 p.m. The IJ began on 8/14/22, and the immediacy was removed on 9/22/22. The above findings constituted substandard quality of care, and an extended survey was conducted from 9/21/22 to 9/22/22. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/07/2022

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 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and document reviews, the facility failed to assess a change in condition when family member (FM)-A approached facility staff to report increased secretions for 1 of 1 residents (R1). Furthermore, a nurse handed a medication to FM-A to administer to R 1 without a nursing assessment. This resulted in an immediate jeopardy (IJ) when the facility failed to assess change in condition during end of life. R1 died shortly after. The IJ began on 8/14/22 when FM-A reported concerns of R1's increasing secretions to licensed practical nurse (LPN)-A. LPN-A failed to complete an in person assessment of R1's condition, instead, gave FM-A a medication to administer to R1 and left the unit. The facility administrator and director of nursing (DON) were notified of the IJ on 9/21/22 at 1:06 p.m. The IJ was removed on 9/22/22, at 5:30 p.m.. However, noncompliance remained at the lower scope and	F 684	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. Resident R1 is no longer impacted as they are deceased.	10/7/22

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F 684	Continued From page 2 severity level 2: D- meaning isolated, and no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 8/10/22, indicated R1 was receiving hospice services, was able to understand others and could make herself understood. R1 was not assessed to have been depressed, nor had she made any statements indicating she felt life was not worth living or wishing for death. The MDS included R1 was able to participate in her daily cares, but required extensive assistance with mobility and repositioning. The MDS indicated R1 had a diagnosis of life expectancy of less than six months with a primary diagnosis of cardorespiratory conditions. During the look-back assessment period, R1 did not suffer any incidents of shortness of breath. On 8/14/22 a tracking MDS was completed indicating R1 had died at the facility. R1's last Care Plan Review dated 6/8/22, included a focus problem area for terminal illness with diagnosis of hypertension with congestive heart failure and chronic kidney disease stage 3 with less than 6 months terminal prognosis. Diagnoses included alteration in comfort, anticipatory grief, potential for ineffective coping related to diagnosis of Alzheimer's disease with dementia and behaviors. Resident may become very anxious when she is experiencing symptoms as she had a diagnosis of anxiety. She has support of family. Resident has cognitive impairment which may have impact upon her ability to process declines/changes as she	F 684	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents with PRN medications in the facility could be impacted. 3. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. LPN-A was counseled on August 19, 2022 by the Staff Development Coordinator on the following topics: " Administration of PRN medications including assessment and effectiveness. " Medication Administration policy in regards to medications need to be administered by nursing staff unless there is a completed self-administration assessment and order. " Response and interventions for change of condition. " LPN-A was monitored during med pass on August 19, 2022. No concerns were noted. LPN-A was suspended on September 21, 2022 pending investigation. In addition to the previous counseling from the Staff Development Coordinator on August 19, 2022, LPN-A received additional education on change of condition assessment, medication administration, action and interventions for change of condition on September 22, 2022.	

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F 684	Continued From page 3 approaches death." Associated interventions included: "follow comfort measures, advanced directives, provide diversional activity such as soft music, 1:1 visits etc., encourage relaxation techniques, watch for pain/discomfort, provide peaceful/comfortable environment, provide support to family and significant others, notify family/MD/NP of changes in condition." During an interview on 9/20/22, at 10:32 a.m. FM-A stated he had visited R1 each evening, usually between 5 p.m. and 10 p.m. On 8/14/22 FM-A arrived around 5:30 p.m. and did not notice anything out of the ordinary. R1 had her supper tray in her room and was feeding herself and watching television. Shortly after, FM-A noticed R1 was grabbing tissues and trying to clear mucus from her mouth. FM-A said he went to the nurses' station which was next to R1's room and told LPN-A, R1 was having some difficulty with secretions. FM-A stated, LPN-A handed FM-A a pill. FM-A said he returned to R1's room and gave R1 the medication without staff present . After giving R1 the medication, FM-A stated, "things were happening quickly" and R1 complained she was having trouble breathing. She began to look "alarmed and scared". FM-A stated he went to the nurses' station. FM-A walked around but could not see any other staff and returned to R1's room. FM-A stated R1 was having "difficulty catching her breath" and FM-A attempted to apply oxygen which did not seem effective. FM-A stated he looked for the nurse again, and at some point turned the call-light on. FM-A stated R1 had been in distress for 15-20 minutes, and he did not want to leave her alone, but after making at least three attempts to find the nurse, he finally went to another unit where he located LPN-B. FM-A and LPN-B returned to	F 684	All licensed staff was trained on change of condition assessment, medication administration, action and interventions for change of condition by 11:59pm on September 22, 2022. One PRN nurse was unable to be reached due being out of the country, this nurse will be required to receive education/training prior to the start of his next shift. Notification of Changes policy was reviewed and found to be in compliance. Full house audit of residents receiving PRN medications that were given within the past 24 hours through September 22, 2022 was completed and were monitored for actions, interventions and effectiveness pre and post medication administration which were be documented in the resident medical record. After September 22, 2022, five residents who received PRN medications will be audited three times per week for four weeks to determine proper actions, interventions and effectiveness pre and post medication administration. Surveyor was provided the name and address of attending physician for resident found to have received sub-standard quality of care on 9/22/22. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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F 684	Continued From page 4 R1's room to find R1 leaning forward in her recliner, slumped over with some sort of thick liquid, mucous or phlegm coming from her mouth. FM-A recalled asking the staff to call 911. FM-A stated he thought LPN-A came to R1's room. LPN-B said they should lean R1 back in her recliner, but FM-A stated he thought the emergency medical staff (EMS) on the phone had told the LPN's to lay her down in bed and place her on her side. EMS arrived assessed R1 and informed FM-A, R1 did not have a pulse, and was deceased. FM-A recalled R1 had had a similar problem about a month prior. On that evening, the nurse had remained with R1 until R1's condition improved. FM-A also stated medications at the facility had been routinely given by nurses, and he had never before given a medication while R1 was residing at the facility. The MAR indicated R1 received Hyoscyamine Sulfate 0.125 mg to be placed under the tongue every 4 hours as needed for increased secretions. Dose was documented as having been given at 5:50 p.m. on August 14th. The effectiveness of this PRN dose was marked as "unknown." No other doses of Hyoscyamine Sulfate were documented as having been given in August of 2022. According to R1's health record, R1 was assessed on 8/14/22 at 8:40 a.m. as having an oxygen saturation of 98% , at 11:39 a.m., R1's temperature was recorded as 96.4 F; pulse 77 beats per minute. R1's medical provider's recertification note dated 7/21/22, read a hospice nurse practitioner (NP)-A	F 684	The results of the audits conducted prior to 9/30 emergency QAPI were reviewed by the QAPI committee. Results of continuing audits will be reviewed by the QAPI committee and the committee□s recommendation for further action including but not limited to reeducation and/or future monitoring will be followed.	

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F 684	Continued From page 5 indicated R1 had initially been admitted to hospice services on 8/10/21 with a primary terminal diagnosis of major neurocognitive disorder, among other physical co-morbidities. NP-A wrote that a diagnosis of heart failure had worsened and superseded the neurocognitive disorder as R1's primary diagnosis for hospice certification. NP-A's note indicated R1 suffered dyspnea with any exertion, and she was chairbound, spending the majority of her day in her recliner. R1 exhibited wheezing in her lungs during the provider's assessment and had increasing edema of her lower limbs which was reported as difficult to manage with medications due to her low blood pressures. NP-A noted a history of swallowing problems but had not had any recent pneumonia related to that problem. R1 was described as lethargic, but easily aroused with normal attention and mood. R1's progress note dated 8/15/22, at 12:35 a.m. LPN-A wrote, "Resident passed away at 1830 [6:30 p.m.] tonight. She had gone to breakfast and to lunch out in dining room earlier. Ate in her room for supper with her [FM-A]. At 1745 [5:30 p.m.] [FM-A] told me he thought she needed some Hyoscyamine for increased secretion's which I gave to him, said he would give it to her himself. At 1815 [6:30 p.m] while I was out on a break, I was brought back in and informed she was having a hard time breathing. Her secretion's had increased with labored breathing and she had become less responsive. We tried to upright her to make her breathing easier. [FM-A] had requested an ambulance, so went to give them directions to the facility and to her room on the phone. Went back into room and laid her on her side in bed per suggestion from the EMT tech on phone. She had grown very pale by this time.	F 684		

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	245626	A. BUILDING _____ B. WING _____	C 09/22/2022

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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 684	Continued From page 6 EMT arrived then, 1825? [6:25p.m.] and took over evaluation. They said there was no pulse at this time, 1830 [6:30 p.m.]. Hospice was called, DON and ED informed. Many family arrived and then she was taken to Rochester Cremation Society facility around 2000 [8:00 p.m.]. No papers were requested or signed at this time." During an interview on 9/20/22, at 11:51 a.m. LPN-A stated he recalled FM-A was visiting R1 on 8/14/22 as the evening meal was being served. LPN-A stated FM-A often visited during the evenings. On that evening, LPN-A remembered FM-A reporting R1 was having increased secretions, and recalled he had gone to the medication cart and retrieved a dose of Hyoscyamine Sulfate, handed it to FM-A and instructed him to place it under R1's tongue. LPN-A also recalled discussing some cookies FM-A wanted to give to R1. LPN-A stated he did not go to R1's room to do a nursing assessment of her condition, and was unable to describe her appearance. LPN-A stated he had learned in his nurse's training that when a person had excess oral or respiratory secretions it was important to reposition them, and make sure their airway was open. LPN-A stated he had not gone in to see R1 because "FM-A did not express any crisis", and because FM-A thought she was stable enough to eat cookies. LPN-A stated he knew it was not standard practice for families to give medication, but stated FM-A had agreed to it and "everything seemed okay at that time." LPN-A stated before giving a PRN medication, a nurse "generally" would "check the resident to see what the situation was", but he had not done so because, "[FM-A] was there every day taking care of her and he knew how she would respond. He would take her to the bathroom and everything." LPN-A	F 684		

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F 684	Continued From page 7 stated he had gone on his break after giving FM-A the medication to administer to R1. LPN-A recalled staff coming to find him in the break area, telling him R1 was having trouble breathing. LPN-A stated he had returned to the unit, obtained a vital sign (VS) machine and went to R1's room. LPN-A was unable to obtain VS using the machine and stated he did not have a stethoscope to listen to her heart or lungs and did not take a manual pulse. LPN-A recalled that LPN-B was present and FM-A was trying to wipe mucous from R1's mouth as she was having trouble breathing. LPN-A stated they attempted to reposition R1 in the chair so she could breathe better but were not successful. He then went to talk to emergency response on the phone. When he returned, LPN-A recalled R1 was very pale. LPN-A stated they laid R1 down in bed and opened her airway, but "she was so white." LPN-A stated, 10-15 minutes after he had returned to the room, the emergency response team arrived and declared R1 deceased. During an interview 9/20/22, at 1:35 p.m. hospice registered nurse (RN)-A stated nursing standards are to assess a patient prior to giving any PRN medication. In the case of increasing respiratory secretions, RN-A stated a nurse "should at least put eyes on the patient, monitor their respiratory rate, watch for nonverbal signs of distress and try to determine if this was a new symptom or not. If warranted, do a full respiratory assessment." RN-A stated a facility nurse could call hospice if needed, to discuss the treatment regime as hospice services are supportive of the facility in providing comfort to the resident. RN-A stated R1 had several medications that could be given for respiratory discomfort: Hydromorphone/Dilaudid for dyspnea, pain or shortness of breath or	F 684		

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F 684	Continued From page 8 Hyoscyamine Sulfate which can help reduce secretions. RN-A stated she had been a professional hospice nurse for approximately ten years, and had observed patients experiencing increased respiratory secretions and shortness of breath. RN-A described the patient may experience "feeling scared, panicked, worried and having a sense of impending doom." During an interview on 9/20/22, at 2:21 p.m. a certified nurse practitioner (NP)-A stated a nurse should follow the facility and hospice protocol when administering medication. NP-A stated a nursing assessment was generally expected when giving a PRN medication unless otherwise written in facility protocol. NP-A stated residents or family could not administer medications in a facility without a provider's written order. During an interview on 9/20/22, at 2:34 p.m. DON stated, when a resident has excess respiratory/oral secretions, a nursing assessment should be done. DON described this as the nurse going to where the resident might be, monitoring respiratory status-the breathing rate and oxygen saturation, determining if anything was abnormal. DON stated a nurse should not have a family member administer medication unless there was an order allowing this. DON stated there was no order for family to give medications to R1. DON stated if R1 required a PRN medication, LPN-A should have done a nursing assessment, but she understood he had not. DON said she had had a conversation with LPN-A after reading a progress note indicating LPN-A had given a medication to FM-A. DON stated she then informed the staff development nurse (SD-RN) of the incident and a need to re-train LPN-A, but did not know if any training had been provided since the incident.	F 684		

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F 684	Continued From page 9 DON stated SD-RN would communicate with her regarding if training is done, but she did not recall such communication. DON did not have any written records of any training being done with LPN-A. During an interview on 9/20/22, at 3:45 p.m. the facility administrator stated nurses needed to follow policy for medication administration, and they should follow the MAR for specific orders. The administrator stated he thought the DON had started an investigation related to the incident with R1 on 8/14/22, but did not know what follow-up had occurred with LPN-A. The administrator stated that was the responsibility of the staff development nurse who was out, but stated an expectation of SD-RN to have kept a record of any education provided. The administrator stated he did not know if the Human Resources department had been involved, but they would keep any records related to employee corrections. During an interview on 9/21/22 at 9:25 a.m. SD-RN handed over two typed documents, one dated 8/18/22 and one dated 8/19/22. Neither document was signed by SD-RN, LPN-A or any other person. SD-RN stated the papers were records she kept regarding educating LPN-A. SD-RN stated the incident with R1 on 8/14/22 was unusual so "I took it upon myself to talk to all the staff members to debrief. I wanted to talk to them to see how they feel and see if we needed hospice to come re-educate. I did set it up, but we haven't had it yet, but will have hospice come educate on what to do at end-stage of life. Also, what to do if family wants to change something or doesn't understand what DNR means." SD-RN said LPN-A told her he was off the floor on break	F 684		

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F 684	Continued From page 10 when the incident occurred, but arrived back from his break when LPN-B went to the unit to call paramedics per FM-A's request. SD-RN stated she understood from her discussion with LPN-A nothing unusual had occurred prior to going on break, and the meal trays had not yet been delivered. SD-RN stated nurses are not allowed to leave the unit after meal trays have been delivered, and they are to stay present until the meal is complete. SD-RN stated she talked with all staff involved in the incident briefly on Monday 8/15/22 or Tuesday 8/16/22 and at some point the DON asked her to review the medication pass policy with LPN-A and watch him do a medication administration pass because he had "given a med to [FM-A] to give to [R1]. She (DON) wanted to ascertain what was going on. At that time I did not know what the medication was, but [LPN-A] came in on Thursday (8/18/22) and I spoke with him." SD-RD stated she and LPN-A had discussed symptom management and whether R1 had been drinking or eating, and how to deal with her symptoms. SD-RD stated an expectation for LPN-A to have assessed R1 before giving a PRN medication, and stated a nurse should know to look at a resident and listen to lungs if there are increased secretions, and said, "I thought, why would you hand it off to [FM]-A?" SD-RD then stated she had reviewed the facility policies related to giving PRN medications with LPN-A, and then said she had watched him pass medications on 8/19/22, and had no concerns. SD-RD stated "going forward, I need to check that [LPN-A] still gets it and his practice pattern is strong." SD-RD stated she had not gone back to determine if LPN-A required further evaluation or information, but planned to do so. During a follow-up interview on 9/21/22, at 11:17	F 684		

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F 684	Continued From page 11 a.m. LPN-A stated on 8/14/22 he was not due to give R1 any routine medications until about 8 p.m., and stated he had not seen her or assessed her prior to returning from his break that evening. LPN-A stated he had not received any nurse to nurse report that R1 was undergoing a change in condition. LPN-A stated he had not gone into the room to do an assessment because he felt R1 was stable because FM-A was going to give her cookies, and because about a month prior, R1 had had a similar incident and had responded to the medication given by the nurse immediately. Following the incident, LPN-A stated he had gone to the facility on Monday or Tuesday to talk with the DON to "clear the air." LPN-A stated he had not received any training after the event, saying, "not yet, but I am expecting that will happen." LPN-A stated he had had a discussion with SD-RN about the night of the incident, but stated SD-RN had not mentioned him giving the medication to the son. LPN-A said, "she may not have been aware of it on Thursday, probably she wasn't or she would have said something." LPN-A stated, "I have been expecting it. Normally they do that. I would expect to do some refresher stuff." LPN-A stated he had not been provided any policies to review, and did not recall SD-RN being on the unit on 8/19/22 when he was passing medications. During a follow up interview on 9/22/22, at 4:41 p.m. the director of nursing stated she did not know why the incident prior to R1's death had not been fully investigated as a vulnerable adult incident, nor why LPN-A had not been removed from the schedule until it was determined that LPN-A understood the facility policies on medication administration, PRN medication administration and nursing assessments or the	F 684		

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F 684	Continued From page 12 facility policy on self-administration of medications or change in condition response. Facility provided a policy last revised 1/1/13 and titled: 6.0 General Dose Preparation and Medication Administration. The policy indicated "facility staff should comply with applicable law and State Operations Manual when administering medications." Procedural steps included: identify the resident, position the resident properly, inform the resident what is to occur, provide any necessary instructions and observe the resident's consumption of the medication." Facility also provided standards of medication administration as given by Pathway Health and Leading Age Minnesota which included the following bullet points: recognition of the problem/need, assessment/diagnosis, medication administration, management, monitoring and documenting. Facility provided a policy dated 5/22/18, titled Self-Administration of Medications, Right to Self-Administer Medications. The policy reviewed the resident right to self-administer medication is assessed to be competent to do so; however, the policy did not include any information about a family member being able to administer medication to the resident. Facility provided several policies regarding resident change of condition; however, all of these policies were in relation to notification of medical providers or family members and did not include nursing actions, such as assessment or interventions to be taken when a change in condition has been reported or identified.	F 684		

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F 684	Continued From page 13 The immediate jeopardy that began on 8/14/22 was removed on 9/22/22, 5:30 p.m. when the facility retrained nursing staff in policies and procedures related to nursing assessment and response to a change of condition, and in medication administration and facility policies related to self-administration of medications. Audits of nursing actions taken in relation to the provision of PRN (as needed) medications were initiated, and retraining of nurses implemented for any break in protocol. Additionally, LPN-A received individualized training and evaluation in medication assessment and nursing assessments as outlined by the facility policies with a plan in place to monitor medication administration for competency.	F 684		

Electronically delivered
October 5, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: IUZU11

Dear Administrator:

The above facility was surveyed on September 20, 2022 through September 22, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 09/22/2022

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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 9/20/22 through 9/22/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT 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: H56264676C (MN86783) with a licensing order issued at ST830. The following complaint was found to be UNSUBSTANTIATED: H56264733C (MN83898), however, a related licensing order was issued at ST830. 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interviews and document reviews, the facility failed to assess a change in condition when family member (FM)-A approached facility staff to report increased secretions for 1 of 1 residents (R1). Furthermore, a nurse handed a medication to FM-A to administer to R 1 without a nursing assessment. This resulted in an	2 830	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	10/7/22

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2 830	Continued From page 3 immediate jeopardy (IJ) when the facility failed to assess change in condition during end of life. R1 died shortly after. The IJ began on 8/14/22 when FM-A reported concerns of R1's increasing secretions to licensed practical nurse (LPN)-A. LPN-A failed to complete an in person assessment of R1's condition, instead, gave FM-A a medication to administer to R1 and left the unit. The facility administrator and director of nursing (DON) were notified of the IJ on 9/21/22 at 1:06 p.m. The IJ was removed on 9/22/22, at 5:30 p.m.. However, noncompliance remained at the lower scope and severity level 2: D- meaning isolated, and no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 8/10/22, indicated R1 was receiving hospice services, was able to understand others and could make herself understood. R1 was not assessed to have been depressed, nor had she made any statements indicating she felt life was not worth living or wishing for death. The MDS included R1 was able to participate in her daily cares, but required extensive assistance with mobility and repositioning. The MDS indicated R1 had a diagnosis of life expectancy of less than six months with a primary diagnosis of cardorespiratory conditions. During the look-back assessment period, R1 did not suffer any incidents of shortness of breath. On 8/14/22 a tracking MDS was completed indicating R1 had died at the facility. R1's last Care Plan Review dated 6/8/22,	2 830	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. Resident R1 is no longer impacted as they are deceased. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents with PRN medications in the facility could be impacted. 3. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. LPN-A was counseled on August 19, 2022 by the Staff Development Coordinator on the following topics: " Administration of PRN medications including assessment and effectiveness. " Medication Administration policy in regards to medications need to be administered by nursing staff unless there is a completed self-administration assessment and order. " Response and interventions for change of condition. " LPN-A was monitored during med pass on August 19, 2022. No concerns	

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2 830	Continued From page 4 included a focus problem area for terminal illness with diagnosis of hypertension with congestive heart failure and chronic kidney disease stage 3 with less than 6 months terminal prognosis. Diagnoses included alteration in comfort, anticipatory grief, potential for ineffective coping related to diagnosis of Alzheimer's disease with dementia and behaviors. Resident may become very anxious when she is experiencing symptoms as she had a diagnosis of anxiety. She has support of family. Resident has cognitive impairment which may have impact upon her ability to process declines/changes as she approaches death." Associated interventions included: "follow comfort measures, advanced directives, provide diversional activity such as soft music, 1:1 visits etc., encourage relaxation techniques, watch for pain/discomfort, provide peaceful/comfortable environment, provide support to family and significant others, notify family/MD/NP of changes in condition." During an interview on 9/20/22, at 10:32 a.m. FM-A stated he had visited R1 each evening, usually between 5 p.m. and 10 p.m. On 8/14/22 FM-A arrived around 5:30 p.m. and did not notice anything out of the ordinary. R1 had her supper tray in her room and was feeding herself and watching television. Shortly after, FM-A noticed R1 was grabbing tissues and trying to clear mucus from her mouth. FM-A said he went to the nurses' station which was next to R1's room and told LPN-A, R1 was having some difficulty with secretions. FM-A stated, LPN-A handed FM-A a pill. FM-A said he returned to R1's room and gave R1 the medication without staff present . After giving R1 the medication, FM-A stated, "things were happening quickly" and R1 complained she was having trouble breathing. She began to look "alarmed and scared". FM-A	2 830	were noted. LPN-A was suspended on September 21, 2022 pending investigation. In addition to the previous counseling from the Staff Development Coordinator on August 19, 2022, LPN-A received additional education on change of condition assessment, medication administration, action and interventions for change of condition on September 22, 2022. All licensed staff was trained on change of condition assessment, medication administration, action and interventions for change of condition by 11:59pm on September 22, 2022. One PRN nurse was unable to be reached due being out of the country, this nurse will be required to receive education/training prior to the start of his next shift. Notification of Changes policy was reviewed and found to be in compliance. Full house audit of residents receiving PRN medications that were given within the past 24 hours through September 22, 2022 was completed and were monitored for actions, interventions and effectiveness pre and post medication administration which were be documented in the resident medical record. After September 22, 2022, five residents who received PRN medications will be audited three times per week for four weeks to determine proper actions, interventions and effectiveness pre and	

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2 830	Continued From page 5 stated he went to the nurses' station. FM-A walked around but could not see any other staff and returned to R1's room. FM-A stated R1 was having "difficulty catching her breath" and FM-A attempted to apply oxygen which did not seem effective. FM-A stated he looked for the nurse again, and at some point turned the call-light on. FM-A stated R1 had been in distress for 15-20 minutes, and he did not want to leave her alone, but after making at least three attempts to find the nurse, he finally went to another unit where he located LPN-B. FM-A and LPN-B returned to R1's room to find R1 leaning forward in her recliner, slumped over with some sort of thick liquid, mucous or phlegm coming from her mouth. FM-A recalled asking the staff to call 911. FM-A stated he thought LPN-A came to R1's room. LPN-B said they should lean R1 back in her recliner, but FM-A stated he thought the emergency medical staff (EMS) on the phone had told the LPN's to lay her down in bed and place her on her side. EMS arrived assessed R1 and informed FM-A, R1 did not have a pulse, and was deceased. FM-A recalled R1 had had a similar problem about a month prior. On that evening, the nurse had remained with R1 until R1's condition improved. FM-A also stated medications at the facility had been routinely given by nurses, and he had never before given a medication while R1 was residing at the facility. The MAR indicated R1 received Hyoscyamine Sulfate 0.125 mg to be placed under the tongue every 4 hours as needed for increased secretions. Dose was documented as having been given at 5:50 p.m. on August 14th. The effectiveness of this PRN dose was marked as "unknown." No other doses of Hyoscyamine	2 830	post medication administration. Surveyor was provided the name and address of attending physician for resident found to have received sub-standard quality of care on 9/22/22. 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 audits conducted prior to 9/30 emergency QAPI were reviewed by the QAPI committee. Results of continuing audits will be reviewed by the QAPI committee and the committee□s recommendation for further action including but not limited to reeducation and/or future monitoring will be followed.	

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2 830	Continued From page 6 Sulfate were documented as having been given in August of 2022. According to R1's health record, R1 was assessed on 8/14/22 at 8:40 a.m. as having an oxygen saturation of 98% , at 11:39 a.m., R1's temperature was recorded as 96.4 F; pulse 77 beats per minute. R1's medical provider's recertification note dated 7/21/22, read a hospice nurse practitioner (NP)-A indicated R1 had initially been admitted to hospice services on 8/10/21 with a primary terminal diagnosis of major neurocognitive disorder, among other physical co-morbidities. NP-A wrote that a diagnosis of heart failure had worsened and superseded the neurocognitive disorder as R1's primary diagnosis for hospice certification. NP-A's note indicated R1 suffered dyspnea with any exertion, and she was chairbound, spending the majority of her day in her recliner. R1 exhibited wheezing in her lungs during the provider's assessment and had increasing edema of her lower limbs which was reported as difficult to manage with medications due to her low blood pressures. NP-A noted a history of swallowing problems but had not had any recent pneumonia related to that problem. R1 was described as lethargic, but easily aroused with normal attention and mood. R1's progress note dated 8/15/22, at 12:35 a.m. LPN-A wrote, "Resident passed away at 1830 [6:30 p.m.] tonight. She had gone to breakfast and to lunch out in dining room earlier. Ate in her room for supper with her [FM-A]. At 1745 [5:30 p.m.] [FM-A] told me he thought she needed some Hyoscyamine for increased secretion's which I gave to him, said he would give it to her himself. At 1815 [6:30 p.m] while I was out on a	2 830		

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2 830	Continued From page 7 break, I was brought back in and informed she was having a hard time breathing. Her secretion's had increased with labored breathing and she had become less responsive. We tried to upright her to make her breathing easier. [FM-A] had requested an ambulance, so went to give them directions to the facility and to her room on the phone. Went back into room and laid her on her side in bed per suggestion from the EMT tech on phone. She had grown very pale by this time. EMT arrived then, 1825? [6:25p.m.] and took over evaluation. They said there was no pulse at this time, 1830 [6:30 p.m.]. Hospice was called, DON and ED informed. Many family arrived and then she was taken to Rochester Cremation Society facility around 2000 [8:00 p.m.]. No papers were requested or signed at this time." During an interview on 9/20/22, at 11:51 a.m. LPN-A stated he recalled FM-A was visiting R1 on 8/14/22 as the evening meal was being served. LPN-A stated FM-A often visited during the evenings. On that evening, LPN-A remembered FM-A reporting R1 was having increased secretions, and recalled he had gone to the medication cart and retrieved a dose of Hyoscyamine Sulfate, handed it to FM-A and instructed him to place it under R1's tongue. LPN-A also recalled discussing some cookies FM-A wanted to give to R1. LPN-A stated he did not go to R1's room to do a nursing assessment of her condition, and was unable to describe her appearance. LPN-A stated he had learned in his nurse's training that when a person had excess oral or respiratory secretions it was important to reposition them, and make sure their airway was open. LPN-A stated he had not gone in to see R1 because "FM-A did not express any crisis", and because FM-A thought she was stable enough to eat cookies. LPN-A stated he knew it was not	2 830		

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2 830	Continued From page 8 standard practice for families to give medication, but stated FM-A had agreed to it and "everything seemed okay at that time." LPN-A stated before giving a PRN medication, a nurse "generally" would "check the resident to see what the situation was", but he had not done so because, "[FM-A] was there every day taking care of her and he knew how she would respond. He would take her to the bathroom and everything." LPN-A stated he had gone on his break after giving FM-A the medication to administer to R1. LPN-A recalled staff coming to find him in the break area, telling him R1 was having trouble breathing. LPN-A stated he had returned to the unit, obtained a vital sign (VS) machine and went to R1's room. LPN-A was unable to obtain VS using the machine and stated he did not have a stethoscope to listen to her heart or lungs and did not take a manual pulse. LPN-A recalled that LPN-B was present and FM-A was trying to wipe mucous from R1's mouth as she was having trouble breathing. LPN-A stated they attempted to reposition R1 in the chair so she could breathe better but were not successful. He then went to talk to emergency response on the phone. When he returned, LPN-A recalled R1 was very pale. LPN-A stated they laid R1 down in bed and opened her airway, but "she was so white." LPN-A stated, 10-15 minutes after he had returned to the room, the emergency response team arrived and declared R1 deceased. During an interview 9/20/22, at 1:35 p.m. hospice registered nurse (RN)-A stated nursing standards are to assess a patient prior to giving any PRN medication. In the case of increasing respiratory secretions, RN-A stated a nurse "should at least put eyes on the patient, monitor their respiratory rate, watch for nonverbal signs of distress and try to determine if this was a new symptom or not. If	2 830		

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2 830	Continued From page 9 warranted, do a full respiratory assessment." RN-A stated a facility nurse could call hospice if needed, to discuss the treatment regime as hospice services are supportive of the facility in providing comfort to the resident. RN-A stated R1 had several medications that could be given for respiratory discomfort: Hydromorphone/Dilaudid for dyspnea, pain or shortness of breath or Hyoscyamine Sulfate which can help reduce secretions. RN-A stated she had been a professional hospice nurse for approximately ten years, and had observed patients experiencing increased respiratory secretions and shortness of breath. RN-A described the patient may experience "feeling scared, panicked, worried and having a sense of impending doom." During an interview on 9/20/22, at 2:21 p.m. a certified nurse practitioner (NP)-A stated a nurse should follow the facility and hospice protocol when administering medication. NP-A stated a nursing assessment was generally expected when giving a PRN medication unless otherwise written in facility protocol. NP-A stated residents or family could not administer medications in a facility without a provider's written order. During an interview on 9/20/22, at 2:34 p.m. DON stated, when a resident has excess respiratory/oral secretions, a nursing assessment should be done. DON described this as the nurse going to where the resident might be, monitoring respiratory status-the breathing rate and oxygen saturation, determining if anything was abnormal. DON stated a nurse should not have a family member administer medication unless there was an order allowing this. DON stated there was no order for family to give medications to R1. DON stated if R1 required a PRN medication, LPN-A should have done a nursing assessment, but she	2 830		

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2 830	Continued From page 10 understood he had not. DON said she had had a conversation with LPN-A after reading a progress note indicating LPN-A had given a medication to FM-A. DON stated she then informed the staff development nurse (SD-RN) of the incident and a need to re-train LPN-A, but did not know if any training had been provided since the incident. DON stated SD-RN would communicate with her regarding if training is done, but she did not recall such communication. DON did not have any written records of any training being done with LPN-A. During an interview on 9/20/22, at 3:45 p.m. the facility administrator stated nurses needed to follow policy for medication administration, and they should follow the MAR for specific orders. The administrator stated he thought the DON had started an investigation related to the incident with R1 on 8/14/22, but did not know what follow-up had occurred with LPN-A. The administrator stated that was the responsibility of the staff development nurse who was out, but stated an expectation of SD-RN to have kept a record of any education provided. The administrator stated he did not know if the Human Resources department had been involved, but they would keep any records related to employee corrections. During an interview on 9/21/22 at 9:25 a.m. SD-RN handed over two typed documents, one dated 8/18/22 and one dated 8/19/22. Neither document was signed by SD-RN, LPN-A or any other person. SD-RN stated the papers were records she kept regarding educating LPN-A. SD-RN stated the incident with R1 on 8/14/22 was unusual so "I took it upon myself to talk to all the staff members to debrief. I wanted to talk to them to see how they feel and see if we needed	2 830		

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2 830	Continued From page 11 hospice to come re-educate. I did set it up, but we haven't had it yet, but will have hospice come educate on what to do at end-stage of life. Also, what to do if family wants to change something or doesn't understand what DNR means." SD-RN said LPN-A told her he was off the floor on break when the incident occurred, but arrived back from his break when LPN-B went to the unit to call paramedics per FM-A's request. SD-RN stated she understood from her discussion with LPN-A nothing unusual had occurred prior to going on break, and the meal trays had not yet been delivered. SD-RN stated nurses are not allowed to leave the unit after meal trays have been delivered, and they are to stay present until the meal is complete. SD-RN stated she talked with all staff involved in the incident briefly on Monday 8/15/22 or Tuesday 8/16/22 and at some point the DON asked her to review the medication pass policy with LPN-A and watch him do a medication administration pass because he had "given a med to [FM-A] to give to [R1]. She (DON) wanted to ascertain what was going on. At that time I did not know what the medication was, but [LPN-A] came in on Thursday (8/18/22) and I spoke with him." SD-RD stated she and LPN-A had discussed symptom management and whether R1 had been drinking or eating, and how to deal with her symptoms. SD-RD stated an expectation for LPN-A to have assessed R1 before giving a PRN medication, and stated a nurse should know to look at a resident and listen to lungs if there are increased secretions, and said, "I thought, why would you hand it off to [FM]-A?" SD-RD then stated she had reviewed the facility policies related to giving PRN medications with LPN-A, and then said she had watched him pass medications on 8/19/22, and had no concerns. SD-RD stated "going forward, I need to check that [LPN-A] still gets it and his practice pattern is	2 830		

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2 830	Continued From page 12 strong." SD-RD stated she had not gone back to determine if LPN-A required further evaluation or information, but planned to do so. During a follow-up interview on 9/21/22, at 11:17 a.m. LPN-A stated on 8/14/22 he was not due to give R1 any routine medications until about 8 p.m., and stated he had not seen her or assessed her prior to returning from his break that evening. LPN-A stated he had not received any nurse to nurse report that R1 was undergoing a change in condition. LPN-A stated he had not gone into the room to do an assessment because he felt R1 was stable because FM-A was going to give her cookies, and because about a month prior, R1 had had a similar incident and had responded to the medication given by the nurse immediately. Following the incident, LPN-A stated he had gone to the facility on Monday or Tuesday to talk with the DON to "clear the air." LPN-A stated he had not received any training after the event, saying, "not yet, but I am expecting that will happen." LPN-A stated he had had a discussion with SD-RN about the night of the incident, but stated SD-RN had not mentioned him giving the medication to the son. LPN-A said, "she may not have been aware of it on Thursday, probably she wasn't or she would have said something." LPN-A stated, "I have been expecting it. Normally they do that. I would expect to do some refresher stuff." LPN-A stated he had not been provided any policies to review, and did not recall SD-RN being on the unit on 8/19/22 when he was passing medications. During a follow up interview on 9/22/22, at 4:41 p.m. the director of nursing stated she did not know why the incident prior to R1's death had not been fully investigated as a vulnerable adult incident, nor why LPN-A had not been removed	2 830		

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2 830	Continued From page 13 from the schedule until it was determined that LPN-A understood the facility policies on medication administration, PRN medication administration and nursing assessments or the facility policy on self-administration of medications or change in condition response. Facility provided a policy last revised 1/1/13 and titled: 6.0 General Dose Preparation and Medication Administration. The policy indicated "facility staff should comply with applicable law and State Operations Manual when administering medications." Procedural steps included: identify the resident, position the resident properly, inform the resident what is to occur, provide any necessary instructions and observe the resident's consumption of the medication." Facility also provided standards of medication administration as given by Pathway Health and Leading Age Minnesota which included the following bullet points: recognition of the problem/need, assessment/diagnosis, medication administration, management, monitoring and documenting. Facility provided a policy dated 5/22/18, titled Self-Administration of Medications, Right to Self-Administer Medications. The policy reviewed the resident right to self-administer medication is assessed to be competent to do so; however, the policy did not include any information about a family member being able to administer medication to the resident. Facility provided several policies regarding resident change of condition; however, all of these policies were in relation to notification of medical providers or family members and did not include nursing actions, such as assessment or	2 830		

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2 830	Continued From page 14 interventions to be taken when a change in condition has been reported or identified. The immediate jeopardy that began on 8/14/22 was removed on 9/22/22, 5:30 p.m. when the facility retrained nursing staff in policies and procedures related to nursing assessment and response to a change of condition, and in medication administration and facility policies related to self-administration of medications. Audits of nursing actions taken in relation to the provision of PRN (as needed) medications were initiated, and retraining of nurses implemented for any break in protocol. Additionally, LPN-A received individualized training and evaluation in medication assessment and nursing assessments as outlined by the facility policies with a plan in place to monitor medication administration for competency. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could provide training to all nursing staff on the importance of resident assessment in conjunction with a change in condition and/or request for a PRN (as needed medication). DON or designee could also review facility policies related to residents and/or families self-administering medications. The facility could audit PRN medication administrations to ensure only the appropriate persons are administering medications, and associated nursing assessments have been done to ensure the resident's condition can be monitored and appropriate care provided. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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