Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 31, 2025

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

RE: CCN: 245626
Cycle Start Date: April 22, 2025

Dear Administrator:

On May 14, 2025, we notified you a remedy was imposed.

On September 25, 2025, the Minnesota Departments of Health and Public Safety 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 September 18, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 29, 2025, be discontinued as of September 18, 2025. (42 CFR 488.417 (b))

In our letter of May 14, 2025, 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 April 22, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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October 31, 2025

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

Re: Reinspection Results
Event ID: VNVR-H2

Dear Administrator:

On August 28, 2025, 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 June 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 29, 2025

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

RE: CCN: 245626
Cycle Start Date: April 22, 2025

Dear Administrator:

On May 14, 2025, we informed you of imposed enforcement remedies.

On June 25, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 29, 2025.

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

On June 17, 2025, the Minnesota Department(s) of Health and Public Safety completed a survey, and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

At the time of this survey, we identified the following deficiencies:

- F0684 -- S/S: G -- Quality of Care
- F0867 – S/S: F -- QAPI/QAA Improvement Activities

This Department continues to recommend that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 29, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 29, 2025.

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.

As we notified you in our letter of May 14, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 22, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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, Regional Operations Supervisor Rochester
District Office
Health Regulation Division

Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 October 22, 2025 (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 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.

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 202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity

assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 29, 2025

Administrator
Rochester Rehabilitation and Living Center
1900 BALLINGTON BOULEVARD NW
ROCHESTER, MN 55901

Re: Event ID: VNVR11

Dear Administrator:

The above facility survey was completed on June 27, 2025, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 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
F0000	INITIAL COMMENTS On 6/24/25, 6/25/25, 6/26/25, and 6/27/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H56267788C (MN00114069) and H56267988C (MN00113174) with a deficiency cited at F684 and F867. 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.	F0000		
F0684 SS = G	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 observation, interview, and document review the facility failed to ensure timely identification, evaluation, and treatment of a worsening skin infection for 1 of 3 residents (R1) reviewed for quality of care.	F0684		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

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F0684 SS = G	Continued from page 1 This resulted in actual harm for R1 who developed a worsening infection in the wound in which necessary treatment and care were delayed. In addition, the facility failed to complete comprehensive skin assessments for non-pressure skin impairments (surgical wounds) for 3 of 3 residents (R1, R4, R5) reviewed for non-pressure (surgical incisions) skin impairments. Findings include: R1's face sheet dated 6/27/25, identified diagnoses of cellulitis (a potentially serious bacterial skin infection) of left lower limb, absence of left leg below the knee, heart failure (a condition where the heart does not pump as well as it should), and diabetes mellitus (a disease that results in too much sugar in the blood). R1's hospital after visit summary (AVS) dated 5/9/25, identified R1 had been hospitalized for a infection in left foot and had a surgical wash out and I &D (incision and drainage) where they found 5.4 millimeters (mm) of glass found in her foot along with purulent drainage (composed of pus, a thick yellowish or greenish fluid associated with infection). R1 had a magnetic resonance imaging (MRI) with no signs of osteomyelitis (bone infection). R1 had been discharged to the skilled nursing facility on oral antibiotics. R1's admission Minimum Data Set (MDS) dated 5/15/25, identified R1 had a surgical wound of the foot, needed maximum assistance for transfers and cognitively intact. Despite the hospital discharge summary and the admission MDS identifying the presence of a surgical wound R1's record did not include an admission skin assessment. R1's focus care plan dated 5/9/25, identified R1 had an alteration in skin integrity related to surgical incision on left foot. Interventions included: observe my site daily for signs of infection or poor healing (drainage, odor, redness, warmth at incision line and notify physician of any signs of infection. R1's physician orders for left foot incision were as follows: -5/11/25-6/9/25: Keep surgical incision clean and dry every shift. -5/12/25-5/15/25: two times a day removing packing strips x 2, cleanse foot wounds top and bottom of foot	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

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F0684 SS = G	Continued from page 2 with Vashe, pack plantar and dorsal foot wound with ¼ inch iodoform packing, cover with 4 x 4's, loosely wrapping with kerlix. -5/12/25-6/9/25: apply betadine (iodine) to incision three times per week. Review of R1's record from 5/9/25 to 5/21/25 it was not evident comprehensive wound assessments were completed and no indication consistent routine monitoring for changes was completed between 5/9/25 through 5/31/25. R1's orthopedic follow up note dated 5/15/25, identified R1 did not need additional iodoform packing required of foot wound and recommended twice dry dressing with gauze and betadine swabs on Monday, Wednesday, and Friday. R1's wound would need an expedited (quickly) workup including emergency department (ED) if systemic changes including fever/night sweats, worsening drainage, spreading erythema (redness) or foul odor from the foot. Review of R1's medical record identified the order for the dressing changed was transcribed into the record, however, revealed no evidence that the directive—to transfer R3 to the emergency department upon signs of systemic symptoms—had been documented or acknowledged. R1's nurse practitioner (NP) visit note dated 5/19/25, identified R1 expressed concern that her wound care was not being completed accurately and was tearful about this. The incorrect dressing was in place with iodosorb packing present on the top of the foot and xeroform placed over the incision to the top and bottom of the foot (instead of using betadine swab and gauze). NP informed the nurse manager and the director of nursing of the incorrect dressing. R1's Wound Evaluation assessment dated 5/22/25, identified R1's surgical wound on the left dorsum foot measuring 7.29 centimeters (cm) x 0.57 cm with no depth. Wound had 70% epithelial tissue (regenerating tissue), 20% slough (dead tissue), and 10% eschar (dead tissue that forms in a wound). Has light serosanguinous (fluid that contains liquid with blood) drainage. Review of R1's corresponding picture dated 5/22/25, identified nine sutures on the top of the foot with sutures not approximated (edges together). Wound base had a yellow substance at the top and bottom of the wound and a dark red area in the middle. The 3rd and 4th toe had a reddish scab like between the toes. R1's foot had swelling on the top of the foot and in the toes. Noted dark brownish skin on the left side of the	F0684		

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Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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F0684 SS = G	Continued from page 3 wound without redness. R1's wound nurse note dated 5/22/25, identified R1 was evaluated for a wound consult for a left foot surgical incision. R1 reported recent infection and subsequent surgery on her left foot. R1 was not having pain but having itching on the central part of the incision. No signs of infection and to follow up with surgeon. To follow up on weekly wound rounds. R1's clinic internal medicine note dated 5/27/25, identified that communication had been received from the facility on 5/24/25 regarding left wound had increase in drainage, no odor but white slough in stitches. Wound cleansed per order and wrapped. Physician assistant said to follow up with in facility provider on 5/28/25. Review of R1's progress notes on 5/24/25 to 5/27/25 did not identify an expedited workup including sending R1 to the ED for increased drainage had been completed per the physician orders from 5/12/25. R1's NP nursing home visit note dated 5/28/25, identified a large piece of callused skin naturally removing from the healthy skin on the bottom of the left foot had begun to pull on the sutures on the bottom of the left foot and had become uncomfortable for R1. NP removed a small amount of devitalized material with surgical scissors. No obvious signs of infection observed. End of last week nursing noted a small amount of drainage on the gauze and over the weekend they noticed slough at the distal (situated away from the center of the body) portion of the sutures on the top of the foot. Will review with orthopedics. Review of R1's record did not identify orthopedics had been notified of the findings. R1's Wound Evaluation dated 5/29/25, identified a surgical wound on the left dorsum foot measuring 7.11 centimeters (cm) x 0.65 cm with no depth. Wound had 50 % epithelial tissue, 10% granulation (pink or red, bumpy, and moist tissue that fills in the wound bed), 20 % slough (dead tissue), and 10% eschar. Has light serosanguinous drainage. Review of the corresponding image dated 5/29/25, identified nine sutures on the top of the foot with incisional line not approximated (edges together) with open areas between the width of the sutures (consistent with dehiscence). Wound base had a yellow substance (consistent with slough) in the entire wound bed. Between the 3rd and 4th toe had an opening with a yellow substance in the base of he wound between the toes. Skin was dry and flaky on the entire foot with	F0684		

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F0684 SS = G	Continued from page 4 swelling on foot. Skin above the sutures near the ankle were dark purple in color and a brownish scab noted on the lateral side of the sutures. [AO1] R1's wound nurse note dated 5/29/25, identified R1 was seen for a wound follow up of left foot. R1 denied pain or concerns with her foot. R1 did complain of itching of foot and stated she was tender in the toe, with a lot of dry and peeling skin. Wound appeared slightly improved today. Wound plan was the following: -twice daily dressing changes. Apply gauze top and bottom of foot over incision. Wrap with Kerlix and secure with tape. Betadine swabs to surgical wound top and bottom of foot Monday/Wednesday/and Friday. -follow up with surgeon -suture removal by surgeon -recommend applying lotion to dry skin daily. R1's progress note dated 5/31/25, identified R1 was sent to the emergency department (ED) for evaluation of suspected infected surgical site of left lower extremity. R1 had swelling and purulent drainage from the surgical incision. R1's hospital admission note dated 5/31/25, identified R1 admitted to the hospital after being seen in the ED for evaluation and treatment of a recurrent left foot infection with progressive drainage, pain, and dehiscence (splitting or bursting open) over the past several days. Computed tomography (CT) scan showed increased gas and fluid collection along the dorsum (top) of the left foot now extending into more laterally and further into the 3rd and 4th toe metatarsophalangeal (joints located in the forefoot) joints. R1 stated her foot became more erythemic (reddened), more swollen, and had some dehiscence after stopping antibiotics a week ago. R1's hospital orthopedic trauma surgery consult note dated 5/31/25, identified R1 was seen in the emergency department (ED) with an apparent recurrent infection in her left foot. R1foot wound showed dehiscence of the distal incision as well as spreading erythema and purulent drainage. R1 reported in the ED that the incision started looking worse over the past few days with increasing drainage. R1's hospital discharge summary dated 6/9/25, identified R1 was hospitalized for ongoing treatment of an recurrent left foot infection. R1 was given	F0684		

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Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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F0684 SS = G	Continued from page 5 intravenous (IV) antibiotics and had an (MRI) of the left foot which revealed a dorsal abscess with osteomyelitis (bone infection) and ultimately had a below the knee amputation of the left leg on 6/4/25. R1 was discharged back to the skilled nursing facility on 6/9/25. During an interview on 6/25/25 at 12:32 p.m., licensed practical nurse (LPN)-A stated when she performed R1's left foot wound care on 5/30/25, R1's foot it looked infected. LPN-A stated she then brought registered nurse (RN)-A to evaluate R1's foot and RN-A told her R1's foot had been seen by the nurse practitioner the day prior and the wound appeared the same. LPN-A did not look at the notes or the image of R1's foot that had been taken the day prior. LPN-A then used the facility phone and took an image of R1's left foot, because she believed R1's foot looked "terrible". LPN-A stated she did not notify the nurse managers, primary physician, or orthopedics of her concern for infection. LPN-A waited until she returned to work the next day and then proceeded to send the image of R1's foot to facility nurse managers and then was instructed by management to send R1 to the ED. LPN-A was not aware of an order for R1 to send her to the ED if the wound had appeared worse and no order was in the electronic health record to her knowledge. During an interview and observation on 6/25/25 at 12:30 p.m., LPN-B explained nurses had an "incident phone" to communicate to management about any concerns during their shifts. LPN-B obtained the incident phone and identified two images were on the phone of R1's foot with a date of 5/30/25 at 1:16pm. The corresponding images of R1's left foot had a surgical incision on the bottom of the foot near the 4th toe with 3 sutures that had dark blackish spot underneath the sutures, under the 4th toe there was a circular shaped area with yellowish material in the center and another area with toes swollen and reddened. 9 sutures on the top of the foot which appeared to be not holding the skin together-inside the wound had a thick yellow-pus like material. The skin surrounding the wound appeared shiny, red, and swollen. In between the 3rd and 4th toe was thick yellowish material. LPN-B further stated the wound appeared like it had "drastic change" from the last time she had seen it and was taken by the nurse due to a concern for infection. During an interview on 6/25/25 at 3:17 p.m., registered nurse (RN)-A stated she observed R1's left foot on 5/30/25 with LPN-A. RN-A explained she thought the foot looked the same, however the night shift had to change R1's dressing due to it being saturated. RN-A did not	F0684		

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F0684 SS = G	Continued from page 6 document her evaluation of R1's wound in her chart or call the physician to update on the increase drainage and was not aware of the recommendation from the orthopedic appointment on 5/15/25 to send R1 to the ED if increase drainage. RN-A stated it would be normal standard of practice for a nurse to communicate to the provider a change in the condition of a surgical wound and would not need to have an order in the chart to give us direction, however, did not think the wound appeared worse when she looked at the wound on 5/30/25. During an interview on 6/27/25, registered nurse (RN)-C observed the wound images of R1's left foot that had been taken on 5/29/25 and 5/30/25. RN-C stated left foot appeared "definitely worse" on 5/30/25. RN-C stated she would have notified the physician right away and sent R1 into the ED for evaluation During an interview on 6/24/25 at 4:06 p.m., R1 stated a nurse had taken a picture of her left foot a few days prior to her being sent to the hospital because she felt her wound looking infected, and by the time she was sent to the ED the infection had went to the bone and needed to have an amputation. The first nurse thought her foot was infected, she brought a second nurse to come and look at her foot and she stated it looked "fine". R1 stated she was so glad the pictures were sent to management, and she was sent to the ED. R1 further stated, the nurse that took them the pictures, "Basically saved my life." During an interview on 6/27/25 at 11:18 a.m., nurse practitioner (NP) reviewed R1's images of her left foot taken on 5/29/25 and again on 5/30/25 and stated the wound appeared to be worse on 5/30/25 and staff should have made provider notification on 5/30/25 and not waited until 5/31/25, however it would have not changed the outcome of her having the amputation due to her diabetes and the extent of infection she had in her foot. During an interview on 6/25/25 at 1:09 p.m., director of nursing (DON) stated the director of nursing at the time on 5/31/25 directed LPN-A to send R1 to the ED after first seeing the photo. In a follow up interview at 6:18 p.m., DON stated if she had been aware of R1's foot looking infected on 5/30/25 she would have had the nurse send her into the ED on that day. DON further stated it is a standard of practice for a nurse to notify the physician if they feel a wound appeared worse to get direction from the provider and confirmed that this was not done until 5/31/25 when she was sent into the ED for evaluation.	F0684		

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F0684 SS = G	Continued from page 7 R4's face sheet dated 6/27/25, identified diagnoses of end stage renal disease, immunodeficiency, diabetes mellitus, and kidney transplant. R4's hospital discharge summary dated 6/2/25, identified R4 had been hospitalized from 5/10/25 to 6/2/25 after having sustained an injury to his right lower extremity after hitting his leg on his scooter. and has a significant right lower extremity hematoma (a localized collection of blood outside of the blood vessels) which needed to be evacuated (a surgical procedure to remove) on 5/11/25. necrotic tissue and fat removed. R4 had subsequent surgical debridement (a medical procedure to remove dead, damaged, or infected tissue from a wound to promote healing) on 5/12, 5/16/25, and 5/22/25. R4 was discharged to the facility on 6/2/25. R4's hospital after visit summary dated 6/2/25, identified R4 had a wound on his right lower extremity and the beefy red tissue to be covered with a saline moistened gauze and then covered with an ABD and then gauze roll to hold dressing in place. R4's nurse practitioner note dated 6/4/25, identified wound orders changed to the following: cleanse with normal saline, pat dry, cover entire area of debridement (fascia and granulation tissue) with double layer xeroform gauze, cover with one to three layers of ABD for absorption, securing with gauze and paper tape. R4's Wound Evaluation dated 6/5/25, identified a surgical wound on front right lower leg that was present on admission. Wound measured 27.65 cm x 7.21 cm, with 60% granulation, and 40% slough. Wound had heavy bloody drainage. Review of R4's record from 6/6/25 to 6/25/25 did not identify any comprehensive weekly wound assessments had been completed. R4's trauma surgery follow-up note dated 6/16/25, identified R4's right lower leg wound had progressed quite well and the facility should continue to monitor the wound for signs of infection, which would include fever, chills, nausea, vomiting, purulent drainage, expanding redness from the wound, or increased or new abdominal pain. The new order was to place xeroform over the exposed fascia (connective tissue) and moist to dry dressings to the remainder of the wound bed twice daily. R4's nurse practitioner note dated 6/18/25, identified right lower leg stable with increase in pain in recent	F0684		

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F0684 SS = G	Continued from page 8 days. R4 described the pain as burning or poking pain. Pain medication added every six hours as needed. Note identified R4 was seen two days prior by general surgery and wanted wound care orders to be adjusted and she will follow up for clarification. During an interview on 6/25/25 at 3:30 p.m., licensed practical nurse (LPN)-B stated R4 did not have consistent weekly wound evaluations done by the wound nurse practitioner due to him being out for dialysis appointments on the days she came to look at the wounds. LPN-B was not aware if another nurse in the facility had been assigned to complete the weekly wound assessments if the wound nurse was not able to see the residents on her rounds. During an observation and interview on 6/25/25 at 5:44 p.m., R4 was lying in bed and registered nurse (RN)-B was performing wound care. R4's right lower had a white gauze dressing in place, the dressing had moderate amount of wet liquid with a no color. When the dressing was removed another dressing was covering the wound, upon removal, it was noted to have moderate amount of clear liquid. R4 denied pain with the dressing removal. The wound was irregular in shape. Noted area of beefy red skin in the wound with clean edges and without discoloration. At the 12 o'clock position there was a white area approximately 4.0 cm in diameter. This area had a yellowish mesh, which RN-B called xeroform. that had been covering the wound. R4 stated his wound is healing slowly due to his immune system being impaired, but it looked better. Wound was measured and 25.0 cm x 11.0 cm per RN-B, and stated the wound looks better than since the last time she had seen it. Review of R4's progress notes on 6/26/25, did not identify any documentation of the wound evaluation completed on 6/25/25. During an interview on 6/26/25 at 12:01 p.m., wound nurse practitioner (WNP) stated R4's wound had not consistently been evaluated each week due to R4 being out of the facility on the days she came to the facility. WNP was unsure whether other staff in the facility had been trained to use the skin and wound application to do the weekly assessment if she missed seeing a resident. WNP further stated the purpose of a weekly wound assessment of a resident's wounds would be to track and to monitor healing and inform the physician if the wound was not healing to possibly change the treatment of the wound. WNP further stated the lack of comprehensive wound assessments being consistently completed could put a resident at risk for a worsening wound.	F0684		

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F0684 SS = G	Continued from page 9 During an interview on 6/26/25 at 3:30 p.m., director of nursing (DON) stated that they utilize a wound nurse to come and do the weekly comprehensive wound assessments and she uses the wound application in the electronic health record (EHR). The DON indicated wound assessments had not been completed consistently because staff nurses were not trained on completing wound assessments in the absence of the contracted wound practitioner. DON stated the weekly comprehensive wound assessments are important to evaluate the healing of a wound and without having them done consistently it could lead to a deterioration in a wound, an infection could be missed and could cause an increased risk of serious complications. R5's face sheet dated 6/27/25, identified diagnoses of joint replacement surgery, obesity (excessive body fat), and chronic kidney disease (damage to the kidneys). R5's hospital discharge summary dated 6/16/25, identified R5 had been hospitalized to perform a left hip arthroplasty (replacement) due to an infection and inflammatory reaction of the left hip prosthesis. R5 was discharged to the skilled nursing facility on 6/16/25. R5's hospital After Visit Summary dated 6/16/25, identified R5 had a wound vac (a medical device used to help wounds heal) and was to be left on for one week after surgery. R5's physician orders identified a wound vac over the incision and was discontinued on 6/18/25. Review of R5's chart from 6/16/25 to 6/25/25 did not identify a comprehensive wound assessment had been completed on the surgical wound. R5's progress note dated 6/25/25, identified surgery team notified of drainage to the distal (situated away from the center of the body) part of the surgical wound and strong odor noticed. R5's record did not identify a wound evaluation was completed on 6/25/25. R5's Skin and Wound Evaluation dated 6/26/25, identified a surgical wound located at the left front trochanter (hip) that was present on admission. Wound measured 37.90 cm x 1.80 cm x 0.1 cm Noted light serosanguinous drainage. Area marked as a new wound. R5's progress note dated 6/26/25, identified surgery team will see R1 on 6/27/25 for labs and in clinic	F0684		

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F0684 SS = G	Continued from page 10 visit to evaluate wound. R5's orthopedic surgery note dated 6/27/25, identified that wound appeared normal for this stage of surgery and continued oral antibiotics for two more weeks. During an interview on 6/26/25 at 5:40 p.m., medical director (MD)-H stated her expectation would be for the facility to document a weekly wound assessment for all wounds to track and monitor healing and allows them to look for changes in the wound and is needed to avoid the risk of the wound becoming worse. Review of the facility's Notification of Changes policy dated 12/16, identified immediate notification of the resident; consult with the resident's physician is to be done in the following situations: -A significant change in the resident's physical, mental, or psychosocial status including a deterioration in the health, mental, cognition, medication change, or psychosocial status in either life-threatening conditions or clinical complications. Review of the facility's Wound Assessment Protocol dated 2/24/25, identified comprehensive wound assessment is necessary during every dressing change. Comparing the assessment results to the previous findings helps monitor, communicate, treat, and document wound healing progression or complications. Documentation associated with wound assessment included: -date and time of the wound assessment. -general appearance of the skin and bony prominences -location, size, and appearance of the wound site -presence or absence of	F0684		
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F0867		

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F0867 SS = F	Continued from page 11 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety	F0867		

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F0867 SS = F	Continued from page 12 problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F0867		

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F0867 SS = F	Continued from page 13 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to wound assessments not being completed by developing and implementing action plans for process improvement. This had the potential to affect all 36 residents that resident in the facility. Findings include: See F684: Based on observation, interview, and document review the facility failed to ensure timely identification, evaluation, and treatment of a worsening skin infection for 1 of 3 residents (R1) reviewed for quality of care. This resulted in actual harm for R1 who developed a worsening infection in the wound that delayed treatment and care. In addition, the facility failed to complete comprehensive skin assessments for non-pressure skin impairments (surgical wounds) for 3 of 3 residents (R1, R4, R5) reviewed for non-pressure (surgical incisions) skin impairments. During the facility resident record review on 6/25/25 for resident sample selection revealed from 5/9/25 to 6/25/25, the facility had three residents that did not have consistent wound evaluation assessments completed on surgical wounds. Review of R1's record from 5/9/25 to 5/21/25 did not identify a comprehensive wound assessment had been completed for a surgical wound on her left foot. Review of R4's record from 6/6/25 to 6/25/25, identified there was a wound assessment completed on 6/5/25, however was not completed again until 6/26/25. Review of R5's record from 6/16/25 to 6/25/25 did not identify a comprehensive wound assessment had been completed on the surgical wound. A copy of the facility's current quality action plans was received on 6/30/25, and did not identify any plan for assessing or monitoring of skin related issues. During an interview on 6/27/25 at 12:19 p.m., director of nursing (DON) stated prior to the beginning of the survey, a few weeks ago (but could specify a date), she	F0867		

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F0867 SS = F	Continued from page 14 had been informed by the certified wound nurse practitioner that wound assessments had not been completed consistently on the residents with current wounds. DON stated she had not brought the practitioner's concerns forward to the quality team nor did she create an action plan to address the issue. DON further stated, the quality team met on 6/26/25 (during the survey) to discuss the concerns with the facility's wound management program and were currently working on a plan to correct. The quality team had been monitoring pressure related skin issues, however, DON indicated non-pressure related skin concerns were not being addressed and would be monitoring those concerns at the next quality meeting. Review of the facility's Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) Committee Policy and Procedure dated 11/21, identified the following: -When improvement or innovation is indicated based on outcomes and/or new information, Performance Improvement Plans (PIP's) will be chartered as needed. -A Root Cause Analysis (RCA) or equivalent process will be completed when needed to define the problem or need. -The QAPI team will define who is on the PIP team which will utilize the Model for Improvement process to determine what change is indicated based on the RCA findings and additional information identified. -The team then proceeds with testing the change, making any necessary changes, and then designing an implementation plan. -Once the plan is completed a sustainability (monitoring) plan is created. The metric or process to monitor this issue will be added to the QAPI Surveillance Data and Reporting Schedule as the feedback loop for on-going monitoring.	F0867		

Minnesota State Department of Health

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20000	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 6/24/25, 6/25/25,6/26/25, and 6/27/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 The following complaints were reviewed: H56267788C (MN00114069) and H56267988C (MN00113174) with a licensing order issued at 0875 and 0255. 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 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 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.	20000		
20255	Quality Assessment and Assurance Committee CFR(s): MN Rule 4658.0070 A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance	20255		

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20255	Continued from page 2 committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to wound assessments not being completed by developing and implementing action plans for process improvement. This had the potential to affect all 36 residents that resident in the facility. Findings include: See F684: Based on observation, interview, and document review the facility failed to ensure timely identification, evaluation, and treatment of a worsening skin infection for 1 of 3 residents (R1) reviewed for quality of care. This resulted in actual harm for R1 who developed a worsening infection in the wound that delayed treatment and care. In addition, the facility failed to complete comprehensive skin assessments for non-pressure skin impairments (surgical wounds) for 3 of 3 residents (R1, R4, R5) reviewed for non-pressure (surgical incisions) skin impairments. During the facility resident record review on 6/25/25 for resident sample selection revealed from 5/9/25 to 6/25/25, the facility had three residents that did not have consistent wound evaluation assessments completed on surgical wounds. Review of R1's record from 5/9/25 to 5/21/25 did not identify a comprehensive wound assessment had been completed for a surgical wound on her left foot. Review of R4's record from 6/6/25 to 6/25/25, identified there was a wound assessment completed on 6/5/25, however was not completed again until 6/26/25. Review of R5's record from 6/16/25 to 6/25/25 did not identify a comprehensive wound assessment had been completed on the surgical wound. A copy of the facility's current quality action plans was received on 6/30/25, and did not identify any plan for assessing or monitoring of skin related issues.	20255		

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20255	Continued from page 3 During an interview on 6/27/25 at 12:19 p.m., director of nursing (DON) stated prior to the beginning of the survey, a few weeks ago (but could specify a date), she had been informed by the certified wound nurse practitioner that wound assessments had not been completed consistently on the residents with current wounds. DON stated she had not brought the practitioner's concerns forward to the quality team nor did she create an action plan to address the issue. DON further stated, the quality team met on 6/26/25 (during the survey) to discuss the concerns with the facility's wound management program and were currently working on a plan to correct. The quality team had been monitoring pressure related skin issues, however, DON indicated non-pressure related skin concerns were not being addressed and would be monitoring those concerns at the next quality meeting. Review of the facility's Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) Committee Policy and Procedure dated 11/21, identified the following: -When improvement or innovation is indicated based on outcomes and/or new information, Performance Improvement Plans (PIP's) will be chartered as needed. -A Root Cause Analysis (RCA) or equivalent process will be completed when needed to define the problem or need. -The QAPI team will define who is on the PIP team which will utilize the Model for Improvement process to determine what change is indicated based on the RCA findings and additional information identified. -The team then proceeds with testing the change, making any necessary changes, and then designing an implementation plan. -Once the plan is completed a sustainability (monitoring) plan is created. The metric or process to monitor this issue will be added to the QAPI Surveillance Data and Reporting Schedule as the feedback loop for on-going monitoring. Suggested method of correction: The DON/designee in collaboration with the quality committee and facility staff could audit resident records at risk for impaired skin integrity to determine extent of quality gaps and complete a causal analysis. Then develop an action plan based on the audits and causal analysis to ensure ongoing compliance. Time period of correction: Twenty-one (21) days.	20255		

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20255 20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 l Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: l. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely identification, evaluation, and treatment of a worsening skin infection for 1 of 3 residents (R1) reviewed for quality of care. This resulted in actual harm for R1 who developed a worsening infection in the wound in which necessary treatment and care were delayed. In addition, the facility failed to complete comprehensive skin assessments for non-pressure skin impairments (surgical wounds) for 3 of 3 residents (R1, R4, R5) reviewed for non-pressure (surgical incisions) skin impairment. Findings include R1’s face sheet dated 6/27/25, identified diagnoses of cellulitis (a potentially serious bacterial skin infection) of left lower limb, absence of left leg below the knee, heart failure (a condition where the heart does not pump as well as it should), and diabetes mellitus (a disease that results in too much sugar in the blood). R1’s hospital after visit summary (AVS) dated 5/9/25, identified R1 had been hospitalized for a infection in left foot and had a surgical wash out and I &D (incision and drainage) where they found 5.4 millimeters (mm) of glass found in her foot along with purulent drainage (composed of pus, a thick yellowish or greenish fluid associated with infection). R1 had a magnetic resonance imaging (MRI) with no signs of osteomyelitis (bone infection). R1 had been discharged to the skilled nursing facility on oral antibiotics. R1’s admission Minimum Data Set (MDS) dated 5/15/25, identified R1 had a surgical wound of the foot, needed maximum assistance for transfers and cognitively intact. Despite the hospital discharge summary and the admission MDS identifying the presence of a surgical	20255 20875		

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20875	Continued from page 5 wound R1's record did not include an admission skin assessment. R1's focus care plan dated 5/9/25, identified R1 had an alteration in skin integrity related to surgical incision on left foot. Interventions included: observe my site daily for signs of infection or poor healing (drainage, odor, redness, warmth at incision line and notify physician of any signs of infection. R1's physician orders for left foot incision were as follows: -5/11/25-6/9/25: Keep surgical incision clean and dry every shift. -5/12/25-5/15/25: two times a day removing packing strips x 2, cleanse foot wounds top and bottom of foot with Vashe, pack plantar and dorsal foot wound with ¼ inch iodoform packing, cover with 4 x 4's, loosely wrapping with kerlix. -5/12/25-6/9/25: apply betadine (iodine) to incision three times per week. Review of R1's record from 5/9/25 to 5/21/25 it was not evident comprehensive wound assessments were completed and no indication consistent routine monitoring for changes was completed between 5/9/25 through 5/31/25. R1's orthopedic follow up note dated 5/15/25, identified R1 did not need additional iodoform packing required of foot wound and recommended twice dry dressing with gauze and betadine swabs on Monday, Wednesday, and Friday. R1's wound would need an expedited (quickly) workup including emergency department (ED) if systemic changes including fever/night sweats, worsening drainage, spreading erythema (redness) or foul odor from the foot. Review of R1's medical record identified the order for the dressing changed was transcribed into the record, however, revealed no evidence that the directive—to transfer R3 to the emergency department upon signs of systemic symptoms—had been documented or acknowledged. R1's nurse practitioner (NP) visit note dated 5/19/25, identified R1 expressed concern that her wound care was not being completed accurately and was tearful about this. The incorrect dressing was in place with iodosorb packing present on the top of the foot and xeroform placed over the incision to the top and bottom of the foot (instead of using betadine swab and gauze). NP informed the nurse manager and the director of nursing	20875		

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20875	Continued from page 6 of the incorrect dressing. R1's Wound Evaluation assessment dated 5/22/25, identified R1's surgical wound on the left dorsum foot measuring 7.29 centimeters (cm) x 0.57 cm with no depth. Wound had 70% epithelial tissue (regenerating tissue), 20% slough (dead tissue), and 10% eschar (dead tissue that forms in a wound). Has light serosanguinous (fluid that contains liquid with blood) drainage. Review of R1's corresponding picture dated 5/22/25, identified nine sutures on the top of the foot with sutures not approximated (edges together). Wound base had a yellow substance at the top and bottom of the wound and a dark red area in the middle. The 3rd and 4th toe had a reddish scab like between the toes. R1's foot had swelling on the top of the foot and in the toes. Noted dark brownish skin on the left side of the wound without redness. R1's wound nurse note dated 5/22/25, identified R1 was evaluated for a wound consult for a left foot surgical incision. R1 reported recent infection and subsequent surgery on her left foot. R1 was not having pain but having itching on the central part of the incision. No signs of infection and to follow up with surgeon. To follow up on weekly wound rounds. R1's clinic internal medicine note dated 5/27/25, identified that communication had been received from the facility on 5/24/25 regarding left wound had increase in drainage, no odor but white slough in stitches. Wound cleansed per order and wrapped. Physician assistant said to follow up with in facility provider on 5/28/25. Review of R1's progress notes on 5/24/25 to 5/27/25 did not identify an expedited workup including sending R1 to the ED for increased drainage had been completed per the physician orders from 5/12/25. R1's NP nursing home visit note dated 5/28/25, identified a large piece of callused skin naturally removing from the healthy skin on the bottom of the left foot had begun to pull on the sutures on the bottom of the left foot and had become uncomfortable for R1. NP removed a small amount of devitalized material with surgical scissors. No obvious signs of infection observed. End of last week nursing noted a small amount of drainage on the gauze and over the weekend they noticed slough at the distal (situated away from the center of the body) portion of the sutures on the top of the foot. Will review with orthopedics. Review of R1's record did not identify orthopedics had been notified of the findings.	20875		

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20875	Continued from page 7 R1's Wound Evaluation dated 5/29/25, identified a surgical wound on the left dorsum foot measuring 7.11 centimeters (cm) x 0.65 cm with no depth. Wound had 50 % epithelial tissue, 10% granulation (pink or red, bumpy, and moist tissue that fills in the wound bed), 20 % slough (dead tissue), and 10% eschar. Has light serosanguinous drainage. Review of the corresponding image dated 5/29/25, identified nine sutures on the top of the foot with incisional line not approximated (edges together) with open areas between the width of the sutures (consistent with dehiscence). Wound base had a yellow substance (consistent with slough) in the entire wound bed. Between the 3rd and 4th toe had an opening with a yellow substance in the base of he wound between the toes. Skin was dry and flaky on the entire foot with swelling on foot. Skin above the sutures near the ankle were dark purple in color and a brownish scab noted on the lateral side of the sutures. [AO1] R1's wound nurse note dated 5/29/25, identified R1 was seen for a wound follow up of left foot. R1 denied pain or concerns with her foot. R1 did complain of itching of foot and stated she was tender in the toe, with a lot of dry and peeling skin. Wound appeared slightly improved today. Wound plan was the following: -twice daily dressing changes. Apply gauze top and bottom of foot over incision. Wrap with Kerlix and secure with tape. Betadine swabs to surgical wound top and bottom of foot Monday/Wednesday/and Friday. -follow up with surgeon -suture removal by surgeon -recommend applying lotion to dry skin daily. R1's progress note dated 5/31/25, identified R1 was sent to the emergency department (ED) for evaluation of suspected infected surgical site of left lower extremity. R1 had swelling and purulent drainage from the surgical incision. R1's hospital admission note dated 5/31/25, identified R1 admitted to the hospital after being seen in the ED for evaluation and treatment of a recurrent left foot infection with progressive drainage, pain, and dehiscence (splitting or bursting open) over the past several days. Computed tomography (CT) scan showed increased gas and fluid collection along the dorsum (top) of the left foot now extending into more	20875		

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20875	Continued from page 8 laterally and further into the 3rd and 4th toe metatarsophalangeal (joints located in the forefoot) joints. R1 stated her foot became more erythemic (reddened), more swollen, and had some dehiscence after stopping antibiotics a week ago. R1's hospital orthopedic trauma surgery consult note dated 5/31/25, identified R1 was seen in the emergency department (ED) with an apparent recurrent infection in her left foot. R1foot wound showed dehiscence of the distal incision as well as spreading erythema and purulent drainage. R1 reported in the ED that the incision started looking worse over the past few days with increasing drainage. R1's hospital discharge summary dated 6/9/25, identified R1 was hospitalized for ongoing treatment of an recurrent left foot infection. R1 was given intravenous (IV) antibiotics and had an (MRI) of the left foot which revealed a dorsal abscess with osteomyelitis (bone infection) and ultimately had a below the knee amputation of the left leg on 6/4/25. R1 was discharged back to the skilled nursing facility on 6/9/25. During an interview on 6/25/25 at 12:32 p.m., licensed practical nurse (LPN)-A stated when she performed R1's left foot wound care on 5/30/25, R1's foot it looked infected. LPN-A stated she then brought registered nurse (RN)-A to evaluate R1's foot and RN-A told her R1's foot had been seen by the nurse practitioner the day prior and the wound appeared the same. LPN-A did not look at the notes or the image of R1's foot that had been taken the day prior. LPN-A then used the facility phone and took an image of R1's left foot, because she believed R1's foot looked "terrible". LPN-A stated she did not notify the nurse managers, primary physician, or orthopedics of her concern for infection. LPN-A waited until she returned to work the next day and then proceeded to send the image of R1's foot to facility nurse managers and then was instructed by management to send R1 to the ED. LPN-A was not aware of an order for R1 to send her to the ED if the wound had appeared worse and no order was in the electronic health record to her knowledge. During an interview and observation on 6/25/25 at 12:30 p.m., LPN-B explained nurses had an "incident phone" to communicate to management about any concerns during their shifts. LPN-B obtained the incident phone and identified two images were on the phone of R1's foot with a date of 5/30/25 at 1:16pm. The corresponding images of R1's left foot had a surgical incision on the bottom of the foot near the 4th toe with 3 sutures that	20875		

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20875	Continued from page 9 had dark blackish spot underneath the sutures, under the 4th toe there was a circular shaped area with yellowish material in the center and another area with toes swollen and reddened. 9 sutures on the top of the foot which appeared to be not holding the skin together-inside the wound had a thick yellow-pus like material. The skin surrounding the wound appeared shiny, red, and swollen. In between the 3rd and 4th toe was thick yellowish material. LPN-B further stated the wound appeared like it had “drastic change” from the last time she had seen it and was taken by the nurse due to a concern for infection. During an interview on 6/25/25 at 3:17 p.m., registered nurse (RN)-A stated she observed R1’s left foot on 5/30/25 with LPN-A. RN-A explained she thought the foot looked the same, however the night shift had to change R1’s dressing due to it being saturated. RN-A did not document her evaluation of R1’s wound in her chart or call the physician to update on the increase drainage and was not aware of the recommendation from the orthopedic appointment on 5/15/25 to send R1 to the ED if increase drainage. RN-A stated it would be normal standard of practice for a nurse to communicate to the provider a change in the condition of a surgical wound and would not need to have an order in the chart to give us direction, however, did not think the wound appeared worse when she looked at the wound on 5/30/25. During an interview on 6/27/25, registered nurse (RN)-C observed the wound images of R1’s left foot that had been taken on 5/29/25 and 5/30/25. RN-C stated left foot appeared “definitely worse” on 5/30/25. RN-C stated she would have notified the physician right away and sent R1 into the ED for evaluation During an interview on 6/24/25 at 4:06 p.m., R1 stated a nurse had taken a picture of her left foot a few days prior to her being sent to the hospital because she felt her wound looking infected, and by the time she was sent to the ED the infection had went to the bone and needed to have an amputation. The first nurse thought her foot was infected, she brought a second nurse to come and look at her foot and she stated it looked “fine”. R1 stated she was so glad the pictures were sent to management, and she was sent to the ED. R1 further stated, the nurse that took them the pictures, “Basically saved my life.” During an interview on 6/27/25 at 11:18 a.m., nurse practitioner (NP) reviewed R1’s images of her left foot taken on 5/29/25 and again on 5/30/25 and stated the wound appeared to be worse on 5/30/25 and staff should have made provider notification on 5/30/25 and not	20875		

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20875	Continued from page 10 waited until 5/31/25, however it would have not changed the outcome of her having the amputation due to her diabetes and the extent of infection she had in her foot. During an interview on 6/25/25 at 1:09 p.m., director of nursing (DON) stated the director of nursing at the time on 5/31/25 directed LPN-A to send R1 to the ED after first seeing the photo. In a follow up interview at 6:18 p.m., DON stated if she had been aware of R1's foot looking infected on 5/30/25 she would have had the nurse send her into the ED on that day. DON further stated it is a standard of practice for a nurse to notify the physician if they feel a wound appeared worse to get direction from the provider and confirmed that this was not done until 5/31/25 when she was sent into the ED for evaluation. R4's face sheet dated 6/27/25, identified diagnoses of end stage renal disease, immunodeficiency, diabetes mellitus, and kidney transplant. R4's hospital discharge summary dated 6/2/25, identified R4 had been hospitalized from 5/10/25 to 6/2/25 after having sustained an injury to his right lower extremity after hitting his leg on his scooter. and has a significant right lower extremity hematoma (a localized collection of blood outside of the blood vessels) which needed to be evacuated (a surgical procedure to remove) on 5/11/25. necrotic tissue and fat removed. R4 had subsequent surgical debridement (a medical procedure to remove dead, damaged, or infected tissue from a wound to promote healing) on 5/12, 5/16/25, and 5/22/25. R4 was discharged to the facility on 6/2/25. R4's hospital after visit summary dated 6/2/25, identified R4 had a wound on his right lower extremity and the beefy red tissue to be covered with a saline moistened gauze and then covered with an ABD and then gauze roll to hold dressing in place. R4's nurse practitioner note dated 6/4/25, identified wound orders changed to the following: cleanse with normal saline, pat dry, cover entire area of debridement (fascia and granulation tissue) with double layer xeroform gauze, cover with one to three layers of ABD for absorption, securing with gauze and paper tape. R4's Wound Evaluation dated 6/5/25, identified a surgical wound on front right lower leg that was present on admission. Wound measured 27.65 cm x 7.21 cm, with 60% granulation, and 40% slough. Wound had heavy bloody drainage.	20875		

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20875	Continued from page 11 Review of R4's record from 6/6/25 to 6/25/25 did not identify any comprehensive weekly wound assessments had been completed. R4's trauma surgery follow-up note dated 6/16/25, identified R4's right lower leg wound had progressed quite well and the facility should continue to monitor the wound for signs of infection, which would include fever, chills, nausea, vomiting, purulent drainage, expanding redness from the wound, or increased or new abdominal pain. The new order was to place xeroform over the exposed fascia (connective tissue) and moist to dry dressings to the remainder of the wound bed twice daily. R4's nurse practitioner note dated 6/18/25, identified right lower leg stable with increase in pain in recent days. R4 described the pain as burning or poking pain. Pain medication added every six hours as needed. Note identified R4 was seen two days prior by general surgery and wanted wound care orders to be adjusted and she will follow up for clarification. During an interview on 6/25/25 at 3:30 p.m., licensed practical nurse (LPN)-B stated R4 did not have consistent weekly wound evaluations done by the wound nurse practitioner due to him being out for dialysis appointments on the days she came to look at the wounds. LPN-B was not aware if another nurse in the facility had been assigned to complete the weekly wound assessments if the wound nurse was not able to see the residents on her rounds. During an observation and interview on 6/25/25 at 5:44 p.m., R4 was lying in bed and registered nurse (RN)-B was performing wound care. R4's right lower had a white gauze dressing in place, the dressing had moderate amount of wet liquid with a no color. When the dressing was removed another dressing was covering the wound, upon removal, it was noted to have moderate amount of clear liquid. R4 denied pain with the dressing removal. The wound was irregular in shape. Noted area of beefy red skin in the wound with clean edges and without discoloration. At the 12 o'clock position there was a white area approximately 4.0 cm in diameter. This area had a yellowish mesh, which RN-B called xeroform. that had been covering the wound. R4 stated his wound is healing slowly due to his immune system being impaired, but it looked better. Wound was measured and 25.0 cm x 11.0 cm per RN-B, and stated the wound looks better than since the last time she had seen it. Review of R4's progress notes on 6/26/25, did not	20875		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29822	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation And Living Center	1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901

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20875	Continued from page 12 identify any documentation of the wound evaluation completed on 6/25/25. During an interview on 6/26/25 at 12:01 p.m., wound nurse practitioner (WNP) stated R4's wound had not consistently been evaluated each week due to R4 being out of the facility on the days she came to the facility. WNP was unsure whether other staff in the facility had been trained to use the skin and wound application to do the weekly assessment if she missed seeing a resident. WNP further stated the purpose of a weekly wound assessment of a resident's wounds would be to track and to monitor healing and inform the physician if the wound was not healing to possibly change the treatment of the wound. WNP further stated the lack of comprehensive wound assessments being consistently completed could put a resident at risk for a worsening wound. During an interview on 6/26/25 at 3:30 p.m., director of nursing (DON) stated that they utilize a wound nurse to come and do the weekly comprehensive wound assessments and she uses the wound application in the electronic health record (EHR). The DON indicated wound assessments had not been completed consistently because staff nurses were not trained on completing wound assessments in the absence of the contracted wound practitioner. DON stated the weekly comprehensive wound assessments are important to evaluate the healing of a wound and without having them done consistently it could lead to a deterioration in a wound, an infection could be missed and could cause an increased risk of serious complications. R5's face sheet dated 6/27/25, identified diagnoses of joint replacement surgery, obesity (excessive body fat), and chronic kidney disease (damage to the kidneys). R5's hospital discharge summary dated 6/16/25, identified R5 had been hospitalized to perform a left hip arthroplasty (replacement) due to an infection and inflammatory reaction of the left hip prosthesis. R5 was discharged to the skilled nursing facility on 6/16/25. R5's hospital After Visit Summary dated 6/16/25, identified R5 had a wound vac (a medical device used to help wounds heal) and was to be left on for one week after surgery. R5's physician orders identified a wound vac over the incision and was discontinued on 6/18/25.	20875		

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20875	Continued from page 13 Review of R5's chart from 6/16/25 to 6/25/25 did not identify a comprehensive wound assessment had been completed on the surgical wound. R5's progress note dated 6/25/25, identified surgery team notified of drainage to the distal (situated away from the center of the body) part of the surgical wound and strong odor noticed. R5's record did not identify a wound evaluation was completed on 6/25/25. R5's Skin and Wound Evaluation dated 6/26/25, identified a surgical wound located at the left front trochanter (hip) that was present on admission. Wound measured 37.90 cm x 1.80 cm x 0.1 cm Noted light serosanguinous drainage. Area marked as a new wound. R5's progress note dated 6/26/25, identified surgery team will see R1 on 6/27/25 for labs and in clinic visit to evaluate wound. R5's orthopedic surgery note dated 6/27/25, identified that wound appeared normal for this stage of surgery and continued oral antibiotics for two more weeks. During an interview on 6/26/25 at 5:40 p.m., medical director (MD)-H stated her expectation would be for the facility to document a weekly wound assessment for all wounds to track and monitor healing and allows them to look for changes in the wound and is needed to avoid the risk of the wound becoming worse. Review of the facility's Notification of Changes policy dated 12/16, identified immediate notification of the resident; consult with the resident's physician is to be done in the following situations: -A significant change in the resident's physical, mental, or psychosocial status including a deterioration in the health, mental, cognition, medication change, or psychosocial status in either life-threatening conditions or clinical complications. Review of the facility's Wound Assessment Protocol dated 2/24/25, identified comprehensive wound assessment is necessary during every dressing change. Comparing the assessment results to the previous findings helps monitor, communicate, treat, and document wound healing progression or complications. Documentation associated with wound assessment included: -date and time of the wound assessment. -general appearance of the skin and bony prominences	20875		

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20875	Continued from page 14 -location, size, and appearance of the wound site Suggested method of correction: DON/designee could review the wound policies and procedures. DON/designee could educate facility licensed staff on wound management, develop and implement an auditing system integrated into quality assurance program to ensure ongoing compliance. Time period of correction: Twenty-one (21) days	20875		