*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 10, 2023

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

RE: CCN: 245626
Cycle Start Date: March 1, 2023

Dear Administrator:

On April 19, 2023, we notified you a remedy was imposed. On June 12, 2023 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 May 31, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 1, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 14, 2023, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 1, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 31, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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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August 10, 2023

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

Re: Reinspection Results
Event ID:  M7SS12, MY8812, and UVA012

Dear Administrator:

On April 19, 2023, May 17, 2023, and June 12, 2023 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 surveys completed on March 1, 2023, April 4, 2023, and May 4, 2023.  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

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
March 14, 2023

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

RE: CCN: 245626
Cycle Start Date: March 1, 2023

Dear Administrator:

On March 1, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 1, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 1, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by

the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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 03/01/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROCHESTER REHABILITATION AND LIVING CE | 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) COMPLETE DATE |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 2/28/23 and 3/1/23, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the Minnesota State Licensure, and the following licensing order was issued: 0840 Please indicate in your electronic plan of correction you have | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>reviewed these orders and identify the date when they will be completed.<br><br>The following complaint was reviewed H56268678C (MN00091176), with a licensing order issued at 0840.<br><br>MDH 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.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the MDH 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 MDH 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 MDH. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>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 | | |
| 2 840 | MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin<br><br>Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:<br><br>B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence.<br><br>[ 144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan. ]<br><br>Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of | 2 840 | | 4/7/23 |

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| 2 840 | Continued From page 3<br><br>the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interviews, and document review, the facility failed to provide incontinence care for 1 of 4 residents (R1) reviewed who was totally dependent on staff for incontinence cares.<br><br>Findings include:<br><br>R1's Face Sheet indicated R1 had diagnoses that included cerebral infarction (stroke), hemiplegia (one sided muscle paralyses of the body), hemiparesis (one sided weakness of the body), and dementia (neurocognitive disorder).<br><br>R1's annual Minimum Data Set (MDS) assessment dated 12/21/22, indicated R1 had moderate cognitive impairment. R1 required extensive assistance from staff for toileting and personal hygiene; and was on a urinary toileting program (toileting program to decrease or prevent urinary incontinence, and minimizing or avoiding the negative consequences of incontinence).<br><br>On 10/17/22, medical doctor (MD)-A ordered R1 to be toileted every two hours and to initiate a restorative toileting program (managing bladder | 2 840 | Corrected | |

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| 2 840 | Continued From page 4<br><br>and bowel problems in stroke survivors). Staff were directed to place the toilet schedule under Bowel and Bladder information in PointClickCare electronic medical record and in the Kardex (abbreviated care plan) section. MD-A directed the following toileting schedule: toilet R1 upon arising, before and after meals, and at nighttime; toilet between R1's bedtime 6-7 p.m., between 9-10 p.m., between 11 p.m.-12 a.m., and between 4-5 a.m.<br><br>R1's Care Plan with start date 12/29/22, identified R1 had occasional functional urinary incontinence and was at risk for alteration in skin integrity due to frequently incontinent of urine. Further identified R1 was on a restorative bladder program; toilet schedule in the Kardex. R1 required staff assistance with toileting and hygiene.<br><br>A Progress Note dated 1/31/2023 4:01 p.m. documented R1 has an individualized, resident-specific toileting program based on the assessment of her voiding patterns. In the past seven days R1 was incontinent of bladder on 1/18/23 at 6:10 a.m., 1/19/23 at 5:07 a.m., 1/20/23 at 5:41 a.m., 1/21/23 at 2:33 a.m., 1/22/23 at 5:18 a.m., and 1/23/23 at 5:35 a.m. Most of her incontinence is at night.<br><br>During an observation on 2/28/23, at 2:30 p.m. R1's bathroom cupboard contained two styles of Tena ProSkinTM Briefs. A care card directed to use a lighter absorbent brief during the day and a superabsorbent brief overnight. The overnight Tena ProSkinTM Brief was identified as super absorbent and was rated at 8 of 8 water droplets (the highest absorbency pad available from Tena). | 2 840 | | |

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| 2 840 | Continued From page 5<br><br>During an interview on 2/28/23, at 3:05 p.m. NA-B stated upon entering R1's room on 2/5/23, at approximately 7:00 a.m. there was a very strong smell of urine. After R1's bed covers were pulled back, NA-B observed urine had soaked out of R1's incontinent brief and onto the incontinence pad. NA-B stated it was obvious that urine had soaked the brief because of the urine stain along the back and right side of the brief and the large brownish stain on the incontinence pad. NA-B reported there was not any stool in the brief. NA-B stated she took a cell phone picture of the right side of R1's brief and incontinence pad. NA-B explained R1 was on every two hour check and change, it was obvious she was not changed per her schedule because there was too much urine that leaked out.<br><br>Upon review of NA-B's colored picture dated 2/5/23, at 7:14 a.m. showed the right side of a hip that had an incontinent brief with a solid green line and green dots. The brief was dark all along the right side of the brief and there was a wet looking yellowish stain on the incontinence pad starting at R1's waist, extending to the bottom of incontinence pad and laterally to the right of R1 for approximately 10". There was a brownish stain all along the edge of the yellowish wet stain on the incontinence pad.<br><br>R1's Point of Care (POC) toileting task indicated nursing assistant (NA)-B did not complete the task in "real" time rather documented all episodes at 5:17 a.m. including the scheduled time for 6:00 a.m.<br>Midnight check documented on 2/5/23, at 5:16 a.m. and identified toileting was completed.<br>2 a.m. check documented on 2/5/23, at 5:17 a.m. and identified toileting was completed.<br>4 a.m. check documented on 2/5/23, at 5:17 a.m. | 2 840 | | |

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| 2 840 | Continued From page 6<br><br>and identified toileting was completed.<br>6 a.m. check documented on 2/5/23, at 5:17 a.m. and identified toileting was completed. (documented before scheduled task time).<br><br>During an interview on 2/28/23, at 2:48 p.m. NA-A stated she worked an overnight shift from 2/4/23, to 2/5/23, and provided cares for R1. NA-A stated checking and changing R1 around 12:00 a.m.-1:00 a.m. and then again around 4-5 a.m. NA-A indicated R1 was dry between 1:00 a.m. and 4:00 a.m.<br><br>During an interview on 3/01/23, at 10:00 a.m., after looking at the brief picture NA-C stated the brief is soaked and it would have taken all night to get that full. NA-C stated, "that is a lot of urine!" Further, when a brief was that soaked, urine would leak out the sides of the brief.<br><br>During an interview on 3/01/23, at 10:24 a.m. NA-D indicated the brief picture identified the brief was not changed for several hours. Urine leaked because the brief was so soaked. NA-D stated when she changed R1 in the morning the brief was a little moist but never soaked.<br><br>During an interview on 3/1/23, at 10:39 a.m. director of nursing stated it would take a long time to soak through a depends and onto the incontinence pad. It appeared the incontinence pad had been soaked for a while.<br><br>During an interview on 3/1/23, at 1:05 p.m. registered nurse (RN)A stated the darkish red color is dried old urine and it was obvious the brief was soaked. RN-A indicated looking at the dark spot on the side of the brief showed how wet the brief was. RN-A stated it would have taken most of the night to fill up and be that soaked. | 2 840 | | |

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| 2 840 | Continued From page 7<br><br>The facility policy, Bowel and/or Bladder Program, not dated, directed staff to assist residents with toileting every two hours and the appropriate information will be recorded after each occurrence.<br><br>The facility policy, Toileting Residents, not dated, directed residents are toileted safely on a routine basis in a timely manner according to their individualized plan of care.<br><br>The facility policy, Perineal Care, not dated, identified the purpose for perineal care is to cleanse the perineum, to eliminate odor, to prevent irritation or infection, and to enhance the resident's dignity and self-esteem.<br><br>Suggested Method of Correction: The director of nursing (DON)/designee could re-educate staff on following toileting plans for dependent resident. The DON/designee could then develop and implement an auditing system to ensure dependent residents are recieving the necessary care and services according the comprehensive care plan.<br><br>Time period for correction: twenty-one (21) days. | 2 840 | | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
March 14, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: M7SS11

Dear Administrator:

The above facility was surveyed on February 28, 2023 through March 1, 2023 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 |
|---|---|---|---|
| | 245626 | A. BUILDING _____ B. WING _____ | C 03/01/2023 |

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

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| F 000 | INITIAL COMMENTS<br><br>On 2/28/23 and 3/1/23, a standard abbreviated survey was conducted at your facility. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed. H56268678C (MN00091176) with a deficiency issued at F684.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and | F 684 | F-684 | 4/7/23 |

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

Electronically Signed | 03/23/2023

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 684 | Continued From page 1<br>document review, the facility failed to provide incontinence care for 1 of 4 residents (R1) reviewed who was totally dependent on staff for incontinence cares.<br><br>Findings include:<br><br>R1's Face Sheet indicated R1 had diagnoses that included cerebral infarction (stroke), hemiplegia (one sided muscle paralyses of the body), hemiparesis (one sided weakness of the body), and dementia (neurocognitive disorder).<br><br>R1's annual Minimum Data Set (MDS) assessment dated 12/21/22, indicated R1 had moderate cognitive impairment. R1 required extensive assistance from staff for toileting and personal hygiene; and was on a urinary toileting program (toileting program to decrease or prevent urinary incontinence, and minimizing or avoiding the negative consequences of incontinence).<br><br>On 10/17/22, medical doctor (MD)-A ordered R1 to be toileted every two hours and to initiate a restorative toileting program (managing bladder and bowel problems in stroke survivors). Staff were directed to place the toilet schedule under Bowel and Bladder information in PointClickCare electronic medical record and in the Kardex (abbreviated care plan) section. MD-A directed the following toileting schedule: toilet R1 upon arising, before and after meals, and at nighttime; toilet between R1's bedtime 6-7 p.m., between 9-10 p.m., between 11 p.m.-12 a.m., and between 4-5 a.m.<br><br>R1's Care Plan with start date 12/29/22, identified R1 had occasional functional urinary incontinence | 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 the alleged deficiency. RRLC reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency.<br>F684 SS=D: Based on observation, interview, and document review, the facility failed to provide incontinence care for 1 of 4 residents (R1) reviewed who was totally dependent on staff for incontinence cares.<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on a 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.<br>R1□s care plan has been reviewed and updated to ensure the toileting plan is accurate. All like resident□s care plans have been reviewed and found to be appropriate.<br>The facility policy on Perineal Care has been reviewed and is appropriate. RRLC staff are to toilet and change a resident per resident choice and facility policy.<br>Staff re-education will be completed regarding following care plans in regards | |

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| F 684 | Continued From page 2<br>and was at risk for alteration in skin integrity due to frequently incontinent of urine. Further identified R1 was on a restorative bladder program; toilet schedule in the Kardex. R1 required staff assistance with toileting and hygiene.<br><br>A Progress Note dated 1/31/2023 4:01 p.m. documented R1 has an individualized, resident-specific toileting program based on the assessment of her voiding patterns. In the past seven days R1 was incontinent of bladder on 1/18/23 at 6:10 a.m., 1/19/23 at 5:07 a.m., 1/20/23 at 5:41 a.m., 1/21/23 at 2:33 a.m., 1/22/23 at 5:18 a.m., and 1/23/23 at 5:35 a.m. Most of her incontinence is at night.<br><br>During an observation on 2/28/23, at 2:30 p.m. R1's bathroom cupboard contained two styles of Tena ProSkinTM Briefs. A care card directed to use a lighter absorbent brief during the day and a superabsorbent brief overnight. The overnight Tena ProSkinTM Brief was identified as super absorbent and was rated at 8 of 8 water droplets (the highest absorbency pad available from Tena).<br><br>During an interview on 2/28/23, at 3:05 p.m. NA-B stated upon entering R1's room on 2/5/23, at approximately 7:00 a.m. there was a very strong smell of urine. After R1's bed covers were pulled back, NA-B observed urine had soaked out of R1's incontinent brief and onto the incontinence pad. NA-B stated it was obvious that urine had soaked the brief because of the urine stain along the back and right side of the brief and the large brownish stain on the incontinence pad. NA-B reported there was not any stool in the brief. NA-B stated she took a cell phone picture of the | F 684 | to toileting needs. Staff education will also include dignity in regards to toileting and checking and changing a resident. Staff education will include review of the Perineal Care policy.<br>DON or designee will perform audits on pericare 3 days/week x 4 weeks, weekly x 4 weeks, and monthly x 2 months. Audit results will be reviewed monthly at QAPI meetings for further recommendations. DON is responsible for compliance. | |

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| F 684 | Continued From page 3<br>right side of R1's brief and incontinence pad. NA-B explained R1 was on every two hour check and change, it was obvious she was not changed per her schedule because there was too much urine that leaked out.<br><br>Upon review of NA-B's colored picture dated 2/5/23, at 7:14 a.m. showed the right side of a hip that had an incontinent brief with a solid green line and green dots. The brief was dark all along the right side of the brief and there was a wet looking yellowish stain on the incontinence pad starting at R1's waist, extending to the bottom of incontinence pad and laterally to the right of R1 for approximately 10". There was a brownish stain all along the edge of the yellowish wet stain on the incontinence pad.<br><br>R1's Point of Care (POC) toileting task indicated nursing assistant (NA)-B did not complete the task in "real" time rather documented all episodes at 5:17 a.m. including the scheduled time for 6:00 a.m.<br>Midnight check documented on 2/5/23, at 5:16 a.m. and identified toileting was completed.<br>2 a.m. check documented on 2/5/23, at 5:17 a.m. and identified toileting was completed.<br>4 a.m. check documented on 2/5/23, at 5:17 a.m. and identified toileting was completed.<br>6 a.m. check documented on 2/5/23, at 5:17 a.m. and identified toileting was completed. (documented before scheduled task time).<br><br>During an interview on 2/28/23, at 2:48 p.m. NA-A stated she worked an overnight shift from 2/4/23, to 2/5/23, and provided cares for R1. NA-A stated checking and changing R1 around 12:00 a.m.-1:00 a.m. and then again around 4-5 a.m. NA-A indicated R1 was dry between 1:00 a.m. | F 684 | | |

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| F 684 | Continued From page 4<br>and 4:00 a.m.<br><br>During an interview on 3/01/23, at 10:00 a.m., after looking at the brief picture NA-C stated the brief is soaked and it would have taken all night to get that full. NA-C stated, "that is a lot of urine!" Further, when a brief was that soaked, urine would leak out the sides of the brief.<br><br>During an interview on 3/01/23, at 10:24 a.m. NA-D indicated the brief picture identified the brief was not changed for several hours. Urine leaked because the brief was so soaked. NA-D stated when she changed R1 in the morning the brief was a little moist but never soaked.<br><br>During an interview on 3/1/23, at 10:39 a.m. director of nursing stated it would take a long time to soak through a depends and onto the incontinence pad. It appeared the incontinence pad had been soaked for a while.<br><br>During an interview on 3/1/23, at 1:05 p.m. registered nurse (RN)A stated the darkish red color is dried old urine and it was obvious the brief was soaked. RN-A indicated looking at the dark spot on the side of the brief showed how wet the brief was. RN-A stated it would have taken most of the night to fill up and be that soaked.<br><br>The facility policy, Bowel and/or Bladder Program, not dated, directed staff to assist residents with toileting every two hours and the appropriate information will be recorded after each occurrence.<br><br>The facility policy, Toileting Residents, not dated, directed residents are toileted safely on a routine basis in a timely manner according to their | F 684 | | |

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| F 684 | Continued From page 5<br>individualized plan of care.<br><br>The facility policy, Perineal Care, not dated, identified the purpose for perineal care is to cleanse the perineum, to eliminate odor, to prevent irritation or infection, and to enhance the resident's dignity and self-esteem. | F 684 | | |