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 Therefore, the NATCEP prohibition is rescinded.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

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: 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 19, 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 14, 2023, we informed you that we may impose enforcement remedies.

On April 4, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 1, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 1, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 1, 2023.

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

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 1, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester Rehabilitation And Living Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 1, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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 - 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 September 1, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/3/23 and 4/4/23, 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 complaints were reviewed H56269935C (MN00092214), H56269995C (MN00092390), with deficiencies issued at F755 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.	F 000		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		5/12/23

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

Electronically Signed | 04/27/2023

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.

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 1 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a system was in place for timely administration of medications according to physician order for 4 of 4 residents (R1, R2, R4, R5), reviewed for medication errors. Findings include: R1's face sheet indicated R1 was admitted with diagnoses that included fracture of the left tibia, diabetes type 2, and chronic kidney disease. R1's admission Minimum Data Set (MDS) dated 3/6/23, indicated R1 was cognitively intact and had received antidepressants, anticoagulants, diuretics, and insulin on 7 of 7 days during the MDS assessment period.	F 755	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. F755 SS=E: Based on observation, interview, and document review the facility failed to ensure a system was in place for timely administration of medication in	

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 2 R1's care plan dated 3/20/23, directed staff to give medications as ordered related to pace maker, diabetes, and pain management. R1's Medication Audit Report for March 2023, identified R1 had the following medications administered more than 1 hour before or after the scheduled administration times which was not in accordance with physician's orders: -On 3/1/23 Levothyroxine Sodium (medication for thyroid) 50 milligrams (mg) one time a day, was scheduled at 6:00 a.m.; time administered was 9:23 a.m. (two hours late). -On 3/3/23 Atacand (medication for hypertension) 32 mg one time daily, was scheduled for 7:00 a.m.; time administered 4:30 p.m. (8.5 hour late). -On 3/10/23 Lidocaine External patch (medication for pain) 5% apply to left medial knee in the evening and remove in the a.m. per schedule, to be applied, at 7:59 a.m.; administered at 12:03 p.m. (3 hours late). -On 3/17/23 acetaminophen (medication for pain) 1000 mg ordered to be given 4 times a day. Was scheduled at midnight; administered at 6:25 a.m. (5 hours late). -On 3/28/23 Simvastatin (medication for cholesterol) 20 mg ordered to be given at bedtime was scheduled for 7:00 p.m.; administered at 5:57 a.m. (9.5 hours late). - On 3/30/23 acetaminophen 1000 mg ordered to be given 4 times a day. Was scheduled at noon; administered at 3:33 p.m. (2.5 hours late) -On 3/30/23 Insulin Aspart flexPen 100 units /milliliter (ml) ordered to be given with meals scheduled at noon; administered at 3:33 p.m. (2.5 hours late). R2's Face sheet indicated R2 was admitted with	F 755	accordance to physician order for 4 of 4 residents (R1, R2, R4, and R5), reviewed for medication errors. The facility must provide routine and emergency drugs and biologicals to its residents or obtain them. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. Affected Resident(s): R1, R2, R4, R5 were reviewed for any medication errors, and follow up occurred regarding med error reports completion, with physician notification. All 4 residents have successfully discharged from facility, with no negative impact. Potential Affected Resident(s): All residents receiving medications have the potential to be affected. To ensure all residents are protected, the facility immediately acted by reviewing the medication administration system. Immediate re-education of nurses began regarding medication administration policies & procedures. Immediate auditing began regarding medication administrations and timeliness, and medication errors initiated Nurses are being educated to identify issues and system failures with the medication administration timeliness, and identify ways to correct them, and report ideas or concerns to Nursing Leadership. Measures/Systematic Changes: Facility policy on medication	

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 3 diagnoses that included congestive heart failure, diabetes type 2, chronic kidney disease, and heart failure. R2's admission MDS dated 3/9/23, indicated R2 was cognitively intact and had received antidepressants, anticoagulants, antibiotics, and diuretics on 7 of the 7 assessment days. R2's care plan dated 3/3/23, directed staff to administer medications as ordered for history of heart attack and urinary tract infection (UTI). R2's medication audit report for March 2023, indicated R2 had the following medications administered late: -On 3/3/23 Hydralazine (medication for Hypertension) 10 mg give tablet after meals was scheduled at 1:45 p.m. and was given at 6:54 p.m. (4 hours late). On 3/10/23, the medication was administered two hours late. -On 3/3/23 Amoxicillin (antibiotic) 500 mg every 12 hours scheduled at 8:00 p.m., administered at 11:00 p.m. (2 hours late). On 3/10/23 the med was administered 3.5 hours late and on 3/11/23 was administered 2 hours late. - On 3/3/23,Advair Diskus 250-50 microgram/dose (MCG/dose) (medication for asthma) ordered to be inhaled every 12 hours scheduled at 8:00 p.m. and was administered at 11:03 p.m. (2 hours late). On 3/10/23 the med was administered 3.5 hours late and on 3/11/23 was administered 2 hours late. -On 3/11/23, metoprolol succinate ER 25 mg (medication for hypertension) 24 hour tablet was scheduled at 7:00 a.m. and was given at 3:40 p.m. (7.5 hours late), Was also 7.5 hours late on 3/12/23. -On 3/18/23 isosorbide Dinitrate 40 mg	F 755	administration has been reviewed and remains current. RRLC nurses are to administer medications in a timely manner, according to policy. Medications are administered per physician orders. Pharmacy consultant will audit resident medications and make suggestions on changing medications to different times of the day to help balanced medication passes. Auditing will continue with leadership rounding of observation with medication administrations and timeliness. Medication error reports will be initiated if applicable, and training or coaching will occur. Nurses will continue being educated to identify issues and system failures with the medication administration timeliness, and identify ways to correct them, and continue to report ideas or concerns to Nursing Leadership The Nursing Leadership morning meeting will include Medication Administration as a topic for discussion regarding observations, chart reviews, suggestions from staff, to ensure Medication Administration practice is being implemented. Education: Nurses will be educated on how to complete a medication error report at time of incident, notifications of physician, and reporting to nursing leadership when identified. Nurses will be re-educated regarding policy and procedure for administration of medications. Education will focus on	

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 4 (medication for chest pain) give before meals, was scheduled at 11:00 a.m. and was given at 2:02 p.m. (2 hours late). R4 face sheet dated indicated R4 was admitted on 3/2/23, with diagnoses that included diabetes type 2 with neuropathy, Sjogren syndrome (immune system disorder characterized by dry eyes and mouth), and chronic pain syndrome. R4's admission MDS dated 3/8/23, indicated R4 was cognitively intact and had received antidepressants, anticoagulants, diuretics, opioid's, and insulin on 7 of 7 days during the MDS assessment period. R4's care plan dated 3/21/23, directed staff to administer medications as ordered for history pain related to cellulitis, rheumatoid arthritis, chronic pain syndrome. R4's medication audit report for March 2023, indicated R4 had the following medications administered late: -On 3/3/23, Torsemide (medication for edema)10 mg give one tablet daily, scheduled at 7:00 a.m. was given at 3:54 p.m. (7.5 hours late). -On 3/3/23, Spironolactone (medication for hypertension) 25 mg give one tablet daily, scheduled at 7:00 a.m. was given at 3:54 p.m. (7.5 hours late). -On 3/5/23, Voltaren External Gel (medication for pain) 1% Apply to areas of pain topically four times a day, was scheduled at 8 a.m. and was given at 11:01 a.m. (2 hours late) This medication was administered late 13 other times throughout the month. -On 3/2/23, Latanoprost (medication for glaucoma) 0.005% drops ordered to be given at	F 755	timing of medications and ensuring medications are administered according to physician orders. Staff education will focus on entering new orders as a liberalized medication time unless they are time sensitive medications. Education will include charting medications immediately after they are given and not waiting until after the shift to complete the charting. Nurse Managers will be educated on the use of Clinical Dashboard on Point Click Care. Nurse managers will utilize the Clinical Dashboard to monitor for late administration of medications and be able to initiate timely follow up. Monitoring: Pharmacy consultant will audit resident medications and make suggestions on changing medications to different times of the day to help balanced medication passes. Pharmacy Nurse to continue reviewing med passes on a monthly basis and follow up as recommended. DON and Nursing Leadership, will perform audits on timely medication administration 3x a week for 4 weeks, and monthly times 2 months, to ensure systems are sustained. Results of monitoring will be reported at QAPI meeting with ongoing frequency and duration to be determined through analysis and review of results. DON is responsible for compliance. Completion Date: Date Certain: May 12th, 2023 Audit Form: Medication Time	

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 5 bedtime, scheduled for 7:00 p.m. given at 2:32 a.m. (6.5 hours late). On 3/28/23 medication was administered 10 hours late. -On 3/2/23, Cevimeline (medication for dry eyes and mouth) 30 mg ordered to be given three times a day, scheduled at 8:00 p.m. given at 2:32 a.m. (5.5 hours late) This medication was administered late 7 other times throughout the month. -On 3/17/23, Gabapentin (medication for neuropathy) 400 mg ordered to be given three times a day, scheduled for 8:00 p.m. given at 12:38 a.m. (3.5 hours late). This medication was administered late 4 other times throughout the month. R5's face sheet indicated R5 was admitted on 3/6/23, with diagnoses that included displaced fracture of left lower leg, chronic obstructive pulmonary disease (COPD), hypertension and edema. R5's admission MDS dated 3/12/23, indicated R5 was cognitively intact and had received, anticoagulants, diuretics, and opioid's on 7 of 7 days during the MDS assessment period. R5's care plan dated 3/06/23, directed staff to administer medications as ordered for cardiac diagnosis, pain and anticoagulant use. R5's medication audit report for March 2023, schedule date of 3/1/23-3/31/2, indicated R5 had the following medications administered late: -On 3/8/23, Atenolol (medication for hypertension) 50 mg tablet twice a day, scheduled for 8:00 p.m. given at 12:24 a.m. (3 hours late). This medication was administered late 37 times throughout the month.	F 755	Administration Monitoring	

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 6 -On 3/28/23, Advair Diskus Aerosol 250-50 MCG/dose (medication for COPD) ordered to be given every 12 hours, was scheduled for 8:00 p.m. and was given at 5:47 a.m. (8.5 hours). This medication was given late over 30 times throughout the month. -On 3/31/23, Enoxaparin Sodium 40 MG/ 0.4 milliliters (ml) Injection (medication for preventing blood clots) ordered to be given every 12 hours, scheduled for 8:00 p.m. given at 1:16 a.m. This medication was administered late over 31 times throughout the month. During an observation and interview on 4/3/23, at 10:14 a.m. registered nurse (RN)-A stated she was currently completing her 8:00 a.m. medication pass. RN-A indicated nurses did not have time to complete the medication reconciliation when resident discharged from the facility and pass medications timely. RN-A did not identify that medications administered late were considered medication errors. During an observation and interview on 4/3/23, at 11:09 a.m. licensed practical nurse (LPN)-C was passing medications. LPN-C stated on most days she did not get done with her 8:00 a.m. medication pass done before noon. LPN-C explained over ninety percent of her medications in the morning need vital signs taken before they can be given and the machine was not always available. Therapy also would take many residents before they would get their 8:00 meds. LPN-C stated recently she had been informed that the floor nurses would be responsible for completed resident discharge which would cause her morning med pass to be completed even later. LPN-C reported last week a resident did not get his 8:00 a.m. insulin until after 10:00 a.m. he	F 755		

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 7 had already eaten his breakfast. At 11:30 a.m. the same resident's blood sugar level was over 300 (high blood sugar). Although LPN-C stated she had informed the physician of the resident's high blood sugar, she did not identify the late administration of other mediations as errors. During an interview on 4/3/23, at 10:56 a.m. nurse manager (NM)-A stated she had to fill two medication errors reports in the last month. NM-A stated when she worked on the medication cart passing medications last week she was done before 10:30 a.m., NM-A did not identify the medications that were administered late were considered medication errors. During an observation and interview on 4/3/23, at 11:31 a.m. RN-B was setting up 8:00 a.m. scheduled medications to be administered to a resident. RN-B stated she could usually get her medication pass done by 11 a.m., but today would be later because of a staff scheduling issue. RN-B did not identify late administration of medications were considered an errors. During an interview on 4/3/23, at 12:08 p.m. LPN-D stated if she got help from another nurse then she could be done with her 8:00 medication pass around 10:00 a.m. During an interview on 4/3/23, at 6:00 p.m. director of nursing (DON) stated medications given an more than an hour before or more than an hour after scheduled time was considered a medication error. When a medication error happened, the person who made the error would notify the DON and physician and fill out a medication error report. DON stated she had not received and/or was informed of any medication	F 755		

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 8 error reports related to late administration times. Facility's General Dose Preparation and Medication Administration policy revised 1/1/22, indicated the facility should verify each time a medication is administered that it is the correct medication, correct dose, correct route, correct rate, correct time, correct resident as set forth in the facility's medication administration schedule.	F 755		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §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: §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 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		5/12/23

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 9 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 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	F 867		

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 10 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 §483.70(e). 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	F 867		

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 11 action to correct identified quality deficiencies; (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 Process improvement (QAPI) committee was effective in identifying and implementing appropriate actions to reduce the prevalence of medication errors and failed to monitor, collect data and evaluate the effectives. This had the potential to effect all 43 residents who resided in the facility. Findings include: SEE F755 Based on observation, interview, and document review the facility failed to ensure a system was in place for timely administration of medications according to physician order for 4 of 4 residents (R1, R2, R4, R5), reviewed for medication errors. March 2023 Medication Administration Records (MAR) reviewed for R1, R2, R4, and R5 identified the following late medication administration for combined total of 146 errors (between four residents) related to late administration that the facility did not identify. R1 had seven medications administered late and not in accordance with physician orders: dates of errors included 3/1, 3/3, 3/10, 3/17, 3/28, and 3/30/23. R2 had 11 medications administered late: dates of errors included 3/3, 3/10, 3/11, 3/12, and 3/18/23	F 867	Complaint Survey 4.3-4.4.23 Plan of Correction 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. F867 SS=F: Based on interview and document review the facility failed to ensure the Quality Assurance Process Improvement (QAPI) committee was ineffective in identifying and implementing appropriate actions to reduce the prevalence of medication errors and failed to monitor, collect data, and evaluate the effectiveness. This had the potential to effect all 43 residents who resided in the facility. 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. As part of their performance	

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 12 R4 had 30 medications administered late; dates included but not limited to 3/2, 3/3, 3/5, and 3/17/23. R5 had 98 medications administered late; dates included but not limited to 3/8, 3/28, and 3/31/23 The facility's QA minutes dated 3/20/23 and Performance Improvement Action Plan (PIP) dated 2/19/23 records identified a focus for improvement for medication management, administration, and destruction system. It was not evident the facility had identified issues with timeliness of medication passes that resulted in multiple medication errors. The PIP identified the medication error rate of 12%, however, it was not evident late administration errors were included in that calculation as there were no error reports completed for late administration. Further not evident the facility's PIP addressed activities that would correct or mitigate the risk of late medication administration errors. The facility's PIP dated 2/19/23, included the focus area "facility has submitted multiple self-reports related to medication management, administration and destruction system." Medication error rate of 12%. The associated performance goal was to ensure compliance with medication management, administration, and destruction system. Although multiple action items were identified, the plan did not identify the person who was responsible for the action task and/or goal dates for the actions to be implemented. Examples of action items included: -Root Cause Analysis (RCA) of the medication errors: goal date identified was 2/20/23, person responsible was appointed. In review of QA records, it was not evident RCA was completed nor identifiable how the facility determined action	F 867	improvement activities, the facility must conduct distinct performance improvement projects. The QAPI committee must develop and implement appropriate plans of action to correct identified quality deficiencies; 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. Plan of Correction: • Facility QAPI policy has been reviewed and is appropriate. • RRLC QAPI members are being educated to identify issues and system failures in the facility and identify ways to correct them. Education also includes review of the QAPI policy. • The IDT morning meeting will include QAPI discussion to have experiential learning on a day to day basis. • The QAPI committee will track the data, conduct audits and discuss at the monthly QAPI meeting, to ensure identified problems are being corrected. Administrator is responsible for compliance. Date Certain: May 12th, 2023 Audit Form: QAPI Audit Tool	

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 13 tasks without determining root cause of the non-compliance with the medication management system. -Interview nurses related to why errors occurring and document in soft file: goal date was not identified, person responsible was not assigned, and it was not evident this activity was completed. -Interview health unit coordinators regarding process: identified the goal date of 2/20/23, person responsible was assigned, activity was marked as "done", however, it was not evident this task was completed. -Discharge process and discharge medications: marked as completed, however, no records were provided that identified if the system was analyzed, system or policy changed, monitored, or level of effectiveness of the completed activity. -Anticoagulant medication education: marked as completed, however, no records were provided that identified date(s) education was provided, who the education was provided to, if the system was changed, if education was monitored and analyzed for effectiveness. -Conduct competency check off of staff who were included in the Omnicare audit or whom have had a medication error in the last 90 days: goal date identified as 2/20/23, person responsible was not assigned, and it was not evident this activity was fully implemented or analyzed. -Conduct weekly medication pass audits and report results to QAPI: goal date and responsible person was not identified, and not evident this activity was implemented or completed. Facility Quality Assurance Performance Improvement (QAPI) monthly meeting Agenda dated 3/20/23 indicated the committee reviewed citations and facility reported incidents related to medication errors or the medication management	F 867		

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 14 system. The agenda did not include and was not evident the medication PIP was fully reviewed. In review of QA records provided it was not evident the facility monitored and collected data to determine the effectiveness of the PIP activities that were identified in the plan to reduce errors or correct non-compliance in the medication management systems. During an interview on 4/3/23, at 5:22 p.m. consultant pharmacist (CP)-A stated an awareness of the facility's medication error problems, they have been working on items to improve error rates. CP-A explained the facility informs her when there were medication errors, however, she had not been notified of any medication errors related to late administration. Medications that were given more than an hour before or after the scheduled administration time would be considered a medication error. CP-A stated she had looked at medication process optimization but nothing specific to timing of administration and her efforts were more focused on reduction of medications residents were administered. CP-A reported she was part of the facility's QAPI program; the next meeting was in April. During an interview on 4/3/23, at 6:00 p.m. director of nursing (DON) stated medications given an more than an hour before or more than an hour after scheduled time was considered a medication error. DON stated she had not received and/or was informed of any medication error reports related to late administration times. During an interview on 4/4/23, at 9:21 a.m. regional nurse consultant, director of nursing, and	F 867		

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 04/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 15 administrator explained there had a been a recent change to the facility leadership. They thought there had been a previous plan in place however was not sure where it was located; the plan did not flow to new administration. Stated a new medication PIP was started in February and the facility was currently working on that plan. Facility's Quality Assessment and Assurance / Quality Assurance Performance Improvement (QA&A/QAPI) Committee policy and procedure revised 11/22, indicated the QAPI team was to perform regular review of the facility assessment, pharmacy, PIP sustainability, operational and clinical outcomes, to proactively identify high risk, high volume, problem prone areas for improvement, identification of gaps/variances in current systems, propose data to measure at end of PIP, and to utilizes root cause analysis for outcomes and sustainability.	F 867		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 19, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: MY8811

Dear Administrator:

The above facility was surveyed on April 3, 2023 through April 4, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 04/04/2023

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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/3/23 and 4/4/23, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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 04/04/2023

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
2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H56269935C (MN00092214), H56269995C (MN00092390), with licensing orders issued at 0255 and 1550 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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 04/04/2023

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
2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee 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 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 MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance Process improvement (QAPI) committee was effective in identifying and implementing appropriate actions to reduce the prevalence of medication errors and failed to monitor, collect data and evaluate the effectives. This had the potential to effect all 43 residents who resided in	2 255	Corrected	5/12/23

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 04/04/2023

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
2 255	Continued From page 3 the facility. Findings include: SEE F755 Based on observation, interview, and document review the facility failed to ensure a system was in place for timely administration of medications according to physician order for 4 of 4 residents (R1, R2, R4, R5), reviewed for medication errors. March 2023 Medication Administration Records (MAR) reviewed for R1, R2, R4, and R5 identified the following late medication administration for combined total of 146 errors (between four residents) related to late administration that the facility did not identify. R1 had seven medications administered late and not in accordance with physician orders: dates of errors included 3/1, 3/3, 3/10, 3/17, 3/28, and 3/30/23. R2 had 11 medications administered late: dates of errors included 3/3, 3/10, 3/11, 3/12, and 3/18/23 R4 had 30 medications administered late; dates included but not limited to 3/2, 3/3, 3/5, and 3/17/23. R5 had 98 medications administered late; dates included but not limited to 3/8, 3/28, and 3/31/23 The facility's QA minutes dated 3/20/23 and Performance Improvement Action Plan (PIP) dated 2/19/23 records identified a focus for improvement for medication management, administration, and destruction system. It was not evident the facility had identified issues with timeliness of medication passes that resulted in multiple medication errors. The PIP identified the medication error rate of 12%, however, it was not evident late administration errors were included in	2 255		

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 04/04/2023

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
2 255	Continued From page 4 that calculation as there were no error reports completed for late administration. Further not evident the facility's PIP addressed activities that would correct or mitigate the risk of late medication administration errors. The facility's PIP dated 2/19/23, included the focus area "facility has submitted multiple self-reports related to medication management, administration and destruction system." Medication error rate of 12%. The associated performance goal was to ensure compliance with medication management, administration, and destruction system. Although multiple action items were identified, the plan did not identify the person who was responsible for the action task and/or goal dates for the actions to be implemented. Examples of action items included: -Root Cause Analysis (RCA) of the medication errors: goal date identified was 2/20/23, person responsible was appointed. In review of QA records, it was not evident RCA was completed nor identifiable how the facility determined action tasks without determining root cause of the non-compliance with the medication management system. -Interview nurses related to why errors occurring and document in soft file: goal date was not identified, person responsible was not assigned, and it was not evident this activity was completed. -Interview health unit coordinators regarding process: identified the goal date of 2/20/23, person responsible was assigned, activity was marked as "done", however, it was not evident this task was completed. -Discharge process and discharge medications: marked as completed, however, no records were provided that identified if the system was analyzed, system or policy changed, monitored, or level of effectiveness of the completed activity.	2 255		

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 04/04/2023

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
2 255	Continued From page 5 -Anticoagulant medication education: marked as completed, however, no records were provided that identified date(s) education was provided, who the education was provided to, if the system was changed, if education was monitored and analyzed for effectiveness. -Conduct competency check off of staff who were included in the Omnicare audit or whom have had a medication error in the last 90 days: goal date identified as 2/20/23, person responsible was not assigned, and it was not evident this activity was fully implemented or analyzed. -Conduct weekly medication pass audits and report results to QAPI: goal date and responsible person was not identified, and not evident this activity was implemented or completed. Facility Quality Assurance Performance Improvement (QAPI) monthly meeting Agenda dated 3/20/23 indicated the committee reviewed citations and facility reported incidents related to medication errors or the medication management system. The agenda did not include and was not evident the medication PIP was fully reviewed. In review of QA records provided it was not evident the facility monitored and collected data to determine the effectiveness of the PIP activities that were identified in the plan to reduce errors or correct non-compliance in the medication management systems. During an interview on 4/3/23, at 5:22 p.m. consultant pharmacist (CP)-A stated an awareness of the facility's medication error problems, they have been working on items to improve error rates. CP-A explained the facility informs her when there were medication errors, however, she had not been notified of any medication errors related to late administration.	2 255		

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 04/04/2023

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
2 255	Continued From page 6 Medications that were given more than an hour before or after the scheduled administration time would be considered a medication error. CP-A stated she had looked at medication process optimization but nothing specific to timing of administration and her efforts were more focused on reduction of medications residents were administered. CP-A reported she was part of the facility's QAPI program; the next meeting was in April. During an interview on 4/3/23, at 6:00 p.m. director of nursing (DON) stated medications given an more than an hour before or more than an hour after scheduled time was considered a medication error. DON stated she had not received and/or was informed of any medication error reports related to late administration times. During an interview on 4/4/23, at 9:21 a.m. regional nurse consultant, director of nursing, and administrator explained there had a been a recent change to the facility leadership. They thought there had been a previous plan in place however was not sure where it was located; the plan did not flow to new administration. Stated a new medication PIP was started in February and the facility was currently working on that plan. Facility's Quality Assessment and Assurance / Quality Assurance Performance Improvement (QA&A/QAPI) Committee policy and procedure revised 11/22, indicated the QAPI team was to perform regular review of the facility assessment, pharmacy, PIP sustainability, operational and clinical outcomes, to proactively identify high risk, high volume, problem prone areas for improvement, identification of gaps/variances in current systems, propose data to measure at end of PIP, and to utilizes root cause analysis for	2 255		

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 04/04/2023

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
2 255	Continued From page 7 outcomes and sustainability. SUGGESTED METHOD OF CORRECTION: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues, develop improvement plans, and ensure the committee meets quarterly. The administrator and DON could audit cares to ensure resident needs are met, audit charts for completion of restorative and range of motion programs, and report results to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a system was in place for timely administration of medications according to physician order for 4 of 4 residents (R1, R2, R4, R5), reviewed for medication errors. Findings include: R1's face sheet indicated R1 was admitted with diagnoses that included fracture of the left tibia, diabetes type 2, and chronic kidney disease.	21550	Corrected	5/12/23

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 04/04/2023

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
21550	Continued From page 8 R1's admission Minimum Data Set (MDS) dated 3/6/23, indicated R1 was cognitively intact and had received antidepressants, anticoagulants, diuretics, and insulin on 7 of 7 days during the MDS assessment period. R1's care plan dated 3/20/23, directed staff to give medications as ordered related to pace maker, diabetes, and pain management. R1's Medication Audit Report for March 2023, identified R1 had the following medications administered more than 1 hour before or after the scheduled administration times which was not in accordance with physician's orders: -On 3/1/23 Levothyroxine Sodium (medication for thyroid) 50 milligrams (mg) one time a day, was scheduled at 6:00 a.m.; time administered was 9:23 a.m. (two hours late). -On 3/3/23 Atacand (medication for hypertension) 32 mg one time daily, was scheduled for 7:00 a.m.; time administered 4:30 p.m. (8.5 hour late). -On 3/10/23 Lidocaine External patch (medication for pain) 5% apply to left medial knee in the evening and remove in the a.m. per schedule, to be applied, at 7:59 a.m.; administered at 12:03 p.m. (3 hours late). -On 3/17/23 acetaminophen (medication for pain) 1000 mg ordered to be given 4 times a day. Was scheduled at midnight; administered at 6:25 a.m. (5 hours late). -On 3/28/23 Simvastatin (medication for cholesterol) 20 mg ordered to be given at bedtime was scheduled for 7:00 p.m.; administered at 5:57 a.m. (9.5 hours late). - On 3/30/23 acetaminophen 1000 mg ordered to be given 4 times a day. Was scheduled at noon; administered at 3:33 p.m. (2.5 hours late) -On 3/30/23 Insulin Aspart flexPen 100 units /milliliter (ml) ordered to be given with meals	21550		

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 04/04/2023

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
21550	Continued From page 9 scheduled at noon; administered at 3:33 p.m. (2.5 hours late). R2's Face sheet indicated R2 was admitted with diagnoses that included congestive heart failure, diabetes type 2, chronic kidney disease, and heart failure. R2's admission MDS dated 3/9/23, indicated R2 was cognitively intact and had received antidepressants, anticoagulants, antibiotics, and diuretics on 7 of the 7 assessment days. R2's care plan dated 3/3/23, directed staff to administer medications as ordered for history of heart attack and urinary tract infection (UTI). R2's medication audit report for March 2023, indicated R2 had the following medications administered late: -On 3/3/23 Hydralazine (medication for Hypertension) 10 mg give tablet after meals was scheduled at 1:45 p.m. and was given at 6:54 p.m. (4 hours late). On 3/10/23, the medication was administered two hours late. -On 3/3/23 Amoxicillin (antibiotic) 500 mg every 12 hours scheduled at 8:00 p.m., administered at 11:00 p.m. (2 hours late). On 3/10/23 the med was administered 3.5 hours late and on 3/11/23 was administered 2 hours late. - On 3/3/23,Advair Diskus 250-50 microgram/dose (MCG/dose) (medication for asthma) ordered to be inhaled every 12 hours scheduled at 8:00 p.m. and was administered at 11:03 p.m. (2 hours late). On 3/10/23 the med was administered 3.5 hours late and on 3/11/23 was administered 2 hours late. -On 3/11/23, metoprolol succinate ER 25 mg (medication for hypertension) 24 hour tablet was scheduled at 7:00 a.m. and was given at 3:40	21550		

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 04/04/2023

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
21550	Continued From page 10 p.m. (7.5 hours late), Was also 7.5 hours late on 3/12/23. -On 3/18/23 isosorbide Dinitrate 40 mg (medication for chest pain) give before meals, was scheduled at 11:00 a.m. and was given at 2:02 p.m. (2 hours late). R4 face sheet dated indicated R4 was admitted on 3/2/23, with diagnoses that included diabetes type 2 with neuropathy, Sjogren syndrome (immune system disorder characterized by dry eyes and mouth), and chronic pain syndrome. R4's admission MDS dated 3/8/23, indicated R4 was cognitively intact and had received antidepressants, anticoagulants, diuretics, opioid's, and insulin on 7 of 7 days during the MDS assessment period. R4's care plan dated 3/21/23, directed staff to administer medications as ordered for history pain related to cellulitis, rheumatoid arthritis, chronic pain syndrome. R4's medication audit report for March 2023, indicated R4 had the following medications administered late: -On 3/3/23, Torsemide (medication for edema)10 mg give one tablet daily, scheduled at 7:00 a.m. was given at 3:54 p.m. (7.5 hours late). -On 3/3/23, Spironolactone (medication for hypertension) 25 mg give one tablet daily, scheduled at 7:00 a.m. was given at 3:54 p.m. (7.5 hours late). -On 3/5/23, Voltaren External Gel (medication for pain) 1% Apply to areas of pain topically four times a day, was scheduled at 8 a.m. and was given at 11:01 a.m. (2 hours late) This medication was administered late 13 other times throughout the month.	21550		

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 04/04/2023

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
21550	Continued From page 11 -On 3/2/23, Latanoprost (medication for glaucoma) 0.005% drops ordered to be given at bedtime, scheduled for 7:00 p.m. given at 2:32 a.m. (6.5 hours late). On 3/28/23 medication was administered 10 hours late. -On 3/2/23, Cevimeline (medication for dry eyes and mouth) 30 mg ordered to be given three times a day, scheduled at 8:00 p.m. given at 2:32 a.m. (5.5 hours late) This medication was administered late 7 other times throughout the month. -On 3/17/23, Gabapentin (medication for neuropathy) 400 mg ordered to be given three times a day, scheduled for 8:00 p.m. given at 12:38 a.m. (3.5 hours late). This medication was administered late 4 other times throughout the month. R5's face sheet indicated R5 was admitted on 3/6/23, with diagnoses that included displaced fracture of left lower leg, chronic obstructive pulmonary disease (COPD), hypertension and edema. R5's admission MDS dated 3/12/23, indicated R5 was cognitively intact and had received, anticoagulants, diuretics, and opioid's on 7 of 7 days during the MDS assessment period. R5's care plan dated 3/06/23, directed staff to administer medications as ordered for cardiac diagnosis, pain and anticoagulant use. R5's medication audit report for March 2023, schedule date of 3/1/23-3/31/2, indicated R5 had the following medications administered late: -On 3/8/23, Atenolol (medication for hypertension) 50 mg tablet twice a day, scheduled for 8:00 p.m. given at 12:24 a.m. (3 hours late). This medication was administered	21550		

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 04/04/2023

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
21550	Continued From page 12 late 37 times throughout the month. -On 3/28/23, Advair Diskus Aerosol 250-50 MCG/dose (medication for COPD) ordered to be given every 12 hours, was scheduled for 8:00 p.m. and was given at 5:47 a.m. (8.5 hours). This medication was given late over 30 times throughout the month. -On 3/31/23, Enoxaparin Sodium 40 MG/ 0.4 milliliters (ml) Injection (medication for preventing blood clots) ordered to be given every 12 hours, scheduled for 8:00 p.m. given at 1:16 a.m. This medication was administered late over 31 times throughout the month. During an observation and interview on 4/3/23, at 10:14 a.m. registered nurse (RN)-A stated she was currently completing her 8:00 a.m. medication pass. RN-A indicated nurses did not have time to complete the medication reconciliation when resident discharged from the facility and pass medications timely. RN-A did not identify that medications administered late were considered medication errors. During an observation and interview on 4/3/23, at 11:09 a.m. licensed practical nurse (LPN)-C was passing medications. LPN-C stated on most days she did not get done with her 8:00 a.m. medication pass done before noon. LPN-C explained over ninety percent of her medications in the morning need vital signs taken before they can be given and the machine was not always available. Therapy also would take many residents before they would get their 8:00 meds. LPN-C stated recently she had been informed that the floor nurses would be responsible for completed resident discharge which would cause her morning med pass to be completed even later. LPN-C reported last week a resident did not get his 8:00 a.m. insulin until after 10:00 a.m. he	21550		

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 04/04/2023

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
21550	Continued From page 13 had already eaten his breakfast. At 11:30 a.m. the same resident's blood sugar level was over 300 (high blood sugar). Although LPN-C stated she had informed the physician of the resident's high blood sugar, she did not identify the late administration of other mediations as errors. During an interview on 4/3/23, at 10:56 a.m. nurse manager (NM)-A stated she had to fill two medication errors reports in the last month. NM-A stated when she worked on the medication cart passing medications last week she was done before 10:30 a.m., NM-A did not identify the medications that were administered late were considered medication errors. During an observation and interview on 4/3/23, at 11:31 a.m. RN-B was setting up 8:00 a.m. scheduled medications to be administered to a resident. RN-B stated she could usually get her medication pass done by 11 a.m., but today would be later because of a staff scheduling issue. RN-B did not identify late administration of medications were considered an errors. During an interview on 4/3/23, at 12:08 p.m. LPN-D stated if she got help from another nurse then she could be done with her 8:00 medication pass around 10:00 a.m. During an interview on 4/3/23, at 6:00 p.m. director of nursing (DON) stated medications given an more than an hour before or more than an hour after scheduled time was considered a medication error. When a medication error happened, the person who made the error would notify the DON and physician and fill out a medication error report. DON stated she had not received and/or was informed of any medication error reports related to late administration times.	21550		

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 04/04/2023

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
21550	Continued From page 14 Facility's General Dose Preparation and Medication Administration policy revised 1/1/22, indicated the facility should verify each time a medication is administered that it is the correct medication, correct dose, correct route, correct rate, correct time, correct resident as set forth in the facility's medication administration schedule. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and pharmacist or their designee, could develop and implement policies/procedures and staff training related to assurance that the medication needs of each resident are meet in a timely manner. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		