STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to complete a comprehensive assessment for self-administration of medications for 1 of 1 resident (R1) reviewed for respiratory and oxygen. Findings include: R1's face sheet dated 9/10/25, identified diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe) and asthma (a condition in which a person's airway becomes inflamed, narrows, swells, and produces mucus). R1's admission Minimum Data Set (MDS) dated [DATE] identified R1was oxygen dependent and had moderate impaired cognition. R1's care plan focus dated 8/12/25, identified R1 was at risk for respiratory impairment with a goal to not develop acute respiratory distress. Interventions were as followed: administer medications as ordered; administer oxygen as ordered; encourage deep breathing exercises; and elevate head of bed. R1's physician orders included the following:-Ventolin (inhaler used to treat or prevent bronchospasm-airway tightening) inhaler to take one puff every four hours as needed (PRN) for wheezing or shortness of breath (start date of 8/12/25). -Dulera (corticosteroid) inhaler to take two puffs twice daily for COPD (start date of 8/12/25). R1's progress note dated 8/14/25, identified R1 self-administered Dulera inhaler due it being in her pocket. R1's progress note dated 9/9/25 at 5:33 p.m., identified R1 had taken her Dulera inhaler shortly after lunch and had medication in pocket. R1's record did not include a comprehensive self-administration of medication assessment nor a physician's order for R1 to self-administering medications per facility policy. During an interview and observation on 9/9/25 at 4:52 p.m., registered nurse (RN)-A entered R1's room to administer Dulera inhaler. R1 informed RN-A that she would not take another dose, because she had already self-administered the medication earlier. RN-A then informed R1 that the dose of Dulera was scheduled and she still would need to take the dose. R1 stated to RN-A, I don't want to take it, because then I would get a double dose. R1 then removed a clear baggie out of her left pocket that contained two inhalers (Ventolin and Dulera). R1 stated she had asked her daughter to bring the inhalers from home, because in the event she becomes short of breath she needed to have quick access to her inhalers, and I do not have time to find a nurse to get them for me. R1 had informed staff she wanted to be able to continue to administer them herself, however, staff told her the inhalers need to be kept in the medication cart, so R1 stated I just keep them in my pocket then. During an interview on 9/9/25 at 5:10 p.m., RN-A stated a self-administration medication assessment needed to be completed prior to a resident to be able to keep medications at bedside and be able to self-administer such medications. RN-A stated she had been aware that R1 had the Ventolin and Dulera inhalers in her possession for at least two weeks and had been self-administering the medications herself at times, however, R1 had not had a comprehensive assessment completed to determine if she was able to self-administer the inhalers. During an interview and observation on 9/10/25 at 7:23 a.m., R1 was in her wheelchair sitting in the doorway of her room and informed RN-B she administered her Dulera inhaler and would not need to have a dose. RN-B stated she had been aware R1 had two inhalers (Ventolin and Dulera) in her pocket for the last couple of weeks and had been administering them herself, however, R1 had not had a comprehensive assessment completed to determine if she was capable to administer the medications. During an interview on 9/10/25 at 1:43 p.m., director of nursing (DON) stated R1 had not had a self-administer medication assessment completed due to her not being aware R1 had the inhalers on her person and wanted to self-administer and keep at bedside. DON stated all residents who chose to self-administer medication should have a comprehensive assessment completed to determine if they are able to administer the medications safely and appropriately, however, R1 had not had this completed. Review of the facility's Self-Administration by Resident Policy dated 1/23, identified residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team (IDT) has determined that the practice would be safe and the medications are appropriate and safe for self-administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to maintain a complete, accurate, and readily accessible medical record for 2 of 4 residents (R1, R4) reviewed for medical record accuracy. Findings include:R1's face sheet dated 9/10/25, identified diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), asthma (a condition in which a person's airway becomes inflamed, narrow, and swell, and produce mucus).R1's admission Minimum Data Set (MDS) dated [DATE], identified R1was oxygen dependent. R1's care plan focus dated 8/12/25, identified R1 was at risk for respiratory impairment with a goal to not develop acute respiratory distress. Interventions were as followed: administer medications as ordered; administer oxygen as ordered; encourage deep breathing exercises; and elevate head of bed.R1's physician orders included the following:-Oxygen continuous at 3 liters/minute (L/min) via nasal cannula (NC) (start date 8/12/25 with an end date of 9/9/25) R1's physician progress note dated 8/19/25, included order placed for oxygen at 2 L/min via NC-wean as tolerable; R1's electronic health record (EHR) did not identify the order for oxygen 2 L was transcribed into the physician's orders as directed. R1's August and September 2025 treatment administration record (TAR), identified the physician order for oxygen at 3 L via NC every shift but did not identify the order written by the physician on 8/19/25. In review of the TAR in conjunction with progress notes, it could not be ascertained how much oxygen R1 was administered; R1's TAR identified R1 received 3 L of oxygen from 8/12/25 through 9/8/25 except when documentation identified R1 refused oxygen the evening shifts of 8/26/25 and 9/7/25, and on the day shift of 9/9/25. Even though the TAR identified 3L was administered, R1's progress notes identified R1 was administered 2L of oxygen on 8/14/25; 8/19/25; 8/25/25; 8/29/25; 8/31/25; 9/1/25; and 9/7/25. R1's progress note dated 9/9/25, included a Situation Background Assessment Response (SBAR) was sent to the physician to inform them that R1 refused to wear continuous oxygen and had not used for two days and would like to change oxygen to as needed (PRN). During an interview on 9/10/25 at 10:40 a.m., registered nurse (RN)-C stated R1's TAR was not accurate. R1's TAR consistently showed that R1 was receiving 3 L of oxygen, however, R1's progress notes identified R1 was administered 2 L of oxygen at times. RN-C indicated she had written the SBAR notification to the physician pertaining to R1's oxygen usage. RN-C noted R1's record did not have documentation of refusals. RN-C had received verbal reports from nurses that R1 had been refusing her oxygen; she based the notification to the physician on verbal reports and not what was documented. During an interview on 9/10/25 at 7:43 a.m. RN-B stated he documented in R1's progress notes that 2 L of oxygen was administered, however, documented in the TAR that R1 received 3 L of oxygen. RN-B stated that this would make R1's medical record inaccurate. During an interview on 9/10/25 at 1:43 p.m., director of nursing (DON) stated R1's 8/19/25 physician order to change oxygen to 2 L per minute- wean as tolerable, was not entered into R1's medical record and the physician order for R1's oxygen remained at 3 L continuous, however, R1's progress notes identified that R1 had been getting oxygen at 2 L and the TAR was being signed since 8/12/25 that R1 was getting 3 L of oxygen. DON stated R1's record was inaccurate due to conflicting information regarding oxygen use. R4's face sheet dated 9/11/25, identified diagnoses of chronic kidney disease, cellulitis of left toe, diabetes, and heart failure. R4's Significant Change Minimum Data Set (MDS) dated [DATE], identified R4 received dialysis and was taking an antibiotic. R4's hospital after visit summary (AVS) dated 8/27/25, included a physician order for Augmentin (antibiotic) 500 milligram (mg)-125 mg take one tablet by mouth two times per day for 28 doses. R4's electronic health record (EHR) physician orders identified an order entered into the system as a verbal order dated 8/28/25 for Augmentin 500 mg-125 mg give one tablet twice daily for 28 administrations with a start date of 8/28/25. The order was updated on 8/29/25 to identify a stop date of 8/29/25. There was no further information regarding the stop date of the order. In review of R4's record which included but was not limited to progress notes, physician's orders, and documents electronically scanned into the MISC tab of the facility's EHR system there was no corresponding written order and/or physician note that addressed the discontinuation of the antibiotic that was on the hospital AVS dated 8/27/25. During an interview on 9/10/25 at 5:30 p.m. RN-D reviewed R4's facility electronic records and was unable to find a physician order and/or visit note that addressed the discontinuation of the Augmentin on 8/29/25 and indicted she did not know where it would be or came from. During an interview on 9/10/25 at 9:06 a.m. health unit coordinator (HUC) stated she had access to the outside medical records but was not aware of the process on who was responsible for pulling