

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Rochester Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, document review the facility failed to ensure the physician was notified of a change in pressure ulcer status for 2 of 3 residents (R2, R3) reviewed for pressure ulcers who had pressures ulcers that deteriorated. Findings include R2's Face Sheet printed 7/16/26, identified R2 had diagnoses of diabetes, chronic kidney disease (gradual loss of kidney function), peripheral vascular disease (poor blood circulation), muscle weakness, difficulty in walking, bladder disorder (problems controlling the bladder), and retention of urine (trouble emptying the bladder completely).R2's after visit summary (AVS) dated 3/12/26, identified R2 was hospitalized from [DATE] to 3/12/26 with admitting diagnosis of bradycardia. AVS identified that R2 had blanchable redness to coccyx.R2's admission minimum data set (MDS) dated [DATE], identified R2's cognition was intact and R2 was at risk for pressure ulcers and did not identify any current pressure ulcers.R2's Situation, Background, Assessment, and Recommendation (SBAR) note dated 4/26/26 at 2:26 p.m. identified R2 had a stage 2 pressure ulcer on the coccyx and a stage 1 non-blanchable erythema on the buttocks area, with staff applying zinc oxide (a thick skin-protecting ointment typically used to shield raw or irritated skin from moisture and incontinence) and a sacral Mepilex dressing (a padded, absorbent foam bandage designed to protect wounds and cushion pressure points).R2's MD progress note dated 5/4/26, identified R2 was readmitted to the facility following a hospitalization from 4/27/26 to 5/4/26. The progress note further identified R2 had a Stage 2 sacral pressure injury and contact irritant dermatitis (a skin rash caused by direct contact with an irritating substance, such as urine or feces).R2's Weekly Wound Observation dated 5/4/26, identified R2 had a Stage 2 pressure ulcer to the coccyx measuring 3.0 centimeters (cm) x 2.5 cm x 0.1 cm, with a scant amount of serous drainage, no wound odor, and no signs of infection. The wound observation further identified the wound bed had granulation tissue present, which is a deeper tissue type that cannot be present in a partial-thickness Stage 2 pressure ulcer. A Stage 2 pressure ulcer only involves the top layers of skin and requires new skin cells, called epithelial tissue, to heal.R2's Weekly Wound Observation dated 5/12/26, identified a Stage 2 pressure ulcer to the coccyx measuring 6.0 cm x 4.0 cm x 0.1 cm, with a scant amount of serous drainage, no wound odor, and no signs of infection or inflammation. The observation further identified necrotic tissue was present in the wound bed, and the overall impression was unchanged since 5/4/26. Additionally, the observation identified the physician was last notified on 5/4/26.R2's Weekly Wound Observation dated 5/19/26 identified a Stage 2 pressure ulcer to the coccyx measuring 8.0 cm x 6.0 cm x 0.1 cm, with no drainage, no wound odor, and a date acquired of 5/4/26. The observation further identified the wound bed had necrotic tissue present with irregular edges. Additionally, the observation identified the physician was last updated on 5/4/26. However, the observation lacked written documentation identifying that the (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider was notified of the continued wound expansion and tissue decline since 5/12/26. During an interview on 7/16/26 at 1:35 p.m., the newly assigned Wound Nurse, Registered Nurse (RN)-C, reviewed R2's clinical record and verified that the provider was not notified when the pressure ulcer worsened and stated that the provider should be notified when pressure ulcers worsen so they can decide if a new treatment should be put in place. During an interview on 7/16/26 at 1:02 p.m., the Director of Nursing (DON) stated that upon identification of a pressure ulcer, a comprehensive wound assessment must be completed immediately to include location, staging, wound dimensions, and a wound bed description tracking tissue type, exudate, odor, signs/symptoms of infection, peri wound, edge characteristics and the provider should be notified for a treatment order. The DON clarified that these assessments must be completed at least weekly and the provider should have been notified immediately after each significant change in the wound to ensure appropriate treatment. Upon review of R2's record, the DON confirmed that the pressure ulcer had worsened on 5/12/26 and 5/19/26, but the provider was not notified of these changes, and no new treatment orders were put in place. During an interview on 7/16/26 at 3:00 p.m., the Medical Director stated that when a resident's pressure ulcer increased in size and develops necrotic tissue, nursing staff must notify the provider. Upon review of the sequence of events regarding R2's sacral pressure ulcer, including the wound increasing in size with documented necrotic tissue on 5/12/26 and 5/19/26 while continuing to be incorrectly documented as a Stage 2 pressure ulcer, the Medical Director confirmed that a provider should have been notified on those dates so the treatment plan could be reevaluated. R3's Face sheet printed 7/16/26, identified diagnoses of T11-T12 fracture (a broken bone in the upper back), spinal stenosis of the lumbar region (narrowing of the lower spinal canal that causes nerve pain and numbness), diabetes, severe protein-calorie malnutrition (a severe lack of nutrients needed to maintain healthy skin tissue), muscle weakness, difficulty walking, lack of coordination, unsteadiness on feet, nutritional anemia (a lack of healthy red blood cells needed to carry oxygen to tissues), and a disorder of the bladder (problems controlling the bladder). R3's quarterly MDS dated [DATE], identified R3 had severe cognitive impairment and no current skin concerns. R3's weekly skin assessments dated 5/4/26, 5/11/26, 5/18/26, 5/28/26, 6/22/26, and 6/29/26, identified no skin issues were noted. R3's skin/wound progress note dated 7/4/26, identified an open wound on R3's coccyx during routine care. The progress note further identified the wound bed was open with no drainage, the surrounding skin was intact, and no wound odor was present. Additionally, the progress note identified the area was cleansed, zinc oxide (a thick white cream used to protect skin from moisture and friction) was applied, and the provider was notified and wound orders were requested. R3's Situation Background Assessment Response (SBAR) note dated 7/4/26, identified a newly noted, undocumented wound on R3's coccyx with a width of 0.1 cm and a depth of 0.2 cm. The SBAR note further identified the facility failed to record a length measurement, leaving the template placeholder blank. The SBAR note further identified that the facility failed to fill out the remaining clinical details on the form, leaving template placeholders blank for the appearance of the wound bed, the type of drainage, and the condition of the surrounding skin. Review of R3's clinical record identified the facility failed to accurately assess, monitor, and communicate significant changes in R3's skin condition to the physician. Specifically, the record identified that when reporting a newly discovered pressure ulcer on 7/4/26, staff transmitted an incomplete template to the physician that completely lacked the wound's length, color description, and drainage type. R3's nurse practitioner (NP) progress note dated 7/10/26, identified R3 was seen for a change in mental status, was seated in a wheelchair, and had documented histories of a spinal fracture and malnutrition. The progress note failed to identify any skin concerns and lacked any documentation indicating the provider was notified of R3's newly (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discovered coccyx pressure ulcer. Review of R3's clinical record identified the facility failed to accurately monitor, evaluate, and communicate significant changes in R3's skin condition to medical providers. Specifically, the record identified that during an advanced clinical visit on 7/10/26, the nurse practitioner documented no skin concerns were present, despite a separate facility wound alert being generated six days prior on 7/4/26. During an interview on 7/14/26 at 11:41 a.m., Trained Medication Assistant (TMA)-A stated that R3 had a small, open area on his coccyx that was identified a couple of weeks prior, which had not progressed or improved. TMA-A stated that she notified the nurse right away when it was discovered and assumed staff were still applying zinc oxide because R3 did not have a dressing on his wound when she assisted him out of bed that morning. TMA-A described the open area as a stage 2 wound about the size of a pea with a pink wound bed and no visible drainage. During an interview on 7/15/26 at 11:47 a.m., RN-A stated he was completely unaware that R3 had a pressure ulcer on his coccyx until reviewing the 7/4/26, electronic progress notes with the surveyor during the interview. RN-A confirmed there were no active medical treatment orders. During an interview on 7/15/26 at 12:13 p.m., Nurse Manager (NM)-A stated that a small wound was documented on R3's coccyx on 7/4/26 but assumed it had healed despite a complete lack of follow-up documentation. NM-A verified that an SBAR alert was transmitted on 7/4/26 but confirmed there was no recorded provider response or subsequent clinical monitoring. During an interview on 7/15/26 at 3:24 p.m., Registered Nurse (RN)-C, the wound nurse, stated that upon identification of a new pressure injury, a nurse must complete a comprehensive weekly wound assessment-including measurements, wound bed description, drainage, surrounding skin condition, localized pain, and signs of infection. RN-C specified that these findings must be transmitted to the physician via an SBAR alert to secure initial treatment orders, the weekly wound observation tool must be initiated, and the resident must be placed on the weekly wound provider tracking list for evaluation. Upon review of R3's record, RN-C confirmed that R3 was never placed on the facility's wound provider rounding list and verified she was completely unaware that R3 had any active skin concerns. During a clinical observation on 7/15/26 at 3:48 p.m., The surveyor observed RN-C (the wound nurse) perform a skin inspection on R3. Examination of R3's backside revealed two distinct pressure ulcers. The first wound, located on the coccyx, measured 1.0 cm by 0.8 cm with a wound bed covered in necrotic gray slough; RN-C verified that this pressure ulcer was unstageable due to the inability to visualize the wound base. The second wound, located on the right buttock, was a Stage 2 pressure ulcer measuring 0.9 cm long, 0.7 cm wide, and 0.2 cm deep with a red, beefy wound bed and dark surrounding skin. During an interview on 7/15/26 at 4:14 p.m., the Director of Nursing (DON) verified that R3 had an unstageable pressure ulcer and a Stage 2 pressure ulcer with no comprehensive assessments or clinical treatment orders in place. The DON acknowledged that an open area was identified on R3's bottom on 7/4/26 but confirmed that the assessment was not comprehensive and that the facility failed to secure a response or treatment orders from the provider after transmitting the SBAR alert. During an interview on 7/16/26 at 3:12 p.m., the Medical Director reviewed the sequence of events regarding R3's pressure ulcers and stated that upon identifying the coccyx wound on 7/4/26, nursing staff should have immediately notified the provider so treatment orders could be put in place. The Medical Director noted he could not definitively interpret why subsequent weekly skin assessments on 7/6/26 and 7/13/26 documented no skin concerns when there was no documentation that the initial wound had resolved and R3 was subsequently found to have a Stage 2 and an unstageable pressure ulcer on 7/15/26.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively assess, monitor, evaluate, and implement individualized interventions to prevent and treat pressure ulcers, including timely physician notification following significant changes in wound condition, for 2 of 3 residents (R2 and R3) reviewed for pressure ulcers. Findings include: R2's Face Sheet printed 7/16/26, identified R2 had diagnoses of diabetes, chronic kidney disease (gradual loss of kidney function), peripheral vascular disease (poor blood circulation), muscle weakness, difficulty in walking, bladder disorder (problems controlling the bladder), and retention of urine (trouble emptying the bladder completely). R2's after visit summary (AVS) dated 3/12/26, identified R2 was hospitalized from [DATE] to 3/12/26 with admitting diagnosis of bradycardia. AVS identified that R2 had blanchable redness to coccyx. R2's Braden Scale dated 3/15/26, identified a score of 17, which indicated R2 was at risk for pressure ulcers. The assessment further identified R2 had slightly limited sensory perception, was chairfast with a severely limited ability to walk, had slightly limited body mobility, and had a potential problem with friction and shear. R2's admission minimum data set (MDS) dated [DATE], identified R2's cognition was intact, did not walk, used a wheelchair for mobility, and required partial to moderate assistance with toileting hygiene, lower body dressing, and experienced occasional bowel and bladder incontinence. The MDS further identified R2 was at risk for pressure ulcers and did not identify any current pressure ulcers. Finally, the MDS identified no skin treatments were implemented for prevention, including a pressure-reducing device for the chair or bed, and no turning and repositioning program was noted. R2's care area assessment (CAA) dated 3/18/26, identified R2 was at risk for developing pressure ulcers. The CAA further identified contributing factors included incontinence and a need for touching assistance or supervision with bed mobility, such as rolling and sitting up. To minimize these risks, the CAA identified that staff would check R2's skin weekly, monitor food and fluid intake, and assist R2 with repositioning at least every two hours. R2's care plan initiated 3/17/26, identified a focus alteration in skin integrity related to readmit on 5/4 with stage 2 pressure area to coccyx/sacral area. The care plan identified interventions dated 3/17/26, included barrier cream to peri area/buttocks as needed, encourage to reposition as needed; use assistive devices as needed, observe skin condition with ADL care daily; report abnormalities, pressure redistributing device on bed/chair, mattress on bed and cushion in wheelchair (w/c), provide preventative skin care routinely and PRN (as needed), and use pillows/positioning devices as needed. R2's admission medical doctor (MD) progress note dated 3/19/26, identified R2 was admitted for rehabilitation following a fall at home, had a history of poor food intake, and had diagnoses of diabetes, nerve damage, kidney disease, anemia, and a history of chronic lower extremity wounds. R2's Braden Scale dated 3/22/26, identified a score of 19, which indicated R2 was not at risk for pressure ulcers. R2's Braden Scale dated 3/29/26, identified a score of 14, which indicated R2 was at moderate risk for pressure ulcers. R2's NAR Bath Day Worksheet/Skin Update, dated 4/5/26, identified R2 received a shower and had no identified skin concerns. R2's hospital After Visit Summary (AVS) dated 4/23/26, identified R2 was hospitalized from [DATE] to 4/23/26 for cervical myelopathy (spinal cord compression), a bladder mass, pneumonia, hypoalbuminemia (low protein levels), and weakness. The AVS further identified that R2 underwent emergent neck surgery on 4/17/26, resulting in persistent quadriparesis (weakness in all four limbs) with no movement in the legs or left arm. Additionally, the AVS identified R2 required total assistance for all mobility, required an indwelling urinary catheter, and required specialized therapy for positioning and skin protection. R2's Braden (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Scale dated 4/24/26, identified a score of 11, which indicated R2 was at high risk for pressure ulcers. The assessment further identified R2 had completely limited sensory perception, skin was occasionally moist, and R2 was chairfast and completely immobile. Additionally, the assessment identified R2's nutrition was probably inadequate, and a potential problem with friction and shear existed. R2's Braden Scale dated 4/26/26, identified a score of 13, which indicated R2 was at moderate risk for pressure ulcers. R2's NAR Bath Day Worksheet/Skin Update dated 4/26/26, identified R2 received a shower and next to skin concerns the word, yes, was circled. The document further identified a picture of the backside of a body was present below this and the coccyx area was circled but did not identify any written documentation of what the skin concern was. R2's Situation, Background, Assessment, and Recommendation (SBAR) note dated 4/26/26 at 2:26 p.m. identified R2 had a stage 2 pressure ulcer on the coccyx and a stage 1 non-blanchable erythema on the buttocks area, with staff applying zinc oxide (a thick skin-protecting ointment typically used to shield raw or irritated skin from moisture and incontinence) and a sacral Mepilex dressing (a padded, absorbent foam bandage designed to protect wounds and cushion pressure points). However, the note lacked any written documentation regarding the specific measurements of the pressure ulcers, a description of the wound beds, or the presence of any drainage. R2's SBAR note dated 4/27/26 at 8:56 a.m. identified R2 had spinal myelopathy with cervical fusion, quadriplegia deficits, was short of breath, and had bilateral limb edema, resulting in a referral to the emergency department. However, the note lacked any written documentation regarding skin assessment, wound measurements, or the condition of the previously identified coccyx and buttocks pressure ulcers prior to transfer. Review of R2's clinical record identified the facility failed to thoroughly evaluate, follow up, and implement appropriate interventions for an identified skin concern. Specifically, a skin concern on R2's coccyx was noted during a shower on 4/26/26, but the facility failed to document any descriptive details regarding the condition of the skin or complete a comprehensive wound assessment. The record further identified that staff applied zinc oxide and a sacral Mepilex dressing to the area but lacked any written documentation identifying a physician's order was obtained for these specific wound treatments or that a professional wound evaluation was performed prior to the resident's transfer. R2's hospital Certified Wound Care Nurse (CWCN) progress note dated 4/28/26, identified R2 had a Stage 2 sacral pressure injury with partial-thickness pink and yellow tissue in the wound bed. The progress note further identified ordered wound treatments included twice-daily cleansing with Vashe wound cleanser (a gentle liquid solution used to wash away bacteria, clean out wounds, and remove dead tissue), applying an acetic acid cloth (a cloth soaked in a mild acid solution used to stop dangerous bacteria from growing) for two hours twice daily, applying PluroGel wound gel (a specialized gel that keeps the wound moist and helps soften and remove dead tissue), and covering the area with a Mepilex border foam dressing. Additionally, required interventions included offloading heels on pillows at all times, full 30-degree turns side-to-side every two hours while in bed, repositioning every hour while in a chair, keeping the head of the bed below 30 degrees, and using breathable incontinence underpads instead of adult briefs while in bed. R2's medical doctor (MD) progress note dated 4/30/26, identified R2 was hospitalized due to complications from spinal cord surgery, severe muscle weakness, and poor food intake. The MD note further identified R2 had persistent quadriplegia (total paralysis of all four limbs) with zero movement in the lower legs, required full assistance for all mobility, required an indwelling urinary catheter, had swallowing problems requiring a modified diet, and suffered from malnutrition. R2's hospital After Visit Summary (AVS) dated 5/4/26, identified R2 was hospitalized from [DATE] to 5/4/26 for severe hyponatremia. The AVS further identified that on 4/28/26, a Stage 2 pressure injury to the sacrum was identified (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was omitted or what alternative interventions were implemented to protect the resident's skin.R2's progress note dated 5/6/26 at 10:19 p.m., identified an administration note for an active wound treatment order was not completed. However, the note lacked any written documentation explaining the clinical reason why the ordered treatment was omitted or what alternative interventions were implemented to protect the resident's skin.Review of R2's clinical record identified the facility failed to implement ordered individualized interventions to treat R2's pressure ulcer. Specifically, the record identified that out of four scheduled wound treatments on 5/5/26 and 5/6/26, the facility failed to complete three of them, resulting in two documented omissions and one completely blank entry.R2's Verbal Physician's Order dated 5/6/26, identified an order for a health shake twice daily for nutritional support and wound healing.R2's Verbal Physician's Order dated 5/8/26, identified an active order for an alternating air mattress to assist with wound healing and comfort, requiring staff to check mattress function and settings every shift.R2's Weekly Wound Observation dated 5/12/26, identified a Stage 2 pressure ulcer to the coccyx measuring 6.0 cm x 4.0 cm x 0.1 cm, with a scant amount of serous drainage, no wound odor, and no signs of infection or inflammation. The observation further identified necrotic tissue was present in the wound bed, and the overall impression was unchanged since 5/4/26. Additionally, the observation identified the physician was last notified on 5/4/26. However, the observation lacked accurate clinical staging by continuing to classify a wound with necrotic tissue as a Stage 2 pressure ulcer, and lacked any written documentation identifying the specific percentage of dead tissue present or that the provider was notified that the wound had doubled in size.Review of R2's clinical record identified the facility failed to accurately monitor, evaluate, and notify the physician of a significant change in the resident's skin condition. Specifically, the record identified R2's pressure ulcer doubled in size and developed dead tissue between 5/4/26 and 5/12/26, but the facility failed to notify the physician of this decline. Additionally, the record identified the facility failed to accurately track and stage the wound by documenting granulation and necrotic tissue within a Stage 2 classification, as a Stage 2 pressure injury is defined as partial-thickness skin loss that does not contain necrotic or granulation tissue, and failed to identify the percentage of dead tissue present.R2's Physician Assistant (PA) progress note dated 5/15/26 identified R2 was seen for a declining functional status, was bedridden, was unable to verbalize needs, had a decreased appetite, and experienced pain during repositioning. The note further identified that R2 was dependent on staff for turning every two hours, and repeated active orders to cleanse the sacrum and buttocks with Vashe, apply an acetic acid damp cloth, apply PluroGel wound gel, and cover with a Mepilex dressing. However, the note lacked any written documentation identifying that the provider physically assessed the condition of the pressure ulcer, evaluated the clinical efficacy of the current treatment plan, or addressed the significant wound expansion and tissue decline.R2's Braden Scale dated 5/17/26, identified a score of 13, which indicated R2 was at moderate risk for pressure ulcers.R2's Weekly Wound Observation dated 5/19/26 identified a Stage 2 pressure ulcer to the coccyx measuring 8.0 cm x 6.0 cm x 0.1 cm, with no drainage, no wound odor, and a date acquired of 5/4/26. The observation further identified the wound bed had necrotic tissue present with irregular edges, and the surrounding peri-wound area was pink and natural. Additionally, the observation identified the physician was last updated on 5/4/26. However, the observation lacked accurate staging by continuing to classify a wound with necrotic tissue as a Stage 2 pressure ulcer and lacked any written documentation identifying the specific percentage of necrotic tissue present or that the provider was notified of the continued wound expansion and tissue decline since 5/12/26.R2's progress note dated 5/24/26 at 10:34 a.m., identified R2 was sent to the emergency department (ED).R2's incident progress note dated 5/24/26 at 12:55 p.m., identified the night shift (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rochester Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported R2 was short of breath throughout the night, receiving medications and a rescue nebulizer treatment. The note further identified that at the start of the day shift, R2 was yelling for help, demanding a doctor, and exhibiting increased breathing effort. Additionally, the note identified that staff placed R2 on 2 liters of oxygen and transferred R2 to the ED via ambulance. R2's AVS dated 5/28/26, identified R2 was hospitalized from [DATE] to 5/28/26 for sepsis. The AVS further identified R2's sacral pressure injury was unstageable wound with necrotic eschar and surrounding erythema. The AVS additionally identified that trauma surgery and wound care teams evaluated the wound and recommended twice daily Vashe dressings and a specialty mattress, but bedside debridement (removal of dead tissue) was stopped because R2 declined due to pain. The AVS also identified R2 had severe quadriparesis, remained bedbound with total dependence for daily activities, had moderate malnutrition, and was discharged back to the facility with a referral for hospice services. During an interview on 7/16/26 at 3:00 p.m., the Medical Director stated that when a resident's pressure ulcer increased in size and develops necrotic tissue, nursing staff must notify the provider. Upon review of the sequence of events regarding R2's sacral pressure ulcer, including the wound increasing in size with documented necrotic tissue on 5/12/26 and 5/19/26 while continuing to be incorrectly documented as a Stage 2 pressure ulcer, the Medical Director confirmed that a provider should have been notified on those dates so the treatment plan could be reevaluated. R2's Weekly Wound Observation dated 5/28/26, identified a Stage 2 pressure ulcer to the coccyx and sacrum measuring 8.0 cm x 7.5 cm x 0.1 cm, with no drainage, no wound odor, and a date acquired of 4/28/26. The observation further identified the wound bed had 100% necrotic tissue present with edges flush with the peri wound. R2's peri wound had erythema (redness), inflammation, and induration (hardness) present. Additionally, the observation identified the physician was last updated on 5/28/26, and the current treatment plan included cleansing the area, applying PluroGel to the wound bed, and covering it with a sacral Mepilex dressing changed daily and as needed. Review of R2's clinical record identified the facility failed to accurately monitor, evaluate, and correctly stage R2's worsening skin condition. Specifically, the record identified R2's pressure ulcer rapidly expanded from 3.0 cm x 2.5 cm on 5/4/26, to 6.0 cm x 4.0 cm on 5/12/26, to 8.0 cm x 6.0 cm on 5/19/26, and to 8.0 cm x 7.5 cm by 5/28/26. Additionally, the record identified the facility failed to accurately track and stage the wound by continuing to classify it as a Stage 2 pressure ulcer, despite explicitly identifying that the wound bed was covered in necrotic tissue. Furthermore, the record identified the facility failed to notify the physician of any changes in the wound condition between 5/5/26 and 5/28/26 and failed to implement any new treatment orders during this period of decline. R2's Braden Scale dated 5/30/26, identified a score of 14, which indicated R2 was at moderate risk for pressure ulcers. During an interview on 7/16/26 at 1:35 p.m., the newly assigned Wound Nurse, Registered Nurse (RN)-C, reviewed R2's clinical record and stated that the initial 4/26/26 progress note identified a stage 2 pressure ulcer to the coccyx and a stage 1 non-blanchable ulcer on the buttocks but contained no measurements. RN-C stated that the 5/5/26 assessment did not identify the amount of epithelial tissue in the wound bed. Regarding the 5/12/26 assessment, RN-C stated the wound was staged wrong, it got bigger and necrotic, it failed to identify the percentage of necrosis, and it would be unstageable. RN-C stated that the 5/19/26 assessment said the wound was unchanged, but it got bigger and would still be unstageable. RN-C further stated that the 5/28/26 assessment still listed the wound as a stage 2 despite documenting 100% necrosis. Finally, RN-C verified through the medical record that the provider was not notified when the pressure ulcer worsened and stated that the provider should be notified when pressure ulcers worsen so they can decide if a new treatment should be put in place. During a telephone interview on 7/16/26 at 5:16 p.m., RN-B, the former nurse manager, (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that during the assessment on 5/12/26, patchy necrotic tissue and eschar formation were present on R2's pressure ulcer, meaning the wound was almost unstageable. RN-B acknowledged that the wound should have been documented as unstageable, that she missed it, and that if she didn't document that the provider was not notified it was not done. RN-B further stated that the assessment on 5/19/26 should have also been designated as unstageable, and that she should have documented the percentage of necrotic tissue and notified the provider. RN-B concluded that regardless of her belief that it was a Kennedy terminal ulcer, she still should have comprehensively assessed the pressure ulcer, added R2 to the facility's wound rounds, and notified the doctor to determine if the treatment order required modification. During an interview on 7/16/26 at 1:02 p.m., the Director of Nursing (DON) stated that upon identification of a pressure ulcer, a comprehensive wound assessment must be completed immediately to include location, staging, wound dimensions, and a wound bed description tracking tissue type, exudate, odor, signs/symptoms of infection, peri wound, edge characteristics and the provider should be notified for a treatment order. The DON clarified that these assessments must be completed at least weekly and the provider should have been notified immediately after each significant change in the wound to ensure appropriate treatment. Upon review of R2's record, the DON confirmed that the pressure ulcer had worsened on 5/12/26 and 5/19/26, but the provider was not notified of these changes, and no new treatment orders were put in place. The DON verified that the assessments should have been more comprehensive and that the pressure ulcer was staged incorrectly. The DON stated that because necrotic tissue was present, the wound should have been identified as unstageable rather than Stage 2, and the provider should have been notified immediately to determine if a new treatment order was required after each time the pressure ulcer worsened. R3's Face sheet printed 7/16/26, identified diagnoses of T11-T12 fracture (a broken bone in the upper back), spinal stenosis of the lumbar region (narrowing of the lower spinal canal that causes nerve pain and numbness), diabetes, severe protein-calorie malnutrition (a severe lack of nutrients needed to maintain healthy skin tissue), muscle weakness, difficulty walking, lack of coordination, unsteadiness on feet, nutritional anemia (a lack of healthy red blood cells needed to carry oxygen to tissues), and a disorder of the bladder (problems controlling the bladder). R3's care plan dated 2/13/26, identified a focus at risk for alteration in skin integrity related to diabetes, nutritional deficit-malnutrition, spinal stenosis of lumbar area with neurogenic claudication, fracture T11-12-TLSO brace (a rigid plastic back brace used to support the spine) on for comfort, B&B incontinence, and decline in ADL and mobility status. The care plan identified interventions dated 2/13/26, included barrier cream to peri area/buttocks as needed, use pillows/positioning devices as needed, encourage fluids, float heels as able, monitor skin under (braces-TLSO) for breakdown, observe skin condition with ADL care daily; report abnormalities, obtain labs as ordered and notify MD of results, pressure redistributing device on bed/chair, pressure relieving mattress on bed and cushion in w/c, and provide preventative skin care routinely and PRN. R3's CAA dated 2/18/26, identified R3 was at risk for pressure ulcers due to potential skin breakdown, mobility impairments, and incontinence. The CAA further identified R3 required partial to moderate assistance with rolling left to right, moving from sitting to lying, and moving from lying to sitting on the side of the bed. Additionally, the CAA identified intrinsic risk factors included altered mental status, cognitive loss, poor nutrition, the use of antidepressants, and status as a new admission. Review of R3's Braden Scale dated 4/21/26, identified a score of 14, indicating a moderate risk for pressure ulcers. The assessment identified R3 was chairfast with very limited mobility, making only occasional slight changes in body position independently. The assessment further identified R3's nutrition was very poor, and a problem with friction and shear existed because R3 required moderate to maximum (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance to move and frequently slid down in the bed or chair.R3's quarterly MDS dated [DATE], identified R3 had severe cognitive impairment, did not walk, and required substantial to maximal assistance to roll from side to side. The MDS identified R3 was dependent on staff for transfers and repositioning, was occasionally incontinent of bladder, and was at risk for pressure ulcers. The assessment further identified no current skin concerns, but noted that no preventative skin treatments were implemented, including a pressure-reducing device for the chair or bed, and no turning and repositioning program.R3's weekly Braden Scale assessments dated 4/27/26, 5/4/26, and 5/11/26, identified scores of 16, 16, and 17, respectively, which indicated R3 continuously remained at risk for the development of pressure ulcers.R3's weekly skin assessments dated 5/4/26, 5/11/26, 5/18/26, 5/28/26, 6/22/26, and 6/29/26, identified no skin issues were noted, and no preventative measures were in place.R3's NAR Bath Day Worksheet/Skin Update, dated 6/29/26, identified R3 received a shower and had no identified skin concerns.Review of R3's clinical record identified the facility failed to implement individualized interventions to prevent pressure ulcers. Specifically, the record identified that during six consecutive weekly skin assessments between May and June, the facility repeatedly identified R3 had no preventative measures in place, despite separate facility assessments identifying R3 was completely dependent for mobility, chairfast, and severely malnourished.R3's skin/wound progress note dated 7/4/26, identified an open wound on R3's coccyx during routine care. The progress note further identified the wound bed was open with no drainage, the surrounding skin was intact, and no wound odor was present. Additionally, the progress note identified the area was cleansed, zinc oxide (a thick white cream used to protect skin from moisture and friction) was applied, and the provider was notified and wound orders were requested.R3's Situation Background Assessment Response (SBAR) note dated 7/4/26, identified a newly noted, undocumented wound on R3's coccyx with a width of 0.1 cm and a depth of 0.2 cm. The SBAR note further identified the facility failed to record a length measurement, leaving the template placeholder blank. The SBAR note further identified that the facility failed to fill out the remaining clinical details on the form, leaving template placeholders blank for the appearance of the wound bed, the type of drainage, and the condition of the surrounding skin.Review of R3's clinical record identified the facility failed to accurately assess, monitor, and communicate significant changes in R3's skin condition to the physician. Specifically, the record identified that when reporting a newly discovered pressure ulcer on 7/4/26, staff transmitted an incomplete template to the physician that completely lacked the wound's length, color description, and drainage type.R3's NAR Bath Day Worksheet/Skin Update, dated 7/6/26, identified R3 received a shower and had no identified skin concerns.R3's nurse practitioner (NP) progress note dated 7/10/26, identified R3 was seen for a change in mental status, was seated in a wheelchair, and had documented histories of a spinal fracture and malnutrition. The progress note failed to identify any skin concerns and lacked any documentation indicating the provider was notified of R3's newly discovered coccyx pressure ulcer.Review of R3's clinical record identified the facility failed to accurately monitor, evaluate, and communicate significant changes in R3's skin condition to medical providers. Specifically, the record identified that during an advanced clinical visit on 7/10/26, the nurse practitioner documented no skin concerns were present, despite a separate facility wound alert being generated six days prior on 7/4/26, because the facility failed to inform the nurse practitioner of the pressure ulcer or ensure R3's backside was physically inspected.R3's NAR Bath Day Worksheet/Skin Update, dated 7/13/26, identified R3 received a shower and had no identified skin concerns.During an interview on 7/14/26 at 11:41 a.m., Trained Medication Assistant (TMA)-A stated that R3 had a small, open area on his coccyx that was identified a couple of weeks prior, which had not progressed or improved. TMA-A stated that (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she notified the nurse right away when it was discovered and assumed staff were still applying zinc oxide because R3 did not have a dressing on his wound when she assisted him out of bed that morning. TMA-A described the open area as a stage 2 wound about the size of a pea with a pink wound bed and no visible drainage. TMA-A further identified that R3 was bladder incontinent and was at a high risk for pressure ulcers due to his advanced age and low body weight. During an interview on 7/14/26 at 11:50 a.m., Licensed Practical Nurse (LPN)-A stated that she did not think anyone on the 2 [NAME] unit had any pressure ulcers and noted that the wound provider was at the facility that day and had already changed all resident dressings. During an observation on 7/15/26 at 11:41 a.m., R3 was seated in a wheelchair in his room with a wheelchair cushion in place. When interviewed, R3 stated that his bottom was a little sore, and he was unsure if he had a sore on his bottom or not. R3 was cognitively unable to answer whether facility staff assisted him to get up or repositioned him to relieve pressure off his bottom. During an interview on 7/15/26 at 11:46 a.m., Nursing Assistant (NA)-B stated that she assisted R3 out of bed that morning and did not notice any skin concerns. During an interview on 7/15/26 at 11:47 a.m., RN-A stated he was completely unaware that R3 had a pressure ulcer on his coccyx until reviewing the 7/4/26, electronic progress notes with the surveyor during the interview. RN-A confirmed there were no active medical treatment orders in place for R3's pressure ulcer and that his skin care plan lacked any repositioning program to offload pressure from his bottom. RN-A further stated that the nursing assistant who assisted R3 out of bed that morning failed to notify him of any skin concerns. RN-A verified that R3 was at high risk for pressure ulcers because he was fr		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement individualized fall prevention interventions for 1 of 3 residents (R1) reviewed for accidents. Findings include R1's face sheet, printed 7/15/26, identified diagnoses of dementia, progressive supranuclear ophthalmoplegia (a progressive brain disorder that affects balance, walking, eye movements, thinking, and safety awareness), polyneuropathy (nerve damage that can cause weakness, numbness, and poor balance), other abnormalities of gait and mobility (difficulty walking and moving safely), and stress incontinence (loss of urine with movement or activity). R1's Significant Change Minimum Data Set (MDS), dated [DATE], identified R1 had moderate cognitive impairment, spoke Mandarin as the preferred language, and required an interpreter to communicate with health care staff. The MDS further identified R1 required partial to moderate assistance with transfers and toileting and was always continent of urine. R1's Falls Care Area Assessment (CAA), dated 2/16/26, identified R1 was at risk for falls related to cognitive impairment, impaired functional abilities requiring assistance with transfers and toileting, and visual impairment. The Falls CAA identified the care plan would address interventions to minimize falls and injuries while maintaining R1's functional status. R1's Incident Report, dated 5/7/26 at 7:40 p.m., identified a witnessed fall occurred while a certified nursing assistant (CNA) was transferring R1 from the toilet to the recliner. During the transfer, R1 lost balance and tipped to the right side, landing in a sitting position on the floor. No injuries were identified. The report identified gait imbalance as a predisposing physiological factor and the transfer as a predisposing situational factor. R1's Situation, Background, Assessment, and Recommendation (SBAR) note, dated 5/7/26 at 11:15 p.m., identified R1 experienced a witnessed fall while a CNA was transferring R1 from the toilet to a recliner. During the transfer, R1 lost her balance and tipped onto her right side. No injuries were identified. The recommendation following the fall was to change R1's transfer status to two-person assistance. R1's social services note, dated 5/8/26, at 8:38 a.m., identified Family Member (FM)-A emailed with concerns regarding R1's fall and requested two staff assist with transfers. The concerns were forwarded to the unit manager and Director of Nursing (DON). R1's Interdisciplinary Team (IDT) Clinical Review, dated 5/8/26, at 9:30 a.m., identified the reason for review was R1's fall on 5/7/26. The review identified R1 tipped to the side while being assisted by one CNA. The care plan review identified R1's transfer status would be changed to assist of two due to increased weakness and impaired balance. R1's Fall Risk Observation/Assessment, dated 5/10/26, identified R1 had a fall risk score of 30 and was categorized as high risk for falls. The assessment identified a history of falls, unsteady balance, age [AGE] years or older, ambulation with problems using an assistive device, cognitive and behavioral symptoms, multiple health conditions/risk factors, and medications associated with fall risk. R1's care plan, dated 10/21/25, identified R1 was at risk for falls due to degenerative osteoarthritis, spine and knee pain, neuropathy, cognitive impairment, progressive supranuclear palsy, and impulsivity. An intervention, revised 11/26/25, required staff to use a gait belt during transfers and maintain hold of the gait belt throughout the transfer due to R1's poor gait pattern. An intervention, revised 5/8/26, required two-person assistance for functional transfers and short-distance mobility using a gait belt and front-wheeled walker (FWW). Facility document, 2E report sheet, last updated 7/13/26. Identified R1 had diagnosis of dementia, only speaks mandarin, needed assist of 1 staff for adl's, and was a high fall risk. R1's Incident Report, dated 5/29/26 at 7:45 p.m., identified R1 requested assistance to use (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the bathroom after activating the call light. A certified nursing assistant (CNA) placed the walker in front of R1 and turned away to retrieve the gait belt. R1 stood without assistance, leaned to the right, and lost balance. The CNA assisted R1 to the floor. While lowering R1 to the floor, R1's right side rubbed against the recliner, resulting in an abrasion to the right side of the back. R1 complained of pain to the area. The report identified the immediate intervention was to educate R1 to wait for assistance with transfers. R1's SBAR note, dated 5/29/26 at 7:45 p.m., identified a witnessed fall after R1 requested assistance to the bathroom. A certified nursing assistant (CNA) placed a walker in front of R1 and turned away to retrieve the gait belt. R1 stood up unassisted, leaned to the right, and lost balance. The CNA assisted R1 to the floor. While lowering R1 to the floor, R1's right side rubbed against the recliner, resulting in an abrasion to the right side/back. R1 expressed pain/discomfort to the area. The immediate intervention was to educate R1 to wait for assistance with transfers. Neither the SBAR note nor the Incident Report identified whether staff followed R1's care plan requiring two-person assistance during transfers, whether a second staff member was present, or whether failure to implement the care plan contributed to the fall. During an interview on 7/15/26 at 2:20 p.m., the director of nursing (DON) confirmed only one staff member had assisted R1 during the 5/29/26 transfer and acknowledged R1's care plan requiring two-person assistance had not been followed. R1's IDT Clinical Review, dated 6/3/26, identified the reason for review was a fall after R1 tipped to the side while a CNA turned around. The background identified supranuclear palsy. The care plan review identified staff were to continue following R1's fall interventions and provide two-person assistance with transfers. R1's Incident Report, dated 7/8/26 at 10:00 a.m., identified staff heard a loud noise and found R1 lying on the floor with R1's head in the resident room and R1's lower body inside the bathroom. R1's walker was lying beside R1, R1's pants and incontinent brief were not pulled up, and the bathroom call light was within reach. The report identified R1 was self-transferring from the toilet when the unwitnessed fall occurred. R1 struck the back of the head and sustained a 2 cm x 2 cm raised, reddened area. Hospice evaluated R1, and R1 was transferred to the emergency department for further evaluation. The report identified gait imbalance and weakness as predisposing physiological factors. R1's Situation, Background, Assessment, and Recommendation (SBAR) note, dated 7/8/26 at 10:11 a.m., identified staff heard a loud noise and found R1 lying on the floor with R1's head in the resident room and R1's lower body inside the bathroom. R1's walker was lying beside R1, R1's pants and incontinent brief were not pulled up, and the bathroom call light was within reach. The note identified R1 was self-transferring from the toilet when the unwitnessed fall occurred. R1 struck the back of the head and sustained a 2 cm x 2 cm raised, reddened area. Hospice evaluated R1, and R1 was transferred to the emergency department for further evaluation. R1's Progress Note, dated 7/8/26 at 4:00 p.m., identified R1 returned to the facility from the emergency department following evaluation after the fall. The note identified no new injuries were identified, and R1 continued to complain of pain to the back of the head from the fall. During an interview on 7/14/26 at 11:50 a.m., Licensed Practical Nurse (LPN)-A stated she was working on 7/8/26 when R1 fell. LPN-A stated the nursing assistant (NA) transferred R1 onto the toilet and then left to assist another resident. LPN-A stated the NA asked LPN-A to watch R1; however, LPN-A became occupied with other duties. LPN-A stated she heard R1 fall while R1 was attempting to get off the toilet independently. LPN-A stated R1 sustained a bump to the back of the head that was painful. Hospice was notified, R1 was assessed, and R1 was transferred to the emergency department for evaluation. LPN-A stated the care plan was revised after the fall to include an intervention directing staff not to leave R1 alone on the toilet. LPN-A stated R1 forgets to ask for assistance. During an interview on 7/15/26 at 2:20 p.m., DON stated R1's 7/8/26 fall occurred after NA-C transferred R1 onto the toilet and then left to assist (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another resident. The DON stated NA-C asked LPN-A to watch R1. The DON stated LPN-A became occupied administering medications and was unable to observe R1. The DON stated R1 attempted to get off the toilet independently, fell, and sustained a hematoma to the back of the head. The DON stated hospice was notified and assessed R1, and R1 was transferred to the emergency department for evaluation. The DON stated a head computed tomography (CT) scan identified no intracranial bleeding. The DON stated the care plan was revised following the fall to include an intervention directing staff not to leave R1 unattended while using the toilet. Review of R1's 7/8/26 Incident Report and SBAR, together with interviews of the DON and LPN-A, identified staff did not implement R1's care plan requiring two-person assistance during transfers. Despite revising the care plan after the 5/7/26 fall to reduce future falls, staff transferred R1 to the toilet without the required assistance, left R1 unattended, and R1 attempted to transfer independently, fell, struck the head, and required emergency department evaluation. R1's IDT Clinical Review, dated 7/9/26 at 9:45 a.m., identified the reason for review was R1's unwitnessed fall from the toilet. The review identified R1 had a history of falls and impulsive decision making. Following the fall, the care plan was reviewed and revised to include an intervention directing staff not to leave R1 unattended in the bathroom. The Facility 2 East Report Sheet, last updated on 7/13/26, identified R1 had a diagnosis of dementia, spoke only Mandarin, required one-person assistance with activities of daily living (ADLs), and was at high risk for falls. The report sheet did not identify R1 required two-person assistance for transfers or toileting. The report sheet available to direct care staff continued to identify one-person assistance, which was inconsistent with R1's care plan requiring two-person assistance. R1's Visual/Bedside Kardex, printed on 7/15/26, identified R1 required assist of two for functional transfers and short-distance mobility with a gait belt and front-wheeled walker. The Kardex further identified R1, required assist of two for toileting and included a scheduled toileting program upon rising, before and after meals, at bedtime, and during night rounds. During an observation and interview on 7/14/26 at 11:10 a.m., R1 had activated the call light requesting assistance to use the bathroom and was seated on the edge of the bed. At 11:12 a.m., nursing assistant (NA)-A responded, applied R1's shoes and gait belt, and assisted R1 with a front-wheeled walker to the bathroom. During the transfer, R1 had difficulty pivoting to the left and required verbal cueing. After assisting R1 onto the toilet, NA-A removed the gait belt and remained with R1 while R1 used the toilet. NA-A stated staff remain with R1 because R1 is at high risk for falls, does not always remember to use the call light, and will attempt to transfer independently. NA-A further stated R1 has had multiple falls, and staff are required to remain with R1 while R1 is using the bathroom. At 11:24 a.m., NA-A reapplied the gait belt, provided perineal care, assisted R1 in pulling up the brief and pants, and assisted R1 back to bed using the front-wheeled walker while providing verbal cueing and maintaining hold of the gait belt. During the observation, NA-A completed both transfers without assistance from a second staff member. During an observation and interview on 7/14/26 at 1:39 p.m., NA-B assisted R1 to the bathroom using a gait belt and front-wheeled walker. NA-B remained with R1 while R1 was using the toilet. After toileting, NA-B assisted R1 back to bed using the gait belt and front-wheeled walker. NA-B stated R1 had fallen approximately one to two weeks earlier. NA-B stated staff must remain with R1 while R1 is on the toilet because R1 could fall if left alone. NA-B stated all staff should know R1 cannot be left alone in the bathroom because R1 is impulsive and not safe to get up independently. NA-B stated R1 requires frequent toileting and that most of R1's falls occur while attempting to get to the bathroom. During the observation, NA-B completed both transfers without assistance from a second staff member. During a phone interview on 7/14/26 at 1:43 p.m., using a speech interpreter (SI)-A, R1 stated the last fall occurred in the bathroom. R1 stated, I don't know why I fell. R1 stated the fall caused R1 to hit the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rochester Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Eighth Avenue Southeast Rochester, MN 55904	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back of the head and pointed to a bump on the back right side of the head. R1 rated the pain from the injury as a 2 to 3 on a 10-point scale. When asked if staff helped R1 to the bathroom, R1 stated, One of the staff is good; one is not really good at getting me to the bathroom. When asked what staff could do to help prevent future falls, R1 stated it was easy to fall because of pain from a previous right hip fracture that required surgical pinning. R1 stated the hip continued to hurt after surgery and made it difficult to walk. During a telephone interview on 7/15/26 at 9:30 a.m., the Hospice Registered Nurse Case Manager (RNCM)-A stated she had provided hospice services to R1 since 2/10/26. The Hospice RN stated R1's terminal diagnosis was Progressive Supranuclear Palsy (PSP), a progressive neurodegenerative disorder that affected R1's mobility and cognition. The Hospice RN stated R1's mobility had progressively declined from requiring one-person assistance to requiring two-person assistance with transfers and ambulation. The Hospice RN stated R1 demonstrated a shuffling gait, was unable to reliably move the feet forward, and had increasing difficulty communicating due to the progression of the disease. The Hospice RN stated R1's ability to wait for assistance was poor and, if R1 believed no one was coming, R1 would attempt to transfer independently. The Hospice RN stated R1 was a very high risk for falls due to declining cognition and mobility and confirmed R1 had experienced multiple previous falls. The Hospice RN stated hospice was notified immediately after the 7/8/26 fall and she evaluated R1 at the facility. The Hospice RN observed a small bump on the back of R1's head without bleeding or laceration and stated R1 complained of pain to the back of the head and buttocks. The Hospice RN stated R1 appeared alert, responsive, and at baseline neurologically. The Hospice RN stated she added an intervention to the hospice care plan directing staff not to leave R1 alone during bathroom use after the 7/8/26 fall. When asked whether R1 could have been safely left alone in the bathroom on 7/8/26, the Hospice RN stated, No. During follow-up interviews on 7/15/26 at 11:25 a.m., NA-A and NA-B stated they use the Kardex and report sheet to determine how to provide resident care. NA-A stated she believed R1 required one-person assistance for toileting and checked the Kardex, which did not identify the number of staff required. NA-A then reviewed the report sheet, which identified R1 required one-person assistance. After being informed R1's care plan had required two-person assistance for transfers since 5/8/26, both nursing assistants stated the Kardex, report sheet should have reflected the change. Both stated they were unaware R1 required two-person assistance for transfers. NA-A stated she had always transferred R1 with one staff member and had not experienced any problems. NA-A stated she transferred R1 alone twice on 7/14/26 and again on the morning of 7/15/26 because the report sheet directed one-person assistance. NA-A stated, If I was supposed to be using two staff since May, I had no idea. It's not on the report sheet and no one told me. NA-A further stated, I will be glad to use two staff if that's what we should be doing because we can't leave her unattended in the bathroom. Then another staff can watch her while the other staff answers a call light. NA-B stated she had always transferred R1 with one staff member. Both nursing assistants stated R1 was usually transferred by one staff member, and both stated they were not aware R1's care plan required two-person assistance. During an interview on 7/15/26 at 11:32 a.m., LPN-B stated she was R1's nurse on the 2 East unit and believed R1 required one-person assistance for toileting and transfers. After reviewing R1's care plan, LPN-B confirmed it had required two-person assistance for transfers since 5/8/26. LPN-B stated she was not aware of the change. LPN-B stated if staff were assisting R1 with only one person, they would not be following the care plan that was put in place to help prevent future falls. During an interview on 7/15/26 at 2:20 p.m., DON stated R1's care plan had required two-person assistance for transfers and toileting since 5/8/26, following R1's 5/7/26 fall, to reduce the risk of future falls. The DON explained staff are notified of changes in transfer status through shift report, the care plan, and the Kardex, and (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff compliance is monitored through random audits, communication in the electronic medical record, and the daily huddle sheet. After being informed two different nursing assistants had been observed transferring and toileting R1 with one staff member, the DON stated staff should have been following the care plan and using the Kardex rather than the report sheet. The DON confirmed one-person assistance was not acceptable because R1 required two-person assistance to help prevent falls and reiterated the expectation that staff follow R1's care plan because R1 was at very high risk for falls. As a result, staff responsible for providing R1's care did not consistently know or implement the intervention requiring two-person assistance for transfers and toileting that had been put in place following the 5/7/26 fall to reduce the risk of future falls. Facility policy, Accidents and Supervision, revised 2023, identified the facility would provide each resident adequate supervision and assistive devices to prevent accidents by identifying hazards and risks, implementing interventions to reduce hazards and risks, monitoring the effectiveness of interventions, and modifying interventions when necessary. The policy further identified interventions were to be communicated to all relevant staff, documented, put into action, and monitored to ensure they were implemented correctly and consistently. The policy identified adequate supervision was based on the individual resident's assessed needs and identified hazards in the resident environment. Facility policy, Fall Prevention Program, revised 2023, identified each resident would be assessed for fall risk and receive care and services based on the resident's individualized level of risk to minimize the likelihood of falls. The policy identified high-risk residents were to receive interventions based on their assessed risk factors, including scheduled toileting assistance, and each resident's care plan was to be monitored for effectiveness and revised as needed. Following a fall, the policy directed staff to assess the resident, complete a post-fall assessment and incident report, notify the physician and family, review and update the care plan as indicated, document assessments and actions, and obtain witness statements when an injury occurred.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a clinically significant medication was transcribed correctly, made available, and administered as prescribed, leading to repeated omissions of a treatment used for chronic hyponatremia, for 1 of 1 residents (R2) reviewed for quality of care Findings include: R2's Face Sheet printed 7/16/26, identified R2 had diagnoses of hypo-osmolality (having too much water relative to salt in the blood, which makes the blood too diluted), hyponatremia (dangerously low salt levels in the blood, which can make a person confused or dizzy), diabetes, and chronic kidney disease (gradual loss of kidney function, which means the kidneys struggle to filter wastes and balance fluids in the body). R2's hospital after visit summary (AVS) dated 3/12/26, identified R2 was hospitalized from [DATE] to 3/12/26, and the records identified that R2 had medical comorbidities including chronic hyponatremia. R2's admission minimum data set (MDS) dated [DATE], identified R2's cognition was intact. R2's admission Care Area Assessment (CAA) dated 3/18/26, identified a problem with nutritional status noting that R2 would leave a significant proportion of meals daily. The assessment identified that a care plan would be implemented to track her food and fluid intake, and to monitor her laboratory values and weights. R2's care plan dated 5/6/26, identified a focus on the endocrine system related to diabetes and SIADH (Syndrome of Inappropriate Antidiuretic Hormone secretion, a condition where the body holds onto too much water and dangerously lowers blood salt levels). Interventions dated 5/6/26, identified that staff must administer medications per doctor's orders, enforce a strict 2-liter fluid restriction with no water mugs left at her bedside, and complete laboratory tests per the doctor's directions. R2's Physician Assistant (PA) admission visit, dated 3/19/26, identified that on the day of discharge from the hospital (3/12/26), R2's Lisinopril was held due to an elevated potassium level, and the hospital ordered a laboratory basic metabolic panel (BMP) redraw at the facility on 3/12/26 or 3/13/26 to monitor her electrolyte levels. The PA noted that these follow-up laboratory checks were not completed by the facility. As a result, the PA had to issue new orders to obtain a BMP at the next available laboratory draw, and her Lisinopril medication continued to be withheld. R2's laboratory results dated [DATE], identified that her sodium level was 131 mEq/L and her potassium level was 4.7 mEq/L. R2's progress note dated 4/5/26 at 2:05 p.m., identified reports of increased weakness and positional control while sitting, leaning to the left, and having a hard time feeding herself. R2's progress note dated 4/5/26 at 10:17 p.m., identified that R2 had increased weakness from baseline during transfers, leaned to one side while in a wheelchair, and required assistance to propel her wheelchair. R2's progress note dated 4/6/26 at 11:45 a.m., identified that the physician followed up with orders for BMP laboratory draw. R2's progress note dated 4/7/26 at 2:21 p.m., identified that R2 had generalized weakness in her extremities and required a Hoyer lift for the last few days due to leg weakness. R2's progress note dated 4/8/26 at 11:02 p.m., identified that R2 complained of not being able to lift her arms and was unable to reach for the call light. The note identified that the author observed R2 was unable to take her medications when given, requested the medications be placed in her mouth, stated, I can't lift up my arm anymore, and required more help with feeding and activities of daily living. R2's progress note dated 4/9/26 at 2:11 p.m., identified that BMP laboratory results obtained that morning were abnormal with a sodium level of 130 mEq/L, and that the provider gave verbal consent for R2 to be transferred to the hospital for an evaluation. R2's AVS dated 4/23/26, identified R2 was hospitalized from [DATE] to 4/23/26 for admitting diagnoses including hyponatremia and emergent spinal surgery. The records identified that her sodium level on 4/21/26 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was 127 mEq/L and on 4/23/26 was 126 mEq/L. The records identified new discharge orders for [NAME]-Na.R2's Discharge summary dated [DATE], identified that the resident has chronic hyponatremia for which she was started on 30 grams of [NAME]-Na daily. The records identified active issues requiring follow-up by the primary care provider, including a specific instruction to recheck a BMP on 4/30/26.R2's hospital MAR dated 4/14/26 through 4/23/26, identified that R2 consistently received her prescribed 30-gram [NAME]-Na packets daily as ordered during her hospitalization.R2's medication administration record (MAR) dated April 2026, identified an entry for [NAME]-Na oral packet documented as 30 milligrams (mg) by mouth one time a day at 7:00 a.m.A review of the administration tracking codes for this entry revealed that on 4/24/26, a code, 9 was documented, indicating to see the progress note. On 4/25/26, a code 3 was documented, indicating absent from home without medications. On 4/26/26, a code 2 was documented, indicating the drug was refused. On 4/27/26, a code 6 was documented, indicating R2 was hospitalized .A review of the facility's records identified that this entry did not match the Discharge summary dated [DATE], which directed staff to give 30 grams with meals. Record review identified no documentation that facility staff contacted the provider to clarify the order timing or the typographical error listing mg instead of grams. Further identified no documentation that facility staff contacted the healthcare provider to clarify the order timing or the dosage discrepancy.R2's progress note dated 4/24/26 at 11:05 a.m., identified an administration note for [NAME]-Na oral packet was on order.R2's progress note dated 4/25/26 at 10:08 a.m., identified an administration note that the [NAME]-Na was on order.R2's progress note dated 4/26/26 at 9:49 a.m., identified an administration note for [NAME]-Na oral packet was on order.R2's progress note dated 4/26/26 at 12:29 p.m., identified that R2 had 2+ pitting edema on bilateral upper and lower extremities and crackles present in all lobes of her lung fields. The note identified that R2 was short of breath at rest and nursing staff questioned whether a fluid restriction was indicated.R2's progress note dated 4/27/26 at 8:56 a.m., identified that R2 had shortness of breath with difficulty taking deep breaths, bilateral arm and leg edema, and faint crackles in her lung fields. The note identified that R2 requested to be seen in the hospital one more time and the provider gave verbal consent for R2 to be transferred to the hospital emergency room.A review of R2's MAR and progress notes between 4/24/26 and 4/27/26, identified a total of 4 omitted doses of the prescribed [NAME]-Na medication. A review of the facility's clinical records identified no documentation that nursing staff notified the provider regarding these daily medication omissions, and identified no documentation that staff contacted the pharmacy to clarify the transcribed dosage discrepancy.R2's AVS dated 5/4/26, identified that R2 was hospitalized from [DATE] to 5/4/26, with an admitting diagnosis of profound hypo-osmolar hyponatremia with a sodium level of 113 mEq/L. The records identified that her hospital course was complicated by acute on chronic hyponatremia, and hospital medical staff documented that R2 was reportedly not receiving the recommended urea treatments during her prior admission. The records identified that her sodium level was 133 mEq/L on the day of discharge, noting she remained stable with stable sodium levels 72 hours prior to discharge, and she was directed to take urea 15-gram packets three times daily with meals.R2's progress notes dated 5/5/26 through 5/12/26, identified repeated administration entries for [NAME]-Na oral packets noting the medication was unavailable, out of supply, and awaiting pharmacy delivery. Specific entry times included 5/5/26 at 11:16 a.m., 1:50 p.m., and 8:13 p.m.; 5/6/26 at 10:59 a.m., 3:30 p.m., and 5:28 p.m.; 5/7/26 at 9:48 a.m., 12:02 p.m., and 7:30 p.m.; 5/8/26 at 12:08 p.m. and 6:10 p.m.; 5/9/26 at 10:39 a.m., 11:55 a.m., and 5:50 p.m.; 5/10/26 at 10:36 a.m., 12:57 p.m., and 5:02 p.m.; and 5/11/26 at 9:43 a.m., 12:53 p.m., and 5:47 p.m. The note dated 5/11/26 at 12:53 p.m. identified that the unit manager and Director of Nursing (DON) were aware the medication was (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m., and on 5/21/26 at 12:00 p.m. Additionally, the tracking codes identified that a code 2 was documented for a refused dose on 5/13/26 at 12:00 p.m. A review of R2's MAR and progress notes between 5/4/26 and 5/21/26, identified a total of 28 omitted doses of the prescribed [NAME]-Na medication. A review of the facility's clinical records identified no documentation that nursing staff notified the physician, physician assistant, or nurse practitioner regarding these repeated medication omissions, and identified no documentation that the facility executed an emergency procurement plan to obtain the missing medication from an alternative pharmacy source. R2's AVS dated 5/28/26, identified a hospitalization from 5/24/26 to 5/27/26. Admitting diagnoses included sepsis, and other diagnoses included chronic hyponatremia due to SIADH. The brief hospital course identified that R2 presented from the skilled nursing facility after two days of increased work of breathing and hypotension and was managed with fluid resuscitation and antibiotics. The records identified that her electrolyte abnormalities, including hyponatremia, were monitored and repleted as needed, and she was discharged back to the skilled nursing facility with hospice support. During an interview on 7/16/26 at 1:02 p.m., the Director of Nursing (DON) identified that when medication was unavailable, the healthcare provider must be notified. The DON identified that no medication error reports were completed regarding R2's omitted [NAME]-Na doses, and the provider was not notified of the unavailable medication. DON stated his expectation would be to call the pharmacy when medication was unavailable and then to notify the provider for alternative treatment. DON indicated this would be a significant medication error for R2 because she had so many missed doses. During a phone interview on 7/16/26 at 4:27 p.m., pharmacy order entry technician (POET)-A identified that the pharmacy received R2's electronic medical record order on 4/23/26. POET-A identified that the order for [NAME]-Na was transcribed into the pharmacy system to give 30 mg (milligrams) daily for hyponatremia. POET-A identified that the reviewing pharmacist noted the medication comes in 15-gram packets and requested clarification on the dose. POET-A identified that the medication is classified as an over the counter (OTC) product, which requires prior authorization by the facility DON before it can be dispensed, and noted that the medication was not sent following the initial order due to the lack of administrative approval. POET-A identified that on 5/4/26, the pharmacy received a new order to give 15 grams by mouth with meals, which was profiled into the system. POET-A identified that on 5/11/26, the facility submitted an electronic approval alert, and the pharmacy sent a partial supply of 5 packets out of an 8-packet order on 5/11/26 because the pharmacy did not have a full supply in stock for the uncommonly dispensed medication. POET-A identified that the facility submitted a refill request on 5/14/26, and the pharmacy sent the amount they would need. During an interview on 7/16/26 at 5:03 p.m., consultant pharmacist (CP)-A identified that the pharmacy received the original [NAME]-Na order on 4/23/26 but did not dispense it because it was an OTC product requiring administrative billing approval from facility DON. CP-A identified that pharmacy records confirmed the medication was first dispensed on 5/12/26. Additionally, CP-A identified that because [NAME]-Na was a clinically significant medication for R2 to treat her history of SIADH and severe hyponatremia, the repeated missed doses constituted a significant medication error that increased her risk for worsening hyponatremia. During an interview on 7/20/26 at 3:21 p.m., the medical director identified that [NAME]-Na was prescribed to treat R2's hyponatremia. The medical director identified that omitting the medication placed R2 at risk for worsening or recurrent hyponatremia and could have contributed to her subsequent hospital admission with a low sodium level of 113. Additionally, the medical director identified that any time a prescribed medication is unavailable, nursing staff are expected to notify the provider immediately for alternative treatment options rather than allowing a resident to go without therapy. Facility policy, Medication Error dated (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2025, identified that it is the policy of the facility to ensure residents receive care and services safely in an environment free of significant medication errors. The policy defined a significant medication error as one which causes the resident discomfort or jeopardizes his or her health and safety. The policy guidelines identified that medications must be administered according to physician's orders, and errors will be evaluated based on the resident's condition-such as a requirement for rigid control, strict intake and output measurement, or monitoring of laboratory values-and the frequency of the error, including if an omission occurs repeatedly. Additionally, the policy guidelines identified medication omissions as an administration error. The policy procedure identified that if a medication error occurs, the nurse must assess the resident's condition, notify the physician or healthcare practitioner as soon as possible, and complete an incident or occurrence report once the resident is stable. Facility policy, Medication Reordering dated February 2023, identified that it is the policy of the facility to accurately and safely obtain pharmaceutical services, including the provision of routine and emergency medications in a timely manner to meet the needs of each resident. The policy guidelines identified that the acquisition of medications should be completed in a timely manner to ensure medications are administered safely, and noted that in the event of new orders, the facility is allowed 24 hours to begin a medication unless otherwise specified by the physician.		

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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. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: R3's face sheet printed 7/16/26, identified diagnoses including a T11-T12 fracture, spinal stenosis, diabetes, severe protein-calorie malnutrition, nutritional anemia, and a bladder disorder. R3's care plan dated 2/13/26, identified a focus for being at risk for alteration in skin integrity. Care plan interventions included observing R3's skin condition daily with daily care and reporting any identified abnormalities. Review of R3's weekly skin assessments dated 5/4/26, 5/11/26, 5/18/26, 5/28/26, 6/22/26, and 6/29/26, identified that no skin issues were documented. R3's NAR Bath Day Worksheet/Skin Update, dated 6/29/26, identified R3 received a shower and had no identified skin concerns. Review of R3's Situation, Background, Assessment, and Recommendation (SBAR) note dated 7/4/26, identified a newly noted wound on R3's coccyx with a documented width of 0.1 cm and a depth of 0.2 cm. The note identified that the facility failed to maintain a complete clinical record by leaving the template placeholders completely blank for the wound's length measurement, the appearance of the wound bed, the type of drainage, and the condition of the surrounding skin. R3's NAR Bath Day Worksheet/Skin Update, dated 7/6/26, identified R3 received a shower and had no identified skin concerns. R3's NAR Bath Day Worksheet/Skin Update, dated 7/13/26, identified R3 received a shower and had no identified skin concerns. During an interview on 7/15/26 at 4:14 p.m., the Director of Nursing (DON) verified that weekly nursing skin assessments were missing from R3's chart for the weeks of 7/6/26 and 7/13/26. The DON located R3's loose NAR Bath Day Worksheets for those dates and stated they were used in place of documented medical chart assessments. The DON confirmed that these worksheets were not a part of R3's permanent medical record, noting that they are filled out by aides, signed by nurses, and kept on the nurse manager's desk until they are eventually thrown away. Review of R3's clinical record identified the facility failed to maintain permanent, complete, and accurate records of the resident's skin assessments. Specifically, the facility utilized temporary nursing assistant worksheets as the official documentation of R3's weekly skin status, which were excluded from the permanent medical chart and routinely discarded. Policy regarding accurate medical records were requested and not received.		