STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation and Living Center	1900 Ballington Boulevard NW Rochester, MN 55901

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300 Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 3 of 3 (R2, R3, R4) residents reviewed for infection prevention. R2's Diagnoses List undated included open wound of abdominal wall. R2's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition with open lesions, and application of non-surgical dressings. R2's Physician's Orders dated 6/18/24 instructed wound care to abdominal wall wound. Remove old dressing. Clean with Vashe cleanser (a wound cleanser). Gently pat dry. Cover with Xeroform (a wound dressing). Cover with 4x4 Mepilex boarder (a wound dressing). Change daily. The orders lack direction on enhanced barrier precautions. On 6/27/2024 at 2:01 p.m., R2 stated facility staff wear only gloves when completing the daily dressing changes. R3's Diagnoses List undated included non-pressure chronic wound of left heel. R3's admission MDS dated [DATE] indicated intact cognition with pressure and non-pressure injuries and a surgical wound requiring wound care. R3's Physician's Orders dated 6/18/24 instructed to remove old dressing to left heel. Cleanse ulcer base with rough gauze and Vashe in circular motion. Moisten new rough gauze with Vashe. Apply gauze directly to the wound base and areas around the wound. Allow gauze to sit for 20 minutes. Remove gauze and pat dry. Apply a layer of barrier cream around the wound. Apply 1 layer of Derma Blue Transfer (a foam wound dressing) to the ulcer base. Cover with non-woven (soft) gauze and secure with cover roll stretch tape. Change dressing daily. R3's Physician's Orders dated 6/17/24 instructed change midline dressings 2 times daily with saline moistened Kerlix gauze wrap covered with an abdominal pad. The orders lack direction on enhanced barrier precautions. On 6/27/24 at 3:40 p.m., R3 stated the dressings on her wounds are changed as the provider ordered. Staff washed hands and changed gloves frequently during dressing changes, but did not wear a gown. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Diagnoses List undated included orthopedic aftercare following surgical amputation. R4's admission MDS dated [DATE] indicated intact cognition with surgical wounds requiring wound care. R4's care plan dated 6/13/24 indicated a surgical incision to right foot and left below the knee amputation. R4's Physician's Orders dated 6/04/24 instructed moisten soft gauze with Vashe wound cleanser. Apply moistened product directly to wound base. Allow application to sit for at least 1-5 minutes. Remove application and exfoliate with rough gauze to removed devitalized tissue. May place gauze in-between toes and loosely wrap foot with Kerlix gauze wrap twice daily. The orders lacked information on enhanced barrier precautions. On 6/28/24 at 11:29 a.m., licensed practical nurse (LPN)-C was observed completing wound dressing change for R4 wearing gloves. LPN-C was not wearing any other personal protective equipment (PPE). R4 stated staff wear only gloves when completing R4's wound care. On 6/28/24 at 10:16 a.m., LPN-A stated he would look by a resident's door for a sign and precaution cart to know if a resident was on any type of EBP. LPN-A confirmed there was no sign or precaution cart by R3's door. On 6/28/2024 at 10:40 a.m., LPN-B stated there would be a sign and precaution cart by the door if a resident was on EBP. LPN-B confirmed there was no sign or precaution cart by R2's door. On 6/28/24 at 12:05 p.m., LPN-C stated she would get information about what enhanced barrier precautions a resident was on through report, and a sign should be near the resident door. LPN-C confirmed she did not receive any information about EBP for R4, and there were no sign or precaution cart by R4's door. On 6/28/24 at 2:49 p.m., the infection preventionist (IP) stated she was the person who would place a resident in any type of precautions. IP confirmed R2, R3, and R4 were not on EBP. IP stated if a resident is not placed on appropriate precautions there is risk of transmission of a multi drug resistant organism or other bacteria or virus to staff and other residents which could result in illness. On 6/28/24 at 3:30 p.m., the director of nursing (DON) stated the IP oversees placing residents in precautions. Staff are alerted to precautions by an order in the electronic health record and a sign and precaution cart by the resident's door. DON stated according to facility policy, any resident with a wound should be placed in EBP. DON confirmed R2, R3 and R4 should have been placed on EBP because of wounds but currently were not on any type of precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Infection Prevention and Control Manual Transmission-Based Precautions policy dated 2023 directed EBP require gown and glove use for residents with a novel or targeted multi-drug resisted organisms (MDRO) or any resident with a wound or indwelling medical device during specific high-contact resident care activities. High-contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Clear signage should be posted on the door/wall outside the resident room. An isolation care with personal protective equipment (PPE) should be placed immediately outside the resident room. Alcohol-based hand rub should be provided both in and outside of the resident room. A trash receptacle placed inside the resident room for PPE removal. Communication and education should be provided to all staff caring for or entering the resident room as well as the resident and resident family/friends.