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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/22/2025 |
| NAME OF PROVIDER OR SUPPLIER Rochester Rehabilitation and Living Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Based on observation, interview and document review the facility failed to provide the necessary care and services in accordance with the professional standards of practice to comprehensively assess, monitor and evaluate 3 of 4 residents (R3, R1, R4) for congestive heart failure management. Findings include: R3's face sheet dated 8/12/25, identified R3 had diagnoses of heart failure (a condition where the heart does not pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and edema (swelling).R3's care plan focus dated 8/1/25, identified R3 had a cardiac diagnosis requiring monitoring and medication/treatments. Interventions included the following: notify physician and family with any change in condition and medications per physician orders.R3's nurse practitioner (NP) note dated 8/5/25, identified a physician order to continue daily weights for 7 days until 8/12/25 and leg compression/wraps on bilateral legs: apply in the morning and take off in the evening.R3's physician orders included the following:-compression wraps to bilateral lower extremities apply in morning and take off in the evening (start date 8/5/25) -Daily weights. (start date 8/5/25 with a stop date of 8/12/25) R3's medication administration record (MAR) reviewed 8/6/25 through 8/17/25, identified a physician order for daily weights and compression wraps, however, had not been signed off on 8/6/25 and 8/11/25. During an interview on 8/11/25 at 1:11 p.m., registered nurse (RN)-G stated if a resident needs to have a daily weight, it should be done in the morning, however, R3's was not a daily weight, therefore, it had not been obtained today. RN-G stated there is a binder at the nurse's station that will tell staff which residents need to have a daily weight, and the aides will use this book to obtain them and document the weight. RN-G stated R3 had a tad bit of swelling in both of her legs when she applied her wraps, however, did not comprehensively assess R3 for congestive heart failure symptoms like edema, lungs sounds, and shortness of breath. A follow up interview at 1:39 p.m., RN-G stated the daily weight binder has not been updated since 7/30/25, and this is where she would look to see which resident gets a daily weight to be able to document in the EHR.During an interview on 8/11/25 at 1:25 p.m., nursing assistant (NA)-B stated she was unaware of binder at the nursing station to tell staff what daily weights were to be taken each day. During an interview on 8/11/25 at 2:28 p.m., registered nurse/nurse manager (NM)-A stated R3's daily weights were not always being done and if not done per physician order, then the physician should be notified which had not always been done. During an observation and interview on 8/15/25 at 10:25 a.m., R3 was seated in a recliner with both feet in a dependent (hang or dangle) position. R3 stated staff had not applied her compression wraps on her legs. R3 pulled up both of her pant legs showing her feet with slippers with no compression wraps; R3's legs were both swollen with shiny skin. At 10:27 a.m., R3's family member (FM)-C arrived to visit R3. FM-C stated he was an intensive care nurse and had been taking care of R3 while she was at home. FM-C stated R3 used compression wraps at home on her lower extremities to reduce swelling due to her congestive heart failure. FM-C stated many days when he arrived to visit R3 after lunch R3's leg wraps had not yet been wrapped in the morning like they were supposed to be and would have to ask staff to put them on. During an interview on 8/15/25 at 10:40 a.m., registered nurse (RN)-B stated R3's compression wraps were supposed to be applied at 7:00 a.m., however, had not applied R3's wraps today due to being too busy. RN-B was unable to articulate what type of assessment she would perform to evaluate for signs and symptoms of fluid overload related to congestive heart failure, nor the rationale for compression wraps, nor how she would determine if a resident's edema were worsening. RN-B further stated she had not received any formal training for edema monitoring and, I feel I could benefit from some training. During an interview on 8/11/25 at 4:06 p.m., director of nursing (DON) stated R3 did not have her weight obtained on 8/6/25 or 8/11/25 and should have been obtained.During a follow up interview on 8/15/25 at 2:52 p.m., DON stated R3's compression wraps should have been applied prior to R3 getting up for the day and signed off in the MAR, however, were not signed off on 8/6/25 and 8/11/25. DON stated that residents with heart failure and/or edema should be monitored daily for worsening edema and increased CHF symptoms but had not done consistently. DON further stated that nurses had not received any specific to edema and/or CHF monitoring. Review of the facility's Heart failure patient care policy, revised August 19, 2024, identified Heart failure is a progressive clinical condition in which one or both ventricles of the heart cannot fill with or eject blood efficiently due to a structural or functional disorder. -The role in the care of a patient with heart failure includes assessing and monitoring the patient for signs and symptoms of worsening heart failure, assisting with medication management, fluid management -Ask the patient about the presence and severity of common heart failure symptoms including</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p> |

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| <p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the safe and accurate administration of prescribed medications to residents, resulting in Immediate Jeopardy. Systemic Failures were identified across multiple areas, including transcription errors, incorrect dosing, and medication omissions. The facility did not consistently follow the five rights of medication administration, nor did it implement effective systems to identify, prevent, investigate, or track medication errors. These failures directly impacted two residents. Resident R1 did not receive two prescribed diuretic (manage fluid overload) medications, resulting in ongoing congestive heart failure. Resident R4 received 50 mg of prednisone instead of the prescribed 5 mg of a potent anti-inflammatory medication, leading to new cardiac symptoms, hospitalization, and admission to the intensive care unit (ICU), where he remains. The facility's lack of oversight and failure to implement corrective actions placed all residents at risk for serious harm, injury, or death, and necessitated immediate intervention to protect resident health and safety. The immediate jeopardy (IJ) began on 7/21/25 when the interdisciplinary team identified R1's medication errors but failed to conduct a comprehensive analysis of their pharmacy protocols or medication errors to uncover systemic failures in medication management. This led to R4 receiving 10 times the prescribed dose of Prednisone that resulted in ICU admission. The interim administrator, director of nursing were notified of the IJ on 8/14/25 at 12:58 p.m. The IJ was removed on 8/22/25 at 2:51 p.m., but non-compliance remained at a lower scope and severity of D meaning no actual harm with potential for more than minimal harm that is not widespread. Findings include A facility reported incident dated 7/18/25, identified R1's Metolazone (diuretic medication given to treat fluid retention) was not given in accordance with physician orders. R1's annual minimum data set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of biventricular heart failure (a severe form of heart failure where both the left and right sides of the heart are unable to pump blood effectively, leading to symptoms of both left-sided (shortness of breath, fatigue) and right-sided (swelling in the legs, abdomen) heart failure), hypertensive heart and chronic kidney disease (where high blood pressure damages the heart and kidneys, while damaged kidneys exacerbate high blood pressure) and hypertension. Further identified R1 received diuretics. R1's order summary dated 1/8/25 through 7/21/25, directed to give Metolazone give one 2.5 mg tablet daily 30 minutes before AM Torsemide (diuretic medication given to treat fluid retention) when weight is 165 pounds or greater, related to hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease. R1's medication administration record (MAR) dated July 2025, identified R1 was given doses of metolazone when R1's weight was below 165 lbs., not in accordance with physician orders. Administrations included: -7/7/25 weight was 161 pounds, and medication was signed as given. -7/10/25 weight was 163.6 pounds, and medication was signed as given. -7/12/25 weight was 163.6 pounds, and medication was signed as given. -7/18/25 weight was 158 pounds, and medication was signed as given. R1's progress note dated 7/18/25, at 1:03 p.m., identified an aide initially shared to this writer that R1 was complaining of not feeling well while in her wheelchair and leaned forward in her tray table but still conversant. She assisted her to the bathroom, as requested. Vital Signs (VS) checked as resident is still complaining of not feeling well. VS checked and noted initial BP (blood pressure) to be 56/34 (Normal blood 120/80 mmHg). and immediately informed this writer of the low BP. Immediately attended to and saw R1 seated on the toilet. R1 was initially conversant but gradually passed out and observed to have inward stiffening of upper extremities and stopped responding, lasting for about a minute. R1 gradually regained consciousness and was transported back to bed. The note also indicated R1 said, 'I wasn't feeling well and I have a little hard time breathing earlier but it's better.' Will inform NP and continue to monitor. At 2:08 p.m., Writer informed and updated NP about R1's condition and ordered to send her to the ED for further investigation. Informed R1 and agreed. At 2:15 p.m., ambulance came and left the facility at 2:25 p.m. R1's emergency department (ED) note dated 7/18/25, at 5:48 p.m., identified R1 was diagnosed with vasovagal syncope (triggered by an overstimulation of the vagus nerve that leads to a sudden drop-in heart rate and/or blood pressure, resulting in temporary loss of consciousness due to reduced blood flow to the brain). Nursing home reported R1 was hypotensive to the 50's and had lost consciousness when they found her. R1 was still seated on the toilet with her head leaning on the wall to her right. R1 reported similar episodes in the past where she was hypotensive and had similar symptoms. R1 also reported that she checks her weight each day and when she is above a certain weight she takes her diuretic. R1 stated she took her pill yesterday and</p> | | |

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| <p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) plan and program identified, analyzed, implemented corrective actions, and re-evaluated corrective actions to address adverse events and quality deficiencies. This deficient practice had the potential to affect all 35 residents in the facility. Actual harm occurred related to the quality of care to two residents (R4 and R1). Findings include: See F755, facility failed to identify and prevent medication errors due to complete systemic failure. The facility's failures resulted in an immediate jeopardy (IJ) with over 79 medication errors occurred in six weeks, resulting in actual harm for 2 of 5 residents (R4, R1) reviewed who had medication errors. R4 (cardiac ICU admission) and R1 (ongoing CHF exacerbation). The facility lacked systems to prevent errors, notify providers, and investigate incidents-demonstrating a widespread failure in medication management. Further review of medication errors revealed a lack of analysis of root causes, and there were no implemented corrective actions, and re-evaluated corrective actions to address adverse events and quality deficiencies. Review of the requested facility QAPI plans and minutes for April, May, June and July 2025, did not identify a focused topic of medication errors, had not mention of medication error rates, and not evident quality activities to identify and monitor the effectiveness of the facility's pharmacy services were developed or implemented. During an interview on 8/22/25 at 4:00 p. m., interim administrator reviewed QAPI minutes from April 2025 to July 2025 and verified the quality plans did not address medication errors and should have. Facility policy, Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) Committee Policy and Procedure dated 11/21, identified when improvement or innovation is indicated based on outcomes and/or new information, Performance Improvement Plans (PIP's) will be chartered as needed, a Root Cause Analysis (RCA) or equivalent process will be completed when needed to define the problem or need, the QAPI team will define who is on the PIP team which will utilize the Model for Improvement process to determine what change is indicated based on the RCA findings and additional information identified, the team then proceeds with testing the change, making any necessary changes, and then designing an implementation plan and once the plan is completed a sustainability (monitoring) plan is created. The metric or process to monitor this issue will be added to the QAPI Surveillance Data and Reporting Schedule as the feedback loop for on-going monitoring.</p> | | |