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	04/22/2025

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 51379 Based on observation, interview, and document review, the facility failed to follow up on a resident requested medication change in a timely manner for 1 of 1 residents (R138) reviewed for choices. Findings include: R138's quarterly Minimum Data Set (MDS) assessment was not completed at time of survey. R138 had intact cognition and had no rejection of cares. R138 had a diagnosis of right knee prosthesis infection and inflammatory response requiring intravenous (IV) antibiotic therapy. R138 required ongoing limited assistance for dressing and limited assist for hygiene. R138's medication orders included: Ertapenem (medication for infection) 1 gram IV infusion over one hour every day for infection of right knee prosthetic with a start date of 3/28/25. The first dose available at the facility was administered at 11pm. During interview on 4/14/25 at 6:32 p.m., R138 stated she would like to have the Ertapenem infusion done earlier in the evening around 7 or 8 p.m. R138 stated the nurses must wake her up at 11 p.m. to start the infusion and then again in an hour when the infusion is complete. She has asked the nursing staff to change this or request to change this, but the change has not been made. During interview on 4/14/25 7:00 p.m., licensed practical nurse (LPN)-E stated R138 had previously asked him to administer the Ertapenem dose sooner; he had stated to her that the medication could not be done sooner. LPN-E confirmed a situation background assessment recommendation (SBAR) report had not been completed for this request. During interview on 4/16/25 at 9:07 a.m., registered nurse (RN)-A stated the resident had previously told her she wanted medication to be given during the day but told the resident the medication time could only be changed by a provider or a pharmacist. RN-A stated she had not completed a SBAR report to submit the request to the provider. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/16/25 at 10:29 a.m., nurse practitioner (NP)-A stated the antibiotic could be moved to any time R138 preferred. NP-A confirmed she was unaware R138 wanted to change the time of the antibiotic administration. NP-A confirmed she would expect this kind of request to come on the standard SBAR communication. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated medication change requests are completed on a SBAR document. DON confirmed anyone can fill out the SBAR on the resident's behalf. DON confirmed R138 did not have an SBAR note requesting medication administration times. R138 medication administration time for Ertapenem continues to be administered late and was given on 4/17/25 at 12:04 a.m. A policy regarding resident choices was requested and not provided.

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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** 49893 Based on interview and record review, the facility failed to notify resident representative following provider order changes in a timely manner for 1 of 1 residents (R18) who received an order for antibiotics for a urinary tract infection (UTI). Findings include: R18's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R18 was severely cognitively impaired with no behaviors and was incontinent of bladder and bowel. R18's care plan for incontinence/altered elimination indicated R18 had ongoing incontinence and could not communicate the need to void. Interventions included: assist perineal hygiene after toileting, encourage fluid intake, observe for signs/symptoms of UTI (difficulty with urination, frequency, urgency, lower abdominal pain and discomfort, back pain, blood in the urine and report to medical doctor/nurse practitioner (MD/NP), offer toileting upon rising, before and after meals and bedtime and as needed (PRN). R18's medication administration record included: cefdinir 300 mg take 1 capsule by mouth two times a day for UTI for 5 days. Take before morning and evening meals dated 4/11/25 and in/out catheter to get UA (urine analysis) sample dated 4/9/25. R18's provider progress notes indicated the following: -4/8/25 family is noting increased confusion since 4/7/25 and is concerned of UTI. Family is requesting UA. -4/9/2025 indicated order for urine specimen to be sent to lab. -4/11/25 indicated positive urinalysis (test to check for infection) and order for cefdinir 300 mg take 1 capsule by mouth twice a day before morning and evening meal x 5 days. -4/13/25 indicated sensitivities confirming continued use of cefdinir. R18's progress notes lacked resident representative was notified after UA results and R18 was diagnosed with a urinary tract infection, or changes to medication orders. During interview on 4/17/25 at 4:39 p.m., R18's family member (FM)-A reported requesting staff to obtain a urinalysis on 4/4/25 due to R18 having increased vocalizations, however the urine sample was not obtained until 4/10/25. FM-A arrived at the facility on 4/14/25 and still had not heard any updates regarding R18's urine status. At the time FM-A was told R18 was on something for 5 days. FM-A stated it causes so much stress having to dig for information about [R18]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/25 at 11:40 a.m., the director of nursing (DON) stated resident representatives should be notified of any change in condition, medication changes, and anything abnormal, or for clarification of anything. All nurses can update resident representatives of changes. The DON stated occasionally, the provider will update the resident or representative regarding recommendations however, it is expected staff would document notification of representative in a progress note. The DON reported, staff have been updated regarding notifying families and have seen improvement, however this instance must have been missed. A facility policy titled Notification of changes dated 12/2016, indicated immediate notification of the resident and/or representative is to be done in situations including a need to alter treatment/plan of care significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form or treatment). It continues, document, in the resident's medical record, the time called, the person spoken with, what was reported, and their response if any.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to accurately complete comprehensive assessment of a resident's needs, strengths, goals, life history and preferences to determine a resident's functional capacity. In addition, the facility failed to ensure Minimum Data Set (MDS) was completed in a timely and/or in a comprehensive manner to facilitate accurate evaluation of resident' conditions for 5 of 5 residents (R6, R24, R194, R199, and R201) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the MDS as an assessment tool which facilities are required to use. The manual directed comprehensive assessments, include the completion of both the MDS and the CAA process, as well as care planning. The CMS RAI manual also identified the RAI process (i.e., MDS) was completed to help evaluate resident' strengths and areas for care-planning. The manual listed all types of assessments to be completed along with corresponding timeframe's for them via a graph labeled, RAI OBRA-required Assessment Summary. This directed a quarterly MDS should be completed (i.e., signed) within, ARD + 14 calendar days. R6 R6's quarterly MDS, dated [DATE], identified R6 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R6's diagnoses included progressive neurological condition, multiple sclerosis, neurogenic bladder, paraplegia, anxiety and depression. Each resident electronic medical record (EMR) listed a section labeled, MDS, which listed MDS's assessments to date for each resident. R6's quarterly MDS, with an assessment reference date (ARD) dated 3/10/25, although was listed and indicated completed on 4/14/25. R6's medical record was reviewed and lacked reason why the MDS was not completed timely. R24 R24's MDS list indicated Medicare 5 day was completed on 11/29/24 with no assessments listed after that date. R24's medical record was reviewed and lacked why the MDS had not been completed timely. R194 R194's admission MDS, dated [DATE], identified the MDS was In progress. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R194's admission MDS, with an assessment reference date (ARD) 4/10/25, was listed but categorized as, In Progress. The MDS was not completed with multiple sections being red-colored and having little or no data entered and being labeled, In Progress. The uncompleted sections included, Hearing, Speech and Vision, and Behavior, and Bladder and Bowel, among several others. R194's medical record was reviewed and lacked reason why the MDS had not been completed timely. R199 R199's admission MDS, dated [DATE], identified the MDS was In progress. R199's admission MDS, Medicare 5 day assessment, Discharge return anticipated assessment and Medicare 5-day assessment was listed but categorized as, In Progress. All above MDS assessments were not completed with multiple sections being red-colored and having little or no data entered and being labeled, In Progress. The uncompleted sections included, Hearing, Speech and Vision, and Behavior, and Bladder and Bowel, among several others. R199's medical record was reviewed and lacked evidence why the MDS had not been completed timely. R201 R201's admission MDS, dated [DATE], identified the MDS was In progress. R201's Medicare 5 day assessment, Discharge return anticipated assessment and Medicare 5-day assessment, Admission/Medicare 5 day, Discharge return anticipated were listed but categorized as, In Progress. All above MDS assessments were not completed with multiple sections being red-colored and having little or no data entered and being labeled, In Progress. The uncompleted sections included, Hearing, Speech and Vision, and Behavior, and Bladder and Bowel, among several others. R201's medical record was reviewed and lacked evidence why the MDS had not been completed timely per the RAI manual. During interview on 4/21/25 at 3:22 p.m., MDS-A stated she was a consultant and was asked to assist facility with completing MDS assessments last week. MDS stated she received access and started on 4/17/25 but was off on 4/18/25. MDS-A verified they help complete the MDS for the campus. MDS-A confirmed the above noted assessments were not finished and or reported timely. During interview on 4/21/25 at 4:49 p.m., administrator confirmed MDS assessment were behind and/ or had not been completed. Administrator stated they had just hired an external company to help with the MDS process. The facility Minimum Data Set (MDS)/Resident Assessment Instrument (RAI) policy, dated 5/18/23, identified the resident assessment process is completed by the interdisciplinary team (IDT) in accordance with the federal requirements to provide a baseline of the resident's functional status on admission with scheduled assessments to determine ongoing functional status and changes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on interview and document review, the facility failed to implement person-centered interventions for cardiac diagnosis for 1 of 1 residents (R194) reviewed for care plans. R194's admission Minimum Data Set (MDS) assessment was not completed in full at time of survey. R194's cognitive function was noted to be intact. R194 admitted on [DATE], following surgical repair of spinal stenosis (condition that narrows the space in the spine, putting pressure on the spinal cord or nerves). R194 diagnosis included atrial fibrillation (irregular heart rhythm), early ventricular depolarization (electrical signal in the heart come from lower chambers instead of upper chambers), atherosclerosis of the aorta (plaque buildup in the heart), bilateral carotid artery stenosis (partial or full blockage of the carotid artery located on each side of the neck), and hypertensive heart disease (develops due to prolonged high blood pressure, causing heart failure and abnormal heart muscle thickening). R194's admission care area assessment (CAA) report dated 3/28/25 identified a cardiac diagnosis requiring monitoring, medications, and treatments without specific person-centered interventions R194's CAA also identified R194 had a pacemaker requiring monitoring, medication, and treatments on an ongoing basis; no specific person-centered interventions were noted. R194's goals of evaluation for the cardiac diagnosis included R194 would be free of signs and symptoms of complications related to cardiac condition. R194's goals of evaluation for the pacemaker diagnosis included R194's pacemaker checks will be within normal limits. R194's goal of pain management diagnosis was R194 would demonstrate minimal discomfort or absence of acute pain and identify positive coping behaviors for chronic pain. During interview on 4/15/25 1:32 p.m., licensed practical nurse (LPN)-A stated the admission assessment is completed by a health unit coordinator (HUC) or the nurse assessment coordinator. Once the admission assessment entry is complete, the electronic medical record (EMR) will auto-populate a generic care plan. Within 48 hours the nurse assessment coordinator will enter the specific person-centered interventions. LPN-A confirmed R194 had a completed admission assessment, performed on 3/28/25. LPN-A confirmed R194 record did not have person-centered interventions. LPN-A confirmed R194 should have resident specific interventions due to his significant cardiac history and recent surgical procedure which would require pain monitoring and management. During interview on 4/16/25 at 7:27 a.m., RN-A confirmed R194 did not have specific resident-centered interventions. RN-A confirmed R194 should have interventions to include ongoing blood pressure monitoring, vital sign parameters, medication parameters in relation to the current vital signs, and interventions to address cardiac symptoms of dizziness and lightheadedness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated each resident should have an admission assessment completed when they arrive. DON confirmed R194 had an admission assessment upon arrival on 3/28/25. DON confirmed an initial generic care plan was generated for R194 on 3/28/25. DON confirmed R194 did not have a resident-specific care plan with interventions completed within 48 hours of admission. A facility policy titled Comprehensive Care Plan dated 10/2022 stated, the interdisciplinary team (IDT) will create an individual resident-specific care plan with individual interventions to communicate the resident's individual care within 48 hours of admission.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview, observation, and document review, the facility failed to follow physician orders, complete assessments, monitor or input appropriate interventions and recognize changes in condition, for 6 of 6 residents (R31, R201, R21, R194, R6, R18) reviewed for quality of care. As a result of the facility's failures, an immediate jeopardy (IJ) situation was identified for R31 who had displayed respiratory distress with labored breathing, increased anxiety and required additional medication, R201 who had displayed signs of a UTI and was transferred to the ER for treatment, R21 who had displayed signs of a urinary tract infection (UTI) and was transferred to the hospital ER for treatment. The immediate jeopardy began on 4/12/25, when R31's daily weight were not completed as ordered and facility was not monitoring, which led to R31's respiratory distress, and failed to identify, monitor and assess R201 and R21 for change of condition related to blood in the catheters led to kidney/bladder infections. The administrator, assistant administrator, director of nursing (DON), regional vice president was notified of the immediate jeopardy at 5:47 p.m. on 4/18/25. The immediate jeopardy was removed on 4/21/25 at 1:07 p.m., but noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R31 was admitted on [DATE] and admission Minimum Data Set (MDS) assessment dated [DATE], identified the MDS was In progress with no information completed. R31's electronic medical record (EMR), included diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure with hypercapnia (increased levels of carbon dioxide in the blood) and hypoxia (insufficient oxygen at the tissue level), Cor pulmonale (enlargement and failure of the right ventricle of the heart as a response to increased vascular resistance or high blood pressure in the lungs), essential hypertension, anxiety disorder, shortness of breath, and was dependent on supplemental oxygen. R31's physician orders, dated 4/11/25, included the following: Oxygen via nasal cannula 2 L/min (liters per minute) at rest while awake, 4 L via nasal cannula with exercise or activity and 2 L via BiPAP when BiPAP is on; and daily fasting weight for edema and to notify the provider of a two (2) pound weight gain in two days or five (5) pound gain in seven days. Lasix 20 mg (milligrams) daily for edema. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R31's post hospital follow up visit note dated 4/11/25, nurse practitioner (NP), indicated R31 had presented to theER on [DATE] for shortness of breath and was found to be in hypoxic respiratory failure, and tachypneic (abnormally rapid and shallow breathing). R31's was admitted to the intensive care on 3/28/25 to 4/3/25 and was treated for volume overload, pneumonia, and COPD exacerbation. While in the Intensive Care Unit (ICU), R31 was aggressively diuressed (the excretion of a large amount of fluid). R31 required supplemental oxygen via nasal cannula 2 L at rest while awake, 4 L via nasal cannula with exercise or activity and 2 L via BiPAP while sleeping and medications. NP continued the current order of Lasix 20 milligrams (mg) daily and asked nursing to complete daily standing fasting weights and to notify provider of weight gain of two (2) pounds in two (2) days or five pounds in seven days and will follow up the following week to determine dry weight goal. R31's care plan dated 4/11/25, included R31 respiratory diagnosis with abnormal lung sound and shortness of breath. Interventions were identified to administer medications as prescribed by physician, give nebulizer treatment and oxygen therapy as ordered, and to notify physician if increased coughing occurs. The care plan also indicated R31 was at nutritional risk related to diagnoses of COPD, respiratory failure, oxygen dependence, altered skin integrity and recent weight loss with low body weight. Interventions were identified to observe changes in weight and to notify physician. R31's daily weight record from 4/11/25 to 4/18/25 revealed R31 had not been weighed 6 of the 7 days: -4/11/25, wt. (weight) 142.56 lbs. -4/12/25, wt. not taken -4/13/25, wt. not taken -4/14/25, wt. not taken -4/15/25, wt. not taken -4/16/25, wt. not taken -4/17/25, wt. not taken -4/18/25, wt. not taken During observation on 4/16/25 at 10:42 a.m., R31 was sitting in his room with oxygen on. R31 was observed to have labored breathing. During observation on 4/18/25 at 11:32 a.m., R31 was laying in bed with oxygen on. R31 was observed to have labored breathing. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A stated residents who have an order for daily weights should have their weight obtained in the morning before breakfast. RN-A stated any staff can obtain a weight and document the weight in the electronic medical record (EMR). RN-A said whoever obtains the weight are responsible for charting it. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 4/18/25 at 12:09 a.m., NP stated R31 was extremely complicated and fragile. NP stated R31 was experiencing labored breathing, had diminished lung sounds and was on the incorrect oxygen setting while lying in bed during the visit. NP stated R31's oxygen orders were for two liters at rest although was found to be set at four liters while lying in bed. NP stated she had wanted R31 to go to the ER for evaluation although R31 refused. NP stated she had also offered R31 Dilaudid (medication that reduces respiratory rate and reduces breathing difficulties) to help with his breathing and hydroxyzine for anxiety, NP indicated R31 refused. NP stated she was not sure if the Lasix (newly added medication from hospital) was effective or if R31 was having fluid buildup because she did not know what R31's weights were due to facility not following orders to obtain daily weights. NP stated she expected facility to obtain daily weight and to record them and follow any parameters in order to initiate interventions/treatments to help prevent resident from fluid buildup which can make breathing difficult. R31's weight obtained per NP on 4/18/25, was 156.6 lbs, a 14.1 pound increase. During a follow up interview on 4/18/25 at 3:11 p.m., NP stated R31 had slightly improved from the first visit and an action plan was made with R31 and R31's son. NP stated she obtained R31's weight today of ~157 pounds. NP stated R31's dismissal weight from the hospital was 142 pounds. R31 had a 14.4-pound weight gain in the past week. NP stated she was going to increase R31's Lasix. NP stated she felt like R31 could have been in respiratory failure this morning upon her initial assessment. NP stated oxygen orders were not initiated or started over the weekend from 4/11/25 (date of admission) to 4/14/25 and staff were administering the oxygen at whatever liter per minute R31 told them to put it on or whatever they felt was appropriate. NP stated son was very concerned as he noted a change in R31's breathing over the weekend. NP stated she notified the facility of this and that is when the facility initiated and entered the oxygen orders in R31's EMR. NP stated she expected staff to obtain a full set of vitals on residents every day to monitor for any changes in condition. During interview on 4/18/25 at 3:22 p.m., occupational therapist (OT) stated R31 had slowed down while in therapy over the past couple of days and did not have therapy today due to the NP holding therapy services until further notice. During interview on 4/17/25 at 12:03 p.m., licensed practical nurse (LPN)-G stated if there was a change in condition with a resident, she would notify the charge nurse, or the provider and document change in a progress note in the resident's chart. LPN-G stated if a resident had an order for daily weights, it would be reflected on the medication/treatment administration record. LPN-G stated the nursing assistants (NA)'s obtain the weight and would notify a nurse with weight results, who would then document weight in the EMR. LPN-G stated there is not a good system in place regarding weights as weights are missed. LPN-G reviewed R31's chart and confirmed R31 had an order for fasting daily weights and the last recorded weight was on 4/11/25. LPN-G stated it was important to get the daily weights on R31 due to his fragile health concerns and that the provider needed to be notified of any weight change to allow for immediate intervention to be done. During interview on 4/17/25 at 3:02 p.m., RN-C stated when a resident has an order for daily weights, she obtains the daily weight as it is needed and important due to condition and respiratory failure. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 4/18/25 at 2:44 p.m., LPN-A stated the NA's obtain the daily weights but if the nurse noticed it was not completed the nurse should obtain the weight. LPN-A stated daily weights should be done by 10:00-10:30 a.m. but could be delayed due to other factors that may arise. NA's know what weights to be obtained by looking in the EMR under their tasks. LPN-A stated if a daily weight does not get done then she would expect that resident to be the first one obtained the following day. During interview on 4/18/25 at 2:47 a.m., NA-B stated the nurse lets her know and she would write down which residents need weights. Once she got the weight, she would then give it to the nurse who would document. During interview on 4/18/25 at 3:11 p.m., NA-C stated the nurse gives her a paper log at the beginning of the shift, which is where she would write the weights on it and would return it to the nurse to document at the end of the shift. During interview on 4/17/25 at 2:00 p.m., director of nursing (DON) stated the admissions nurse, health unit coordinator (HUC), nurse manager and herself are responsible for processing and entering orders. DON stated the floor nurses are allowed to process orders if order was received after hours. DON stated all orders are verified by another nurse to ensure it was correct. During a follow-up interview on 4/18/25 at 4:25 p.m., DON stated daily weights are to be completed in the morning and if there are parameters in place for a resident and the weight is outside the parameter, she would expect staff to notify the provider of any change. DON confirmed R31 had an order, with parameters for fasting daily weights and the order was not followed. DON stated daily weights are important to be done for a person with any cardiac issues in order to identify immediately. DON confirmed the oxygen order was received on 4/11/25 although was not entered until 4/14/25. R201 R201's was admitted on [DATE] and admission MDS assessment dated [DATE], identified the MDS was In progress with no information completed. R201's EMR, included diagnoses of acute pyelonephritis (kidney infection), urinary tract infections, and chronic kidney disease (stage 4). R201's physician orders, dated 4/11/25, included the following: right nephrostomy (tube inserted into the kidney to drain urine directly into a collection bag outside the body) site care - cleanse with normal saline daily, pat dry and cover with split gauze and paper tape daily every evening shift. R201's care plan dated 4/7/25, indicated R201 had altered elimination and would need treatment/monitoring/cares due to weakness and immobility. Interventions identified R201 had a nephrostomy. Care plan also indicated R201 had an alteration in skin integrity related to surgical incision. Intervention identified staff to observe site daily for signs of infection or poor healing: drainage, odor, redness, warmth of incision line and to notify physician of any signs of infection. The care plan lacked location of surgical incision. (continued on next page)

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	245626	A. Building B. Wing	04/22/2025

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation and interview on 4/14/25 at 6:28 p.m., R201's nephrostomy bag contained dark red urine. R201 stated she was informed by staff she had an episode this morning where R201 became unresponsive and lethargic. During observation on 4/15/25 at 11:27 a.m., R201 just returned from therapy and nephrostomy bag contained dark red urine. During observation on 4/16/25 at 8:49 a.m., R201 was lying in bed with nephrostomy bag with dark red urine present. R201's EMR lacked documentation of monitoring of urine output (change in urine color), nor notification to provider of any changes in condition. During interview on 4/14/25 at 6:44 p.m., R201's family member (FM-B) stated they were not notified of an event related to unresponsiveness and when she went to the nursing station to inquire about the event, FM-B was told that R201 went unresponsive for a few seconds, was ashen (pale gray color) in color and was lethargic following event. During interview on 4/14/25 at 6:47 p.m., RN-C stated she was told in report R201 was hard to wake up that morning and became lethargic. RN-C confirmed there was no documentation in R201's EMR regarding event. R201's progress note, dated 4/16/25 at 4:16 p.m., indicated R201 was sent to ER by provider for further evaluation. During interview on 4/17/25 at 9:26 a.m., FM-B stated when the NP came to R201's room for a regular visit, during her assessment she noticed the urine in R201's nephrostomy bag was red. NP recommended R201 be sent to the ER for further evaluation. FM-B stated R201 had been hospitalized for a kidney and bladder infection and was having a stent exchanged in the morning. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A stated standard catheter, nephrostomy care consisted of ensuring urine is flowing appropriately and monitoring the amount and color of the urine. RN-A stated if there was something abnormal, she would document in the EMR and notify the provider. RN-A stated she did not receive a lot of training on nephrostomies and had only one observation of a nephrostomy. During interview on 4/17/25 at 12:03 p.m., licensed practical nurse (LPN)-G stated NA's empty nephrostomy bag and would notify her of any changes or concerns such as flowing of urine, dark colored urine. LPN-G stated she would notify the charge nurse and would encourage resident to drink more fluids. LPN-G stated she would assess urine for odor, assess resident for change in cognition and would monitor. LPN-G stated she would document abnormal findings in a progress note. LPN-G stated nephrostomy bag is emptied once to twice per shift. LPN-G stated she had not received any training regarding nephrostomies. During interview on 4/17/25 at 2:00 p.m., DON stated if there was a skill, task, or diagnosis not cared for in the facility, we would complete in person training for staff. DON stated the admission nurse would inform the DON prior to admission with what cares may need training on. This will allow the facility to initiate education ahead of time. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 4/17/25 at 2:26 p.m., RN-D stated there were no specific training related to nephrostomies. During interview on 4/17/25 at 3:02 p.m., RN-C stated NA's empty R201's nephrostomy bag and write down the urine output which she would then document in the EMR. RN-C stated NAs notify her of any changes. RN-C stated she would go and assess the abnormality (such as blood in the bag) and would call the provider to obtain an order. RN-C stated she was not notified of the dark red urine in R201's nephrostomy bag by any NA's. During a follow up interview on 4/18/25 at 11:40 a.m., DON stated if a resident is suspected to have a UTI or is displaying symptoms of a UTI, she would expect staff to monitor vital signs and symptoms, update the provider, increase fluids, enter progress note with information and initiate a nursing order on the MAR (medication administration record) for monitoring. During interview on 4/18/25 at 12:03 p.m., NP confirmed she was not notified R201's urine output was red. NP stated when she went to check in on R201 on 4/16/25, she had noticed red urine and had staff send R201 to the ER for further evaluation. NP confirmed when the resident previously had blood in her urine, it was an indication of a kidney, bladder infection. NP confirmed if she had been notified, she may have been able to prevent the visit to the emergency room by ordering a urine test to test for infection. During interview on 4/18/25 at 2:47 p.m., NA-B stated she emptied nephrostomy/catheter bags in the beginning of her shift and again at the end of her shift, document the amount drained. NA-B stated if she noticed a change in the urine, such as blood, she would let the nurse know immediately. During interview on 4/18/25 at 4:25 p.m., DON stated she expected there to be an order to obtain and monitor output for a resident with a nephrostomy/catheter. DON stated monitoring should consist of checking for redness around the insertion site, urine output and characteristics of the output, and any signs of drainage. DON stated she would expect staff to notify the provider immediately of any changes. DON stated staff should have notified the provider immediately when blood was noticed for direction from the doctor on what to do. DON confirmed there was no documentation of notification to the provider regarding dark red urine. 51379 R21 R21's MDS assessment dated [DATE], indicated intact cognition. R21 had a functional impairment of both lower extremities. R21 required substantial assistance with toileting and hygiene. R21 had an indwelling catheter requiring substantial assistance for care. R21's medical diagnosis included benign prostatic hyperplasia (overgrowth of cells causing organ enlargement) with lower urinary tract symptoms causing urinary retention. This diagnosis is further complicated by obstructive and reflux uropathy (blockage preventing urine from flowing normally). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R21's care plan for Foley Catheter dated 9/13/23 included R21 will be free of signs and symptoms of urinary tract infections, will receive catheter cares per order, have catheter emptied every shift, monitor and record output every shift, and monitor/record/request/report to provider change in amount, color, consistency, or odor. R21's physician orders include catheter change every month on the 11th, routine catheter care twice daily, change urinary drainage bag once a week on Mondays, and flush catheter with 30 ml (milliliters) of normal saline every shift as needed. During observation on 4/14/25 at 1:49 p.m., R21 had a leg bag for catheter drainage of urine. The drainage in the leg bag was red in color and filled approximately three quarters of the leg bag. R21 stated he was not in pain, did not recall if the drainage was new, and was unsure when staff had changed the catheter or the drainage bag. During observation on 4/14/25 at 6:09 p.m., R21 continued to have dark red urine in the catheter leg bag. R21's progress note dated on 4/15/2025 at 7:20 a.m., indicated R21 had approximately 600 ml's of blood in his urinary leg bag. The progress note lacked indication if staff notified a provider about the amount or color of the drainage in the urinary leg bag. R21's TAR indicated R21 had routine catheter care performed twice a day for the last seven days. R21's progress note dated on 4/15/2025 at 4:15 p.m., indicated R21 was sent to the emergency department and his son was notified. R21 returned to the facility after emergent evaluation; was diagnosed with a urinary tract infection and started on an oral antibiotic. During interview on 4/17/25 at 11:57 a.m., registered nurse (RN)-A could not state what routine catheter care entailed. RN-A stated she just looked to make sure the catheter was still flowing, what the output looked like, and if the catheter might need to be flushed. RN-A stated she charts the amount of urine output, not the characteristics. RN-A stated if the urine looked abnormal, such as redness, she would enter a progress note and notify the provider via a situation/background/assessment/recommendation (SBAR) note. RN-A confirmed a progress note and SBAR notification was not charted for R21. During an interview on 4/16/25 at 10:33 a.m., the nurse practitioner (NP)-A indicated an unawareness of R21's output included blood. NP-A confirmed when the resident previously had blood in his urine, it was an indication of a urinary tract infection. NP-A confirmed if she had been notified, she would have been able to help prevent the visit to the emergency room by ordering a urine test to test for infection and would start oral antibiotics. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) identified the facility charting does not have a location to document urine characteristics such as color, clarity, and odor. The DON indicated if a provider was notified about a change the staff are expected to input a progress note. The DON confirmed staff communicate these components of urine output via word of mouth or a progress note. DON identified a progress note of R21's urine characteristics dated 4/15/2025 at 7:20 a.m., although DON would have expected a progress note of R21's urine characteristics and notification to the provider when the blood was identified on 4/14/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was removed on 4/21/25, at 1:07 p.m. when it was determined the facility provided re-education and competency testing to licensed nursing staff on the facility's policies/procedures pertaining to change of condition, notification of changes, physician's orders, congestive heart failure, nephrostomy, COPD and catheters to include standards of documentation. In addition, the facility developed and implemented an auditing system for monitoring. R194 R194's admission Minimum Data Set (MDS) assessment was not completed in full at time of survey. R194's cognitive function was noted to be intact. R194 admitted on [DATE], following surgical repair of spinal stenosis (condition that narrows the space in the spine, putting pressure on the spinal cord or nerves). R194 diagnosis included atrial fibrillation (irregular heart rhythm), early ventricular depolarization (electrical signal in the heart come from lower chambers instead of upper chambers), atherosclerosis of the aorta (plaque buildup in the heart), bilateral carotid artery stenosis (partial or full blockage of the carotid artery located on each side of the neck), and hypertensive heart disease (develops due to prolonged high blood pressure, causing heart failure and abnormal heart muscle thickening). R194's care plan dated 3/28/25, identified a cardiac diagnosis and a pacemaker requiring monitoring, medications, and treatments. R194 care plan did not include person-centered interventions. R194's admission medication orders on 3/28/25 included amiodarone 200 mg each morning (used for irregular heart rate), metoprolol tartrate 75 mg twice per day (used for irregular heart rate and high blood pressure), apixaban 5 mg twice per day (used as a blood thinner), nitroglycerin 0.4 mg sublingual tablet every 5 minutes for 4 doses as needed (used for acute chest pain), and torsemide 10 mg every morning (used to treat fluid retention). During an interview on 4/14/25 at 1:47 p.m., R194 stated he fell earlier this morning due to low blood pressure (a condition called hypotension). R194 stated he started to feel dizzy in physical therapy (PT) and the physical therapist was assisting him back to his room. R194 stated he felt dizzy and thinks he might have passed out in the hall on his way back to his room. R194 stated he had been given all his normally scheduled cardiac medications. R194's medication administration record (MAR) identified R194 was administered his scheduled medications. R194's blood pressure summary indicated he had not had his blood pressure (BP) checked before administering the cardiac medications. R194's fall report dated 4/14/25 at 10:45 a.m., included vital signs of a BP result of 83/40, heart rate (HR) of 83, and an oxygen saturation of 89%. At 11:09 am., upon returning to his room BP was 115/49. R194's post fall progress note dated 4/14/25 at 11:30 a.m., read the appropriate staff were notified, provider and family. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R194's follow-up blood pressure was not documented until 4/14/25 at 5:06 p.m., with results being 123/52. R194 vital signs dated 4/15/25 at 10:56 a.m., included a BP of 86/64, a subsequent BP at 10:57 a.m., was noted to be 69/33. During an interview on 4/15/25 at 11:11 a.m., R194 was in his room with his wife and stated he was at PT this morning when he became dizzy again and not able to complete PT. The results of his BP was low and R194 was returned to his room. R194 stated he had been given his normally scheduled BP medications this morning and indicated the staff did not take his blood pressure prior to administering the medications. R194 and his wife were uncertain whether the provider had been notified of R194's recent low BP's. During an interview on 4/15/25 at 11:20 a.m., registered nurse (RN)-A said staff would need an order to check a BP, blood sugar, or oxygen level before administering some medications. RN-A indicated she was aware R194 had an episode of low BP the previous day. RN-A confirmed she did not check the BP prior to giving the scheduled medications this morning. RN-A indicated some of the medications given could potentially have lower 194's BP. RN-A confirmed she did not check R194's BP due to the last results were with in normal range and because there was no order to check vital signs prior to administering medications. RN-A stated she would hold a BP medication if the systolic (first number) BP was less than 90. RN-A stated she would hold a BP medication if the resident was experiencing symptoms such as dizziness, weakness, or falling. RN-A stated she would call an ambulance if the BP was less than 80 and the resident had symptoms of dizziness, weakness, or falling. RN-A confirmed the resident had a BP less than 80 and he has had episodes of dizziness and falling. RN-A stated she had notified licensed practical nurse (LPN)-B (position as a nurse manager) about R194's low BP from this morning. RN-A stated LPN-B would fill out a situation background assessment recommendation (SBAR) report and send to the provider. RN-A reviewed R194's vitals and verified last charted BP was 69/33. During interview on 4/15/25 at 11:35 a.m., physical therapist (PT)-A stated she worked with R194 on 4/14/25 and today (4/15/25). PT-A stated today they were monitoring R194's BP closely. At approximately 10:50 a.m. , R194's BP was within normal limits while on the stationary bike, however, when he sat down in a regular chair, he stated he felt like his BP was low again. PT-A stated she called the nursing staff who assisted R194 back to his room. During observation on 4/15/25 at 11:48 a.m., R194 was seated in his room, leaning towards the left; his appearance pale and R194 stated when he gets up, he has a lot of pressure in his head. During observation and interview on 4/15/25 at 1:02 p.m., R194 confirmed he has not had his BP checked since he returned from therapy. He stated he is feeling ok, although felt his BP was still low. R194 confirmed he had not seen a provider. During observation and interview on 4/15/25 at 1:07 p.m., RN-A confirmed there was no follow up BP checks after R194's last results were 69/33 and had not been directed by a physician to retake. Surveyor encouraged RN-A to verify R194's BP, taken manually the results were 120/72. RN-A confirmed she had not heard back from the provider and had not attempted to reach out to the provider regarding the recent low blood pressures. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/15/25 1:32 p.m., LPN-A and LPN-B stated an SBAR report was sent to the provider regarding R194's low blood pressures although had not received any new orders. LPN-A stated SBAR's are faxed to the providers for less emergent issues and phone calls are made for concerns with urgent situations to include a change in alertness, multiple falls, vital signs are abnormal or passing out. LPN-B confirmed R194 had experienced abnormal vital signs, two falls, and an episode of passing out and confirmed the provider was not phoned. During an interview on 4/15/25 1:55 p.m., director of nursing (DON) stated she was aware R194 experienced recent low blood pressures with two episodes of lightheadedness and dizziness which resulted in falls. DON confirmed the provider had been sent an SBAR report 4/15/25. DON stated she would consider anything less than 100/60 as low and anything less than 50/30 to be emergent, requiring a call to the provider or a call to 911. DON verified R194's documented BP of 69/33. DON confirmed no call was made to the provider. DON's expectation would be to continue monitoring R194 given his status and his cardiac history. DON stated she would expect a complete set of vital signs to include BP, heart rate, respiratory rate, and oxygen saturation prior to giving additional cardiac medications. DON also included their procedure for post-fall monitoring included vitals sign monitoring every 8 hours for 24 hours, notify provider, and document in a progress note. DON confirmed lack of post-fall documentation or provider notification for 4/14/25 or 4/15/25 falls. During interview and observation on 4/15/25 at 3:42 p.m., Medical Doctor (MD)-C visited R194 in the physical therapy room accompanied by the DON. PT-A and DON provided a brief update about R194. During this update, R194 stated he had experienced another fall at approximately midnight. The DON stated she was unaware of the 2nd fall on 4/14/25. MD-C instructed staff to return R194 to his room and complete a full set of orthostatic blood pressures and notify his regular provider with the results and encouraged R194 to remain in his room until seen by his normal provider on 4/16/25. During an observation on 4/16/25 at 7:20 a.m., LPN-C completed R194's necessary orthostatic BP levels without documenting the correlating heart rate. LPN-C stated an unawareness orthostatic BPs required a heart rate. During an interview on 4/16/25 at 7:56 a.m., MD-B confirmed an unawareness of R194's condition and incidents from 4/14/25 and 4/15/25 and would expect staff to notify a provider by phone immediately when there is a significant change in BP readings. MD-B stated staff could call 911 for immediate attention with symptoms of dizziness, falls, or general unwellness like R194 experienced. During an interview on 4/16/25 at 10:13 a.m., nurse practitioner (NP)-A stated she was notified of R194's falls and very low BP's upon arriving to the facility. NP-A stated she would have expected to be notified when a resident's BP is less than 90, and not just a receipt of an SBAR report being faxed. NP-A confirmed 911 should have been called for a BP less than 80 with symptoms such as falling, dizziness, and lightheadedness. NP-A confirmed the expectation is to complete a full set of vital signs prior to administering more than one cardiac medication, NP-A confirmed R194 received more than one cardiac medication. NP-A confirmed the expectation was to monitor vital signs, including a blood pressure, frequently after a fall that was suspected to be due to low blood pressure. NP-A confirmed the process for completing orthostatic BP's included laying, sitting, standing-waiting 3-5 minutes in between position changes with a correlating heart rate. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 4/16/2025 at 12:48 p.m., DON stated it is the expectation to complete a full set of vital signs after a fall; to include BP, pulse, temperature, respirator rate and oxygen saturation. DON confirmed R194 had a BP completed although lacked the remainder of vital signs after his falls. DON confirmed the late entry in the medical record regarding the fall at midnight on 4/15/25. DON confirmed the fall should have been documented at the time of the fall. DON stated an orthostatic blood pressure is completed at laying, sitting, standing positioning, waiting 3-5 minutes between positions with a correlating heart rate. DON confirmed R194 did not receive accurate orthostatic BP's. DON confirmed R194 had fallen 3 times, had not received po [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893 Based on observation, interview, and record review, the facility failed to ensure proper management of indwelling urinary devices for 1 of 1 residents (R6) reviewed for catheter care. R6's quarterly Minimum data Set (MDS) assessment dated [DATE] indicated R6 had severe cognitive impairment with no behaviors, is dependent on staff for all activities of daily living (ADLs) and has an indwelling catheter and ostomy. MDS also included R6 had diagnoses of multiple sclerosis (a progressive disease of the nervous system), neurogenic bladder (disease where the bladder does not function properly), and history of recurrent urinary tract infections. R6's care plan for catheter/urostomy/nephrostomy indicated R6 would remain free from signs and symptoms of urinary tract infections. Interventions included: catheter bag cover when in bed and wheelchair, change catheter as ordered by physician, empty catheter every shift and record output, keep catheter tubing free of kinks, keep drainage bag below bladder level, secure catheter to leg to avoid tension on urinary meatus (opening). Monitor, record, report to MD change in amount, color, consistency, or odor, infection signs and symptoms, chills, fever, nausea/vomiting, and pain. R6's medication administration record included: -suprapubic catheter (a tube inserted into the bladder through the abdomen) 18f change the 28th of every month -suprapubic catheter change drainage bag weekly -routine catheter care every day and evening shift -suprapubic catheter check tubing for proper positioning and cath care every shift -suprapubic catheter monitor intake and output every shift During observation on 4/15/25 at 10:43 a.m., R6 was sitting in common dining area for an activity with catheter drainage bag hanging on the armrest of the wheelchair at a level equal to resident's pelvis. During interview on 4/16/25 at 10:42 a.m., nursing assistant (NA)-B stated, sometimes I put the catheter bag under the chair and sometimes I hang it on the side. NA-B reported the catheter bag continues to drain properly if hanging on the side of the wheelchair. During observation on 4/16/25 at 1:41 p.m., R6 was sitting in wheelchair in the room with catheter bag hooked to arm rest of wheelchair at a level equal to resident's pelvis. During interview on 4/17/25 at 10:04 a.m., NA-D indicated catheter bags are clipped under the wheelchair so the bag does not drag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/17/25 at 1:06 p.m., the medical director (MD)-B stated drainage bags should be placed where gravity works to allow for proper drainage. During interview on 4/17/53 at 1:53 p.m., the director of nursing (DON) stated catheter drainage bags should be placed under the wheelchair to allow for proper drainage, otherwise staff should utilize a leg bag. Catheter bags should remain below the level of the bladder to prevent urine reflux and damage to the bladder. The DON stated drainage bags should not be placed on the arm of a wheelchair. A facility policy titled Indwelling urinary catheter (Foley) care and management dated November 18, 2024 indicated: Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI [catheter-associated urinary tract infection]

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Rochester Rehabilitation and Living Center	1900 Ballington Boulevard NW Rochester, MN 55901

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on observation, interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) (enters a peripheral vein and extends to the supervisor vena cava of the heart) was appropriately managed based on professional standards of practice and in accordance with physician orders for 2 of 2 residents (R138, R140) reviewed for intravenous (IV) medications. Findings include: R138 quarterly Minimum Data Set (MDS) assessment dated [DATE] was incomplete at the time of survey; cognitive function was intact. R138 was receiving IV antibiotic infusions. R138 was admitted on [DATE] with a diagnosis of right knee prosthesis infection and inflammation. R138 had a PICC line inserted into a peripheral vein in the upper right chest. R138's orders dated 3/31/25 lacked orders to change the PICC line dressing. Medication orders stated to administer ertapenem (IV antibiotic) 1 gram every 24 hours starting 3/28/25 at 11pm. During observation and interview on 4/14/25 at 6:32 p.m., R138 stated she was concerned because her PICC dressing had not been changed since 4/4/25. The written date on the PICC line dressing was found to be 4/4/25; the top left corner of the dressing was peeling away from the skin. Resident was also concerned the PICC line medication tubing looked old. PICC line tubing lacked a date as to when it was placed. R138's medication administration record (MAR) indicated ertapenem was administered on 4/14/25 at 12:20 a.m. and 4/15/25 at 12:03 a.m. R138's treatment administration record (TAR) reflected the PICC site care was completed on 4/16/25. R138's quarterly Minimum Data Set (MDS) assessment for R140 dated 4/8/25 was incomplete at the time of survey; cognitive function was intact. R140 was receiving IV antibiotic infusions. R140 was admitted on [DATE] with a diagnosis of left knee prosthesis infection. R140 had a PICC line inserted into a peripheral vein in the right upper arm. R140 R140's orders dated 3/31/25 included changing PICC line dressing every 7 days and as needed if dressing was loose, soiled, or wet. Medication orders stated to administer ceftriaxone (IV antibiotic) 2 grams every 24 hours starting on 3/31/25 at 9pm. During observation and interview on 4/14/25 at 1:16 p.m., R140 stated he is on IV antibiotics for post-operative knee infection. Confirmed the PICC site dressing was undated. PICC site dressing is peeling up on the top left corner and down towards the bottom left corner. The PICC line tubing did not have a date. R140's MAR reflected the ceftriaxone was administered on 4/14/25 at 9:54 p.m. and 4/15/25 at 8:19 p.m. R140's TAR reflected the PICC site care was completed on 4/16/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/15/25 at 11:20 a.m., RN-A stated PICC site care should be done once per week and PICC line medication IV tubing should be replaced every 24 hours. RN-A stated if she encountered a PICC line dressing without a date, if there was an order, she would change the dressing. If there wasn't an order to change the PICC line dressing, she would submit a situation background assessment recommendation (SBAR) report to ask the provider for an order. During interview on 4/16/25 at 10:29 a.m., nurse practitioner (NP)-A stated it is an expectation that PICC site dressing changes are done every 7 days. NP-A confirmed it is an expectation PICC line medication IV tubing is replaced every 24 hours. NP-A confirmed she had instructed nursing staff on 4/11/25 the PICC site dressing needed to be changed on 4/11/25. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated the general parameters, and expectation is PICC site dressing changes are done every 7 days. DON confirmed the expectation is to date the dressing with the date it was changed. DON stated she would expect staff to change the PICC site dressing if it was due even if there was not an order to do so. DON would expect staff to change the PICC site dressing if it was undated. Staff can fill out an SBAR to request an order after the PICC site dressing has been changed. DON confirmed the expectation is to change PICC line medication IV tubing every 24 hours. Per facility policy titled Central Vascular Access Device Dressing Change dated 6/1/24 a PICC line site care should be changed every 7 days from the date on the dressing label or more frequently if integrity of the dressing is compromised (wet, loose, or soiled). Per facility policy title Administration of an Intermittent Infusion dated 6/1/21 a PICC line medication IV tubing is replaced every 24 hours.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on observation, interview and document review, the facility failed to identify and treat pain for 1 of 1 residents R194 reviewed for pain management. Findings include: R194's resident admission assessment was not completed at time of survey. R194's cognitive function was intact. R194 was admitted [DATE] following surgical repair of spinal stenosis. His past medical history included: pain in right hip, pain in left hip, lower back pain related to surgery and post-surgical treatment. R194's care plan dated 3/28/25 indicated he could have post-surgical pain, and the intervention was to administer pain medication as ordered. R194's orders stated R194 should have pain monitoring every shift using the pain scale of 0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-8=severe pain, and 9-10=very severe/horrible pain. Non-pharmacological pain interventions should be documented for individualized pain as 1=ice, 2=relaxation/distraction, 3=repositioning, 4=re-medicating, 5=notify MD, 6=diversional activities, 7=music, 8=re-repositioning, 9=warm blanket, 10=stretching, 11=massage, 12=rest, 13=reduce stimuli, and 14=other. R194's active medication orders did not include any medication for pain. R194's medication administration record (MAR) dated 4/1/2025 to 4/15/2025 did not show pain medication was given. R194's treatment administration record (TAR) dated 4/1/2025 to 4/15/2025 did not show non-pharmacological treatments were given. The TAR also indicates R194 did not have pain assessed on 4/14/25 for the morning shift. The TAR indicated pain was assessed for the morning shift on 4/16/25 to be 5/10 indicating moderate pain. The MAR indicated no pain medications were given on this day and no non-pharmacological interventions were performed. The TAR indicated pain was assessed for the morning shift on 4/17/25 to be 7/10 indicating severe pain. The MAR indicated no pain medications were given on this day and no non-pharmacological interventions were performed. During observation and interview on 4/14/25 at 01:41 p.m., R194 stated his pain was doing ok until late last week, now he is having increased back pain with movement. R194 showed slight facial grimaces when repositioning, stating he doesn't have anything for pain relief. Record review showed R194 did not have any pain medications actively ordered. During observation and interview on 4/15/25 at 11:17 a.m., R194 stated he has 3/10 pain with movement today, he stated he told the nurse today but hasn't heard back from her if he can have something. During interview on 4/15/25 at 11:20 a.m., registered nurse (RN)-A stated R194 did tell her he had 3/10 pain. RN-A stated the resident does not have any active pain medication orders. RN-A stated she could give him a dose of Tylenol from the nursing standing orders. RN-A confirmed R194 has non-pharmacological interventions ordered; she has not offered him any of these medications or interventions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 4/16/25 at 7:23 a.m., R194 stated he continued to have pain yesterday afternoon and into the evening. R194 stated he had not been asked about his pain and he had not been offered any medications or non-pharmacological pain interventions. R194 stated he must breathe through the pain of getting up, further stating physical therapy (PT) has gotten harder as his pain continues to increase. R194 stated he fears not being able to complete PT since his pain keeps increasing. During interview on 4/16/25 at 7:27 a.m., RN-A stated she was aware the resident was rating his pain a 5/10. RN-A stated again R194 could have Tylenol from the standing orders since he still did not have anything ordered for his pain. RN-A stated she did not notify the provider about his increasing pain yesterday, and she had not notified the provider about the continued increase in pain today. During interview on 4/17/25 at 2:49 p.m., RN-A stated she assessed R194's pain around 2pm and he told her when he gets up it is 7. RN-A stated she had given R194 Tylenol, an ice pack, and sent a situation background assessment response (SBAR) report to the provider. RN-A stated she completed a progress not about this interaction so others would know she acted upon R194's pain. R194 progress note dated on 4/17/25, reflects the Tylenol was offered, although did not included the Tylenol was given. The TAR does not reflect the ice was given. During interview on 4/16/2025 at 12:48 p.m., the director of nursing (DON) stated it is an expectation staff contact a provider for pain management medication if resident stated they have pain, but no pain medication is ordered. DON confirmed the R194 did not receive pain medication or non-pharmacological pain interventions. DON confirmed she could not locate the SBAR report notification to the provider to order pain medications. DON confirmed R194 could have prolonged treatment if his pain continued to go untreated. Per facility policy titled Pain Evaluation and Management, dated 10/24/2022, stated If the resident has a diagnosis which could cause pain or discomfort, and they show no sign or symptoms of pain or discomfort, continue to reassess for indicators of pain and behavioral changes. Staff should notify provider of any pain management change needed. Ensure non-pharmacological pain interventions have been included in the resident's pain management plan of care. Facility standing orders were requested but not received.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. 51576 Based on interview and document review the facility failed to ensure clinical laboratory (lab) reports were filed into the medical record for 1 of 3 residents (R237) reviewed for laboratory reports. R237's face sheet dated 4/22/25, identified diagnoses of osteomyelitis (bone infection) and pyelonephritis (kidney infection). Review of R237's hospital discharge summary dated 3/11/25, identified R237 received intravenous (IV) antibiotics until 3/26/25 and was to have weekly bloodwork tests performed. Review of R237's clinic laboratory reports dated 3/14/25 and 3/21/25, identified R237 had labs completed. Review of R237's medical record from 3/11/25 through 4/21/25 did not identify any laboratory results in chart or notification of laboratory results were faxed to infectious disease. During an interview on 4/21/25 at 12:26 p.m., director of nursing (DON) stated R237's had an order to receive weekly bloodwork while taking IV antibiotics from 3/11/25 through 3/26/25, however, the labs performed on 3/14/15 and 3/21/25 had not been received from the outside laboratory and had not been filed into R237's medical record. Review of the facility's laboratory Services Policy dated 8/14/23, identified that when qualified laboratory services must be performed out of the facility, the facility will: -Schedule the laboratory services. -When appropriate, obtain the laboratory specimen or have the resident prepared for the laboratory services to obtain the specimen. -Be responsible to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges. -File in the resident's clinical record laboratory reports dated and contain the name and address of the testing laboratory.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) for 2 of 2 (R138, R140) residents reviewed for infection prevention related to presence of peripherally inserted central catheter (PICC) line (enters a peripheral vein and extends to the supervisor vena cava of the heart). Findings include: R138 quarterly Minimum Data Set (MDS) assessment dated [DATE] was incomplete at the time of survey; cognitive function was intact. R138 was receiving IV antibiotic infusions. R138 was admitted on [DATE] with a diagnosis of right knee prosthesis infection and inflammation. R138 had a PICC line inserted into a peripheral vein in the upper right chest. R138's orders dated 3/31/25 did not include orders to change the PICC line dressing. Medication orders stated to administer ertapenem (IV antibiotic) 1 gram every 24 hours starting 3/28/25 at 11pm. R138's orders did not include orders for enhanced barrier precautions. During observation on 4/14/25 at 6:32 p.m., a PICC line was noted in R138's peripheral vein in the upper right chest. R138's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 4/15/25 at 13:56 p.m., registered nurse (RN)-A was observed entering R138's room to administer medication, RN-A did not put on PPE. R140 quarterly Minimum Data Set (MDS) assessment dated [DATE] was incomplete at the time of survey; cognitive function was intact. R140 was receiving IV antibiotic infusions. R140 was admitted on [DATE] with a diagnosis of left knee prosthesis infection. R140 had a PICC line inserted into a peripheral vein in the right upper arm. R140's orders dated 3/31/25 included changing PICC line dressing every 7 days and as needed if dressing was loose, soiled, or wet. Medication orders stated to administer ceftriaxone (IV antibiotic) 2 grams every 24 hours starting on 3/31/25 at 9pm. R140's orders did not include orders for enhanced barrier precautions. During observation on 4/14/25 at 1:16 p.m., a PICC line was noted in R140's peripheral vein in the right upper arm. R140's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 4/15/25 at 9:48 a.m., RN-A was observed entering R140's room to administer medications, RN-A did not put on PPE. During interview on 4/16/25 10:24 a.m., nurse practitioner (NP)-A stated both R138 and R140 should have been placed in EBP precaution upon admission due to both having PICC lines placed prior to admission at facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/15/25 at 11:20 a.m., RN-A stated it is common to use EBP for residents with urinary catheters, indwelling lines, ostomies, or other things coming out of the body. RN-A stated if a resident required EBP then they should have and EBP sign placed on the door. RN-A stated the health unit coordinator (HUC) or admission nurse would place the EBP signs on the doors. During interview on 4/16/2025 at 12:48 p.m., director of nursing (DON) stated EBP precautions are used for residents who have open wounds, catheters, PICC lines, or a known infection. DON confirmed R138 and R140 did not have enhanced barrier precautions initiated at admission. Per undated facility policy titled IPC Manual Chapter 8 Transmission Based Precautions, EBP precautions are initiated for residents with PICC lines, urinary catheters, and feeding tubes. Further, clear signage should be hung on the door with an isolation cart containing PPE placed outside the room.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure 2 of 5 residents (R194 and R199) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 11/21/24, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer, after 5 years, the Pneumococcal 20-valent Conjugate Vaccine (PCV20) or Pneumococcal 21-valent Conjugate Vaccine (PCV21) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. This also identified an adult over [AGE] years old, who received one dose of PPSV23 at any age should be offered either option A (PCV20 or PCV21) or option B (PCV15) after one year. R194's face sheet dated 4/22/25, indicated he admitted to the facility 3/28/25 and was [AGE] years old. The immunization record dated 4/18/25, indicated he received a PPSV23 on 11/02/06 and a PCV13 on 12/19/14. The record lacked evidence of shared clinical decision making with his physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R5 was offered or received PCV20. R199's face sheet dated 4/21/25, indicated she admitted to the facility 3/10/25 and was [AGE] years old. The immunization record dated 4/18/25, indicated she received a PPSV23 on 5/5/10 and a PCV13 on 3/9/15. The record lacked evidence of shared clinical decision making with her physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R5 was offered or received PCV20. During interview on 4/21/25 at 2:34 p.m., the director of nursing (DON) stated she was responsible for the facility infection control program including ensuring resident eligibility for and offering routine vaccinations. The DON stated the facility procedure and expectation was to determine each resident's vaccine history and eligibility for vaccines upon admission. The DON acknowledged R194 and R199 had been eligible for the PCV20 however had not been educated on the risk and benefit or offered the PCV20 vaccine per CDC guidelines. The facility Pneumococcal Vaccine Program Policy dated 5/17/23, indicated residents will be offered immunizations again pneumococcal disease in accordance with CDC recommendation on vaccinations. Pneumococcal disease is a serious illness that can cause sickness and even death. Adults [AGE] years and older: CDC recommends pneumococcal vaccination for all adults [AGE] years or older. The tables below provide detailed information. For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Give 1 dose of PCV15 or PCV20. o If PCV15 is used, this should be followed by a dose of PPSV23 at least 1 year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. o If PCV20 is used, a dose of PPSV23 is NOT indicated. For adults [AGE] years or older who have only received PPSV23, CDC recommends you: *Give 1 dose of PCV15 or PCV20. o The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. o Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults [AGE] years or older who have only received PCV13, CDC recommends you either: *Give 1 dose of PCV20 at least 1 year after PCV13 Or *Give 1 dose of PPSV23 at least 1 year after PCV13.