STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 2 of 2 residents (R3, R15) reviewed for self-administration of medications.Findings include:R3R3's quarterly Minimum Data Set (MDS) assessment, dated 4/27/26, indicated R3 was cognitively intact with no signs of delirium or behaviors. R3 had no upper body impairment and bilateral lower body impairment. R3 required setup for eating and oral hygiene, partial assist for toilet hygiene, bathing, and upper body dressing, and substantial assist for lower body dressing, footwear, and personal hygiene. R3 also required substantial assist with bed mobility and transfers to/from bed/chair.R3's careplan indicated R3 required 1 assist for transfers and activities of daily living.During observation and interview on 6/22/26 at 6:45 p.m., an unlabeled bottle of fluticasone nasal spray was noted on R3 bedside table. R3 stated she administers it on her own in the morning and in the evening. R3's medication administration record (MAR) lacked an order for fluticasone nasal spray. R3's self-administration medication assessment dated [DATE] indicated R3 did not wish to self-administer medications or keep medications at bedside. During observation and interview on 6/23/26 at 9:16 a.m., R3 was returning from breakfast and stated she administered the fluticasone nasal spray prior to breakfast. The nasal spray was located on R3's bedside table next to her water glass. R3 stated her family member brought the nasal spray in for her. At 9:21 a.m., registered nurse (RN)-A entered R3's room with morning medications, reached across R3's bed and picked up the water glass. After administering R3's medications, RN-A placed the water glass back on the bedside table, picked up the nasal spray, looked at both sides of the spray, and placed it back on the bedside table. R15R15's quarterly MDS assessment, dated 4/14/26, indicated R15 was cognitively intact with no delirium and no behaviors. R15 had no upper or lower body impairment, was independent with oral and personal hygiene as well as bed mobility. R15 required set-up for meals, partial assist for upper and lower body activities of daily living, and was dependent on staff for transfers. R15 was also receiving dialysis. R15's careplan indicated R15 required 1 staff assist with activities of daily living and transfers and received dialysis treatments. During an observation and interview on 6/22/26 at 1:10 p.m., a bottle of Pepto Bismol (over the counter medication used to treat diarrhea and stomach upset) was on the nightstand between R15's recliner and bed. The bottle was 3/4 full. R15 stated she used it when she had diarrheal episodes about a month ago and likes to keep the bottle on hand incase another episode creeps up on her. R15's MAR record lacked an order for Pepto Bismol.R15's most recent self-administration assessment dated [DATE] indicated R15 does not wish to keep medications at bedside. R15's facility progress notes indicated R15 had 2 diarrheal episodes on 5/1/26 however no mention to having Pepto Bismol in her room. During observation on 6/23/26 at 8:48 a.m., the Pepto Bismol bottle remained on the nightstand. The bottle measures 473 milliliters and does not have a pharmacy label. During an interview on 6/23/26 at 11:39 a.m., registered nurse (RN)-B stated if a medication was found in a resident's room, the medication is removed and the nurse manager or director of nursing (DON) is notified. If a resident wishes to administer a medication independently, a self-administration assessment is performed to make sure the resident is safe to administer the (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication independently. If there is no order for the medication, the medication is removed, and an order is obtained by the provider. During an interview on 6/23/26 at 12:59 a.m., RN-A stated it was her first time working down that hall. RN-A stated if a medication is found in a resident's room, the medication is removed and verified against existing orders. The provider and pharmacy would also be notified. If there was no order for the medication, RN-A stated she would investigate where it came from and not leave the medication in the room. RN-A stated a provider order is required if a resident requests to administer a medication independently. RN-A confirmed R3 did not have an order for fluticasone and said did I leave it in her room? I don't recall giving it to her this morning. RN-A also confirmed R3 did not have a self-administration order from the provider. RN-A stated R15 was already at dialysis at the start of her shift, so she had not been in R15's room yet. RN-A entered room and confirmed bottle of Pepto Bismol on the nightstand and confirmed it was 3/4 full with no pharmacy label. RN-A confirmed R15 did not have an order for Pepto Bismol. During an interview on 6/23/26 at 1:14 p.m., RN-C stated if a resident brings in medications from home, the family is asked to take it with them. The facility is only permitted to dispense medications from the pharmacy. If a resident requests to administer a medication independently, a self-administration assessment is performed. An order is then obtained from the provider authorizing the resident to administer the medication independently. RN-C stated medications should not be left in a resident's room without a self-administration assessment and providers' order. RN-C reviewed R3's medical record and confirmed R3 did not have an order for fluticasone. RN-C confirmed R3's last self-administration assessment was dated 1/26/26 and indicated R3 did not wish to self-administer or keep medications at bedside. RN-C then reviewed R15's medical record and confirmed R15 did not have an order for Pepto Bismol. RN-C also confirmed R15's most recent self-administration assessment dated [DATE] indicated R15 did not want to self-administer medications or have medications left in her room. During interview on 6/23/26 at 1:57 p.m., the director of nursing (DON) stated if family brought in medication from home, the facility would verify the medication is correct, make sure it is labeled, and make sure there is a provider order. Medications should remain locked up in the medication cart. If a resident requested to self-administer a medication, a self-administration assessment is performed and an order would be obtained from the provider. The director of nursing confirmed R3 did not have an order for fluticasone and R15 did not have an order for Pepto-bismol. A policy titled Self-Administration of Medications dated 5/22/18 indicated It is the right of the resident to self-administer their medications if the interdisciplinary team has assessed and evaluated that the resident is able to physically and cognitively, safely administer the prescribed medication. The policy continues If the resident wishes to self-administer their medications, at the time of admission and during stay at the facility, the interdisciplinary team will initiate a Self-Administration of medication Assessment to determine if the resident is capable and clinically appropriate, based on the resident's cognition, physical ability, functionality and status of health conditions. A physician order will be obtained by the nurse prior to proceeding with self-administration. To ensure safe and accurate self-administration, education will be provided to the resident to ensure that a resident is able to: state the name, dose, strength, route, frequency, and purpose for use of his/her medications. The policy also states the resident should understand the possible side effects of his/her medications and that he/she should notify facility staff if he/she experiences any side effects. The resident should demonstrate correct and timely administration of the medication and demonstrate and consistently maintain, safe storage of his/her medications in a locked storage. Each resident self-administering their medications will have their individualized self0administration plan defined on their careplan. This will include the specific plan for the self-administration including the specific medications the resident is responsible for, the monitoring plan, the reassessment plan, the storage plan-including self-storage, reordering plan. The facility staff should document the self-administration of medications on the resident's MAR/TAR according to the medication administration schedule. The policy also indicates the facility should document in the resident's careplan whether the resident or facility staff is responsible for the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	storage of the resident's medications. If the resident is responsible for the storage, the facility should provide a secure compartment for storage of such medications in accordance with facility policy, applicable law, the State Operations Manual.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide activities of daily living (ADL) for 2 of 2 residents (R41, R20) who were dependent on staff for timely assistance for personal hygiene.Findings Include: R41 R41's quarterly Minimum Data Set (MDS) was not completed at time of survey; R41 admitted to the facility on [DATE]. R41's care plan dated 6/9/26 indicated R41 required extensive assistance to total assistance with personal hygiene and grooming. R41's care plan lacked resident-specific directions about facial hair/removal. R41's provider orders dated 6/9/26 indicated R41 was to have weekly skin checks and vital signs every evening shift every Saturday for bath day, if resident refuses, document reason and attempts. The treatment administration record (TAR) indicated the skin checks and vital signs had been completed; the TAR lacked documentation a bath had been performed. R41's 30 day look back for point of care task history for bathing/showering indicated R41 had not had a shower or bath since her admission. During observation and interview on 6/22/26 at 12:45 p.m., R41 had multiple long hairs on her upper left and upper right lip, additionally, R41 had a patch of long grey hairs on her bottom right chin and several long hairs on her bottom left chin. R41 stated she does not like facial hair, it was embarrassing for her to have facial hair; stating this is a reason she doesn't like to leave her room. During an interview with R41 on 6/22/26 at 1:57 p.m., R41 looked upset with a frown on her face and stated this chin hair really, really bothers her and she is really really upset about it. During an interview on 6/23/26 at 1:56 p.m., registered nurse (RN)-B, stated residents should have facial hair removed, per their preference, on bath days. Additionally, nursing assistant (NA)-C stated R41 did get a bath today and would expect the resident to have gotten her facial hair removed if that was her preference. NA-A stated she did not notice any facial hair on R41 when she gave her a bath today. During an interview on 6/23/26 at 2:24 p.m., R41 stated she was given a bath today, but stated she continued to have facial hair. R41 stated as someone who likes fashion, facial hair is very embarrassing for her. She wishes it was all gone. R41 stated she tried to remove her facial hair on her own but was unable to remove all the hairs, she wished they would help her with this. R20 R20's MDS dated [DATE] indicated R20 had no cognitive impairment and required partial to moderate assistance with personal hygiene, including shaving. R20's care plan dated 6/1/26 indicated R20 required extensive assistance to total assistance with personal hygiene and grooming. R41's care plan lacked resident-specific directions about facial hair/removal. R20's provider orders dated 6/9/26 indicated R20 was to have nursing weekly bath/skin checks and vital signs, if resident refuses, document reasoning and attempts. The treatment administration record (TAR) indicated the skin checks and vital signs had been completed; the TAR lacked documentation a bath had been performed. R20's 30 day look back for point of care task history for bathing/showering indicated R20 completed baths on 6/6/26, 6/9/26, 6/13/26, 6/16/26, 6/20/26, and 6/23/26. R20 had not refused a bath or personal hygiene cares. During an observation and interview on 6/22/26 at 2:18 p.m., R20 had a patch of chin hair on her upper right lip and a patch of hair on her bottom right and left chin. R20 stated she does not like the chin hair, but the facility had not helped her remove it. During observation and interview on 6/23/26 at 11:12 a.m., R20 was sitting outside her room, she stated she was waiting for someone to come take her to a bath. R20 stated she hoped they would assist her with removal of her facial hair; thinks bath time is the perfect time to remove facial hair. During observation and interview on 6/24/26 at 9:49 a.m., R20 stated she had gotten her bath yesterday. However, R20 stated she was disappointed they did not remove her facial hair. R20 stated the bath would have been the best time to remove her facial hair. During an interview on 6/23/26 at 2:06 p.m., nursing assistant (NA)-A, stated she gave R20 a bath today. NA-A stated she did not notice if R20 had any facial hair; acknowledging facial hair on female residents could be distressing to them. Again stating, she did not notice facial hair on R20. During an interview on 6/24/26 at 10:35 a.m., the director of nursing (DON) stated it is an expectation to address facial (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hair during bath days and complete removal per the resident's preferences. Female residents should specifically be addressed for facial hair because it is not normal for them to have facial hair. The DON stated she would expect both R41 and R20 to have had their facial hair removed during their bath time yesterday. A facility policy titled Activities of Daily Living (ADL)'s dated 5/1/25, the purpose of the policy is to establish consistent expectations for providing ADL care and services that preserve resident dignity, promote independence, and prevent avoidable decline in function across all long-term and skilled nursing facilities. Additionally, a resident who is unable to carry out ADL's will be provided the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene.