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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on interview and document review the facility failed to report a significant medication error (an error that causes the resident discomfort or jeopardizes the residents health and safety) was reported to the state agency (SA) for 1 of 3 (R1) residents reviewed for medication errors. Findings include: An INR (International Normalized Ratio): lab test measures how long it takes your blood to clot and is used to assess your risk of bleeding. INR tests are also used to assess the risk of bleeding or the coagulation status of patients. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1's cognition was intact and diagnoses of permanent Atrial Fibrillation (a heart condition that causes an irregular and often rapid heartbeat in the upper chambers of the heart), presence of prosthetic heart valve (at risk for blood clotting complications), and Factor 5 Leiden syndrome (a mutation of one of the clotting factors in the blood. This mutation can increase your chance of developing abnormal blood clots, most commonly in your legs or lungs). R1's Nurse Practitioner (NP) order dated 9/26/24 at 8:50 a.m., identified a new order for enoxaparin 40 milligrams (mg)/0.4 milliliter (ml) subcutaneous syringe (Lovenox). Directions identified to inject 0.9 ml (90 mg total) under the skin two times a day for 7 days. 0.9 ml (90 mg) subcutaneous (SQ) BID (twice a day) until INR is > 2.0. R1's NP visit dated 9/27/24 at 7:54 a.m., identified a visit was completed for anticoagulation management for atrial fibrillation, bioprosthetic mitral valve and Leiden Factor 5 syndrome. R1's INR goal identified 2.0 to 3.0. Current INR was 1.4. Lovenox was not initiated 9/26/24, check INR daily through 9/30/24 and give SQ Lovenox as ordered until INR > 2.0. R1's Medication Administration Record (MAR), dated 9/27/24 at 2:45 p.m., identified to inject Lovenox injection solution 0.9 ml subcutaneously two times a day for blood clotting prevention until 9/30/24. Give only if INR is below 9/30/24. On 9/27/24 the order should have been implemented for an 8:00 a.m. dose and this was omitted. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/9/24 at 4:25 p.m., R1 was seated in his room on his wheeled walker. R1 stated he had been on anticoagulation medications for almost [AGE] years due to several cardiac diagnoses and a genetic blood clotting factor. R1 indicated he had a history of development of 2 blood clots in his lower right leg and a blood clot in his lung. R1 indicated he did receive two injections at night of Lovenox a couple weeks ago when his INR got down to 1.4. R1 stated he has not had to have Lovenox injections for years and has been able to keep his INR within a therapeutic range with his coumadin dosing. R1 further stated the facility did not notify him of any medication errors with his blood clotting medications and stated he would like to be notified if there was an error. During an interview on 10/10/24 at 11:21 a.m., registered nurse (RN)-A stated she was the nurse manager for R1. RN-A stated she was aware that R1 had a medication error when R1 did not receive his Lovenox injection for his morning dose on 9/27/24. RN-A stated NP-A saw R1 on 9/27/24 and had asked her why the order was never initiated. RN-A indicated this significant medication error should have been reported to the state agency. During an interview on 10/10/24 at 5:35 p.m., regional nurse consultant (RNC)-A indicated the facility was aware that R1's Lovenox order was not implemented as ordered and the missed dose would be considered a significant medication error. RNC-A further indicated it should have been reported to the state agency and was not. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, Resident/Client Protection Freedom From Abuse, Neglect, and Misappropriation, revised 11/3/22 identified, I. FACILITY/SERVICE MISSION, PHILOSOPHY AND PLAN OBJECTIVE, It is the policy of Volunteers of America that all resident/client/participants/clients are free from abuse and neglect. All VOA facilities and program serving adults will establish and enforce written policies and procedures related to suspected or alleged maltreatment and will orient residents/clients/participants and mandated reporters to these procedures. In accordance with federal regulation, this Resident/client/participant Protection Plan establishes the policies and procedures for protecting the individuals that live at our facility/service and/or receive our services. Each individual has the right to be free from verbal, sexual, physical, and mental abuse, including injuries of unknown source, misappropriation of resident/participant property, corporal punishment, mistreatment, neglect, and involuntary seclusion. Resident/client/participants must not be subjected to abuse by anyone, including, but not limited to, facility/service staff, other resident/client/participants, consultants or volunteers, staff of other agencies serving the resident/client/participant, family members, or legal guardians, friends, or other individuals. To further that philosophy and as required by law, our facility/service has adopted the Resident/client/participant Protection Plan. The facility/service does not discriminate in providing services on account of membership in any protected class, including, without limitation, race, color, creed, religion, national origin, sex, disability, or sexual orientation .G. Reporting and Response 1. Employees must always report alleged abuse/neglect (i.e. incidents, mistreatment, abuse, neglect, injuries of unknown and known origin, and misappropriation of resident/client/participant property) immediately to the Supervisor or the Building Supervisor. 2. Anyone who reports abuse/neglect/exploitation in good faith will not be retaliated against. 3. The Executive Director/or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail or answering machine. Document date and time of notification .7. Documentation a. Should be objective b. Statements made by the resident/client/participant should be in quotes c. Statements made by staff should be part of the investigation and given to Administration d. Include immediate interventions to keep the resident/client/participant safe e. Include resident/client/participant's behavior and the environment f. Include who was notified and the time the notification occurred. Note: Acceptable means of notification include fax, voice mail, and answering machine. Email is not acceptable method of notification. g. Include social services or designee in the notification h. Do not include another resident/client/participant's name in the note. If another resident/client/participant was involved refer to them as another resident/client/participant. Neglect is the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is: 1) reasonable and necessary to obtain or maintain the vulnerable adults physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult, and 2) which is not the result of an accident or therapeutic conduct. The absence or likelihood of absence of care or services, including but not limited to food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review, the facility failed to follow physician orders, labs, and administer anticoagulant medications and failed to have a system in place to identify, record and report omitted medications as medication errors for 2 of 3 (R1 and R2) residents reviewed for medication errors. Findings include: An INR (International Normalized Ratio): lab test measures how long it takes your blood to clot and is used to assess your risk of bleeding. R1's discharge summary dated [DATE], identified to hold warfarin (blood thinning medication) on [DATE]. Check INR on [DATE] to determine ongoing warfarin dosing. R1's physician visit dated [DATE], identified R1 had permanent atrial fibrillation (a heart condition that causes an irregular and often rapid heartbeat in the upper chambers of the heart), bioprosthetic mitral valve (at risk for blood clotting complications), history of tricuspid valve repair, coronary artery disease, and Factor 5 Leiden syndrome (a mutation of one of the clotting factors in the blood. This mutation can increase your chance of developing abnormal blood clots, most commonly in your legs or lungs) with prior deep vein thrombosis (DVT). R1 was on chronic anticoagulation with warfarin. Warfarin on hold until next INR, will order today. R1's Medication Administration Record (MAR), dated [DATE], identified on [DATE], to check R1's INR. Under INR box was blank indicating INR was not completed. R1's medical record indicated R1's INR was not checked per physician order on [DATE], a physician was not notified to resume R1's Coumadin dosing therefore R1's coumadin was not administered on [DATE]. R1's Nurse Practitioner (NP) visit dated [DATE] at 3:17 p.m., identified a visit was completed for anticoagulation management for atrial fibrillation, bioprosthetic mitral valve and Leiden Factor 5 syndrome. R1's INR goal identified 2.0 to 3.0. R1's INR was 2.0, give 2 mg of warfarin daily and recheck INR on [DATE]. R1's signed medical doctor (MD) verbal order dated [DATE] at 4:14 p.m., identified to give warfarin 2.5 mg daily until [DATE]. R1's NP visit dated [DATE], identified R1's INR was 1.4, R1 did not receive warfarin on [DATE]. On [DATE] give 4 mg of warfarin and on [DATE] give 3 mg. Recheck INR on [DATE]. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1's cognition was intact and received anticoagulants. R1's NP visit dated [DATE], identified R1's INR was 1.4. On [DATE] and [DATE] give warfarin 5 mg. Recheck INR on [DATE]. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's MAR dated [DATE], identified on [DATE], R1 did not receive warfarin 5mg as indicated by a blank space. R1's medical record does not identify if a provider was notified of R1's missed warfarin dose on [DATE]. R1's NP order dated [DATE] at 8:50 a.m., identified a new order for (Lovenox-an injectable anticoagulant) 40 mg/0.4 milliliter (ml) subcutaneous syringe. Directions identified to inject 0.9 ml (90 mg total) under the skin two times a day for 7 days until INR is > 2.0. R1's NP visit dated [DATE] at 7:54 a.m., identified R1's INR was 1.4. Lovenox was not initiated [DATE]. Check INR daily through [DATE] and give SQ Lovenox as ordered until INR > 2.0. R1's MAR dated [DATE], identified on [DATE] at 8:00 a.m., R1 did not receive 90 mg of Lovenox injection, the order was not put in until [DATE] at 1:45 p.m. R1's record identified on [DATE] that his INR was 1.4 and should have received an injection of 90 mg of Lovenox at 8:00 a.m. which was omitted due to the order being put in late. R1's MAR dated [DATE], identified R1's INR was 1.6. R1's MAR dated [DATE], identified on [DATE] at 8:00 p.m., R1's INR was 1.8. R1 did not receive 90 mg of Lovenox injection. An 8 was documented that indicated to see progress note. R1's progress note dated [DATE] at 9:13 p.m., identified Lovenox injection solution was not available. Dosage ends on [DATE]. R1's record does not identify if R1's provider was notified of missed Lovenox injection. R1's NP visit dated [DATE] at 12:41 p.m., identified R1's INR was 2.1. Give 7.5 mg of warfarin on [DATE] and 5 mg daily thereafter. Recheck INR on [DATE]. R1's care plan revised [DATE], identified a focus that R1 had anticoagulant use. Interventions dated [DATE], identified to do labs and give medications as ordered by provider. During an observation and interview on [DATE] at 4:25 p.m., R1 was seated in his room on his wheeled walker. R1 stated he had been on anticoagulation medications for almost [AGE] years due to several cardiac diagnoses, history of blood clots and a genetic blood clotting factor. R1 indicated he did receive two injections at night of Lovenox a couple weeks ago when his INR got down to 1.4. R1 stated he had not had to have Lovenox injections for years and has been able to keep his INR within a therapeutic range with his warfarin. R1 stated the doctors start to get nervous when my INR gets lower than 2.4 because then it really drops. R1 further stated the facility did not notify him of any medication errors with his blood clotting medications and stated he would like to know if there was an error. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:21 a.m., registered nurse (RN)-A stated she was the nurse manager for R1. RN-A stated she was aware that R1 had a medication error when R1 did not receive his Lovenox injection for his morning dose on [DATE]. RN-A stated NP-A saw R1 on [DATE] and had asked her why the order was never initiated. RN-A stated they later found out that when the provider faxed the order it went straight to the pharmacy, and she didn't remember seeing the order. RN-A verified R1 did not have his INR drawn on [DATE] per provider order, missed 5mg dose of warfarin on [DATE], and missed dose of Lovenox on [DATE] at 8:00 a.m. and [DATE] at 8:00 p.m. RN-A was not aware of these medication errors and verified there was nothing documented in R1's medical record that a physician was notified. During an interview on [DATE] at 4:09 p.m., RN-B stated that she found a message in R1's chart that (name of lab) lab technicians had messaged the doctor covering for medical doctor (MD)-A on [DATE] at 1:35 p.m., that the lab techs had left for the day and if it was ok if they just checked R1's INR on [DATE]. RN-B stated she called MD-A on [DATE] because she noticed R1's INR was not checked on [DATE] and there were no current warfarin orders. MD-A told her there was no policy regarding this and we will no longer have that lab following our residents and that we will start doing our own INR's at bedside. RN-B verified R1's warfarin dose was missed on [DATE] due to R1 being in the emergency room (ER), but a provider should have been called when he came back about the missed dose. RN-B stated the fax did come on [DATE] for R1's Lovenox and it said to take the Lovenox out of the Omnicell. RN-B stated the nurses were struggling with using the Lovenox out of the Omnicell because it was not a prepackaged injection, it came in a vial and the nurses were having struggles trying to figure out the correct dosage to give. R1 missed his Lovenox injection on [DATE] because that particular nurse did not have access to the Omnicell and probably could not find R1's medication. RN-B stated that nurse should have notified the provider that the medication was not available. RN-B stated R1 had a genetic clotting factor and several cardiac diagnoses putting him at greater risk for developing a blood clot, heart attack or stroke, especially when his INR was subtherapeutic for almost 8 days. R2 R2's care plan revised [DATE], identified a focus of anticoagulant use for a diagnosis of atrial fibrillation, Intervention dated [DATE], identified to administer anticoagulant and labs per MD orders and [DATE], identified to obtain INR and report to physician as ordered. R2's significant change MDS dated [DATE], identified R2's cognition was intact had diagnoses of atrial fibrillation and tricuspid insufficiency. R2 received anticoagulants. R2's NP visit dated [DATE] at 1:47 p.m., identified R1's INR was 2.0. Give 1.5 mg of warfarin on Fridays and 2 mg all other days, recheck INR on [DATE]. R2's MAR dated [DATE], identified an order dated [DATE] at 2:06 p.m. to give warfarin 2mg every evening on Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday until [DATE] at 2:06 p.m. R2's warfarin order was discontinued on [DATE] at 2:06 p.m. therefore the 2 mg evening dose was not documented as there was no box to document. R2's NP visit dated [DATE] at 10:16 a.m., identified R1's INR was 1.7. Give 3 mg of warfarin on Mondays and Thursdays and 2 mg the rest of the days of the week, recheck INR on [DATE]. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 9:13 a.m., R2 was seated in her wheelchair and stated she had just finished eating breakfast. R2 stated she had been on warfarin for years due to atrial fibrillation, stated she had prior ablations that did not fix it. R2 stated warfarin is a very important medication and her INR levels must be between 2.0 and 3.0 or she would be at risk for a stroke, heart attack or blood clots. I usually get my INR's checked her at the facility they do a fingerstick, unless I am at an appointment at Mayo then they will do a blood draw. During a phone interview on [DATE] at 5:12 p.m., HUC-A stated she does all of the residents INR's through a fingerstick, she will record the INR results in the MAR, will document everything on a tracking sheet and send it to the nursing home desk so NP-A can read the results and give new orders based on the result. HUC-A stated she then puts the order in PCC and will fax the new order to the pharmacy, then I give the new order to the nurse manager so they can doublecheck the order. R1's INR may have been missed because she was on vacation that day and was unaware of who would have covered for her, was guessing the nurse managers. HUC-A stated they have back up medications in the Omnicell but not all nurses have access. HUC-A stated she remembered the mess with R1's Lovenox because it was in a vial in the Omnicell and not everyone had access. HUC-A stated she just hears about medication errors when they happen and stated they do not have discussions about if they are reportable to the state or not. HUC-A stated she was not aware of R2's missed coumadin dose on [DATE]. During an interview on [DATE] at 10:53 a.m., licensed practical nurse (LPN)-A stated she was the nurse manager for R2. LPN-A stated with a medication error, we would document the error on a paper medication form that instructs us to notify the physician of the error, it does not instruct us to notify the resident or resident representative. We would then give the form to the director of nursing (DON). LPN-A indicated R2 should have received 2 mg of warfarin on [DATE], stated it looked like the medication was discontinued too early so there was nothing to alert the nurse to give it. Health Unit Coordinator (HUC)-A does our INR's, sends the results to the provider, when the provider gives new orders, HUC-A will either put the order in or will gives the order to the nurse manager to put into point click care (PCC). LPN-A stated we do not always put the order in the que for a second nurse to doublecheck the orders, but it would be best practice to do that. LPN-A stated R2's medication error would be a significant error due to the fact it's a blood thinner, that would explain why R2's INR was subtherapeutic 1.7 on [DATE]. During an interview on [DATE] at 12:28 p.m., director of nursing (DON) indicated she had been the current DON for two days, and her understanding as the HUC's do the fingerstick INR's and documents the INR's and the provider orders for anticoagulants in the medical record. DON stated with a medication error she would have to investigate the root cause, notify the provider, may have to file a VA if it can seriously impact the residents health. DON stated any anticoagulant medications such as warfarin and Lovenox would be significant medication errors because they are blood thinners and leave the resident at high risk for blood clots, stroke, or heart attack. DON indicated she would document the medication error in the nurses note. DON verified R1 did not have his INR checked per MD order on [DATE], missed a 5 mg dose of warfarin on [DATE], Lovenox was not implemented as ordered and missed [DATE] dose of Lovenox and missed another dose of Lovenox on [DATE] at 8:00 p.m. DON further verified R2 missed a dose of warfarin on [DATE]. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:49 p.m., regional nurse consultant (RNC)-A verified there were no medication errors filled out for any of R1 or R2's medication errors. RNC-A stated with medication errors the provider and resident/resident representative should be notified, medication error form should be filled out to determine a root cause of the error to put interventions in place for prevention. During a phone interview on [DATE] at 2:31 p.m., pharmacist (P)-A stated with medications involving blood thinners such as warfarin and Lovenox you put the resident at risk of subtherapeutic INR. P-A stated for patients with diagnoses with genetic clotting factors and atrial fibrillation if blood thinners are being missed that would be a significant med error, you wouldn't see the results until about 2 days later. Anytime you are not therapeutic between 2.0 and 3.0 it puts you at risk for clots, heart attack or stroke. During a phone interview on [DATE] at 2:48 p.m. NP-A stated she started following residents at the facility for anticoagulation. NP-A stated she was aware of R1 not having his Lovenox started timely but was not aware of R1's medication errors on [DATE] and [DATE]. NP-A stated she would expect a phone call from the nurse for a missed blood thinner so the resident can be dosed appropriately. NP-A stated when INR levels are below 2.0, they become subtherapeutic putting the resident at risk for the development of blood clots, stroke, or heart attack. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, Medication Related Errors, revised [DATE], identified a Procedure: 1. Medication Errors. If a medication reaches a resident in error, facility should: 1.1 Notify pharmacy of any possible dispensing occurrence; and 1.2 Notify physician/prescriber and obtain further instructions and/or orders. Facility staff should monitor the resident in accordance with physician's/prescriber's instructions. 2. Prescribing Errors: In the event of a prescribing error, facility staff should follow facility's occurrence/incident policy, associated forms, and performance improvement processes. Examples of prescribing errors include, but are not limited to: 2.1 Incorrect medication selection based on indications, contraindications, known allergies, existing medication therapy, and other factors., 2.2 Dose, dosage form, quantity, route, concentration, rate of administration, or, 2.3 Incorrect instructions for use of a medication ordered or authorized by a physician/prescriber. 3. Dispensing Errors: If facility believes a dispensing error has occurred, facility staff should follow facility policy relating to dispensing errors. See Policy 10.1 (Pharmacy-Related Occurrence Reporting). Examples of dispensing errors include, but are not limited to: 3.1 Unauthorized medication error: Dispensing to the resident a dose of medication not authorized by Physician/Prescriber for the resident; 3.2 Dose error: Dispensing to the resident of a dose that is greater than or less than the amount originally ordered; 3.3 Route error: Dispensing medication to the resident by a route other than originally ordered; 3.4 Rate error: Dispensing the incorrect rate of administration of a medication to a resident other than that originally ordered; 3.5 Dosage form error: Dispensing to the resident of a medication in a different form than that originally ordered ;3.6 Frequency error: Dispensing to the resident of a medication at an incorrect interval of administration other than that originally ordered 3.7 Dose preparation error: Medications incorrectly formulated or manipulated before administration (e.g., incorrect dilution or reconstitution); 3.8 Medication error: Dispensing to the resident a medication other than that originally ordered; 3.9 Resident/Facility error: Dispensing to a resident or Facility other than the one intended; 3.10 Label error: Dispensing to the resident a medication that has a label affixed which contains information other than that originally ordered or information that is inappropriate for the medication itself; 3.11 Expired medication error: Dispensing to the resident a medication that expires prior to administration; 3.12 Monitoring error: Failure to review a prescribed regimen for appropriateness;3.13 Delivery error: Drug product not received by the resident/facility at the required/expected time; 3.14 Data entry error: Entire order or part of an order was incorrectly entered into computer system by data entry; and 3.15 Transcription error: Entire order or part of an order was incorrectly transcribed from original order. Administration Errors: In the event of an administration error, facility staff should follow facility policy relating to medication administration errors. Examples of administration errors include, but are not limited to 4.1 Transcription error: Facility incorrectly transcribes to pharmacy an entire order or part of an order; 4.2 Unauthorized medication error: Facility administers a medication dose not authorized for the resident; 4.3 Dose error: Facility administers to the resident a medication dose that is greater than or less than the amount originally ordered ; 4.4 Route error: Facility administers to the resident a medication dose by a route other than that originally ordered by or a wrong site of administration; 4.5 Rate error: Facility administers to the resident a medication dose at any rate other than that originally ordered or as established by facility policy; 4.6 Dosage form error: Facility administers to the resident a medication dose by the correct route but in a different dosage form than that specified by the original order. 4.7 Administration time error: Facility administers to the resident a medication dose greater than sixty (60) minutes from its scheduled administration time or if administration exceeds the time in relation to meals; 4.8 Dose preparation error: Facility staff incorrectly formulates or manipulates a drug product before administration (e.g., incorrect dilution or reconstitution, not shaking a suspension, not keeping a light sensitive medication protected from the light, and mixing incompatible medications); 4.9 Omission error: Facility fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of recognized contraindication; 4.1O Administration technique error: Facility administers a medication dose via the correct route and site, but improper technique is used; and 4.11 Monitoring error: Facility fails to review a prescribed regimen for appropriateness or fails to use appropriate clinical or laboratory data for adequate assessment of resident response to prescribed therapy. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Undated form titled, Rochester Rehab and Living Center Medication Error Report Form, identified the following: Resident name, Birth date, Date/Time Error Occurred, By Whom, Date/Time Error Discovered, By Whom, Indicate the Type of Error: Incorrect time, Incorrect medication, Incorrect dosage, Incorrect route of administration, Incorrect person received the medication, Missed medication, Transcription error, or pharmacy error. Describe Error In Detail: How could this error have been prevented? Incorrect person received medication, Incorrect documentation, Missed medication, Transcription error, or Pharmacy error. Name of Nurse notified, Date/Time, By whom, Name of prescriber notified, Date/Time and by whom. Ordered response/intervention, Name of others notified, Date/Time and by whom. Signature of the person completing the report and date and time. Licensed nurse signature (if different) and date and time. Education that was provided, signature of the person receiving the education with date and time, signature of the nurse providing the education with date and time, signature of DON with date and time. Form does not include a section to notify the resident/resident representative. (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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, Physician Orders, dated 2006, identified a purpose:1. To provide accurate, consistent care to each resident 2. To provide a system for distribution of Physician's orders PROCEDURE: 1. Admission Orders at time of admission. a. Admit to facility b. Advance Directive c. Diagnoses d. Rehabilitation potential e. Activity level f. Medications/other allergies g. Food allergies h. Diet i. Generic equivalent drugs? YES or NO j. Discharge planned within 3 months YES or NO k. Medications/treatments and reason (diagnosis/problem). l. Two step PPD (unless contraindicated) m. Any state required orders Notes: If resident will be admitted to a secured unit (i.e. Alzheimer's Unit, CCDI, etc.), a diagnosis which supports this decision is required. Obtain at least above orders at time of admission. Orders are noted and signed (includes date) by licensed Nurse. Medications are ordered at specified pharmacy. Orders are processed according to facility procedure. If orders are not signed by Physician, Licensed nurse calls to verify accuracy of orders and documents the call. If written admission orders are received in the facility, the Licensed Nurse should review the orders for completeness, call the Physician and clarify the orders as necessary. Physician's order sheets are processed/sent to the Physician for a signature according to facility procedure. Medication, treatments, and care items (AOL's, etc.) are transcribed to documentation records by hand or computer generated. Medication and treatment orders required the name of the medication or treatment, dosage, strength, route of administration, frequency, and the reason (diagnosis/problem) as a part of the order. 2. New Orders a. Telephone Orders - If the Physician is contacted by the Licensed Nurse by phone or a new order(s) is received, the Licensed Nurse is responsible to: i. Communicate with the Physician what the actual or probable problem/concern is. ii. Fill out a Telephone Order Form promptly. Note all necessary information Note: Remember to note name of medication or treatment, dosage, and strength, if applicable, ROUTE OF ADMINISTRATION and FREQUENCY. For PRN orders, be sure to note how often PRN (i.e. QD PRN, Q4H PRN, HS PRN, QID PRN, etc.) and also the reason (diagnosis/problem) need to be noted as part of the order. Do not forget to date and sign your name, including your title. iii. Write the new order on the medication/treatment record. Again, be sure it is written on the medication/treatment record exactly as it was written on the telephone order form. Note your initials and the date. iv. a. Write the new order on the current computerized Physician's order that is in the medical record below Physician's signature line. Note your initials and the date. This allows you to have a current comprehensive list of all diagnosis, treatments, and orders. b. If a Health Unit Coordinator or similar person has completed any of the above steps in the transcription of Physician's orders, the Licensed Nurse must check for accuracy and verify by initialing and dating these prior to any implementation of these orders. This includes faxed orders. v. Put the computer input copy in the computer input basket. vi. Place or tape the temporary copy in the appropriate place as designated by your Facility's practice or needs. vii. Put the pharmacy/optional copy in the appropriate place as designated by your Facility's practice or needs. viii. If the Physician makes changes or additions to the telephone order, be sure the designated staff person notifies the Licensed Nurse and the computer input person. Order Processing NOTE: It must be entered into system exactly as it is written/signed; if unclear, clarification must be obtained in the form of another written/signed telephone order. HIM/designee then retain the computer input copies for approximately a month. A designated staff member assures that the original copy is signed by the attending Physician and returned to the nurses station as soon as possible or according to state requirements and for removing the temporary copy upon the return of the original signed telephone order and will permanently attach the original telephone order to the medical record. HIM/designee is responsible for picking the new order up from the computer input box, entering it into computer within a day's time, noting that it has been entered in computer by writing IC (in computer) and writing his or her initials and the date on the computer input copy. The frequency that new orders or changes are entered into computer is specific to each facility. If there are a number of orders or changes, it is recommended to update information in computer on a daily basis. At a minimum, Physician's orders in computer should be updated at least weekly or on Monday if the order is received late Friday, Saturday, or Sunday. NOTE: It must be entered into system exactly as it is written/signed; if unclear, clarification must be obtained in the form of another written/signed telephone order. HIM/designee then retain the computer input copies for approximately a month. A designated staff member assures that the original copy is signed by the attending Physician and returned to the nurses station as soon as possible or according to state requirements and for removing the temporary copy upon the return of the original signed telephone order and will permanently

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	10/10/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested an anticoagulation monitoring policy and was not received.