DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4DZ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00419

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245153**

2.STATE VENDOR OR MEDICAID NO.
(L2) **931216100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADONNA TOWERS OF ROCHESTER INC**
(L4) **4001 19TH AVENUE NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/04/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **62** (L18)
13.Total Certified Beds **62** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 06/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske, Enforcement Specialist 06/11/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/14/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245153 June 11, 2018

Ms. Christine Bakke, Administrator
Madonna Towers of Rochester, Incorporated
4001 19th Avenue Northwest
Rochester, MN 55901

Dear Ms. Bakke:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 27, 2018 the above facility is certified for:

62 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 62 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 11, 2018

Ms. Christine Bakke, Administrator
Madonna Towers of Rochester, Incorporated
4001 19th Avenue Northwest
Rochester, MN 55901

RE: Project Number S5153027

Dear Ms. Bakke:

On May 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 18, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 4, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 18, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 27, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 18, 2018, effective May 27, 2018 and therefore remedies outlined in our letter to you dated May 2, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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ID: 4DZ9

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(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **2** (L8)

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3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/18/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
12/31

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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE NE II 05/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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03/14/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
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04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 2, 2018

Ms. Christine Bakke, Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 55901

RE: Project Number S5153027

Dear Ms. Bakke:

On April 18, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 28, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 28, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 18, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on April 16, 17, & 18, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On April 16, 17, & 18, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's pan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		5/27/18

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

Electronically Signed | 05/11/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide bathing preferences for 1 of 1 resident (R57) reviewed for choices. Findings include: R57's, undated face sheet, identified an admit date of 7/31/17, and diagnoses of adjustment disorder with depressed mood, urge incontinence, urinary incontinence, and unspecified abnormalities of gait and mobility. R57's quarterly Minimum Data Set (MDS) dated 4/5/17, identified R57 without cognitive deficits, 1	F 561	Madonna Towers of Rochester staff respect the residents right to self-determination and support residents in 1) choosing activities, schedules, and heath care that is consistent with their interests, assessments, and plans of care and 2) making choices about the aspects of their life that are significant to the resident. The facility staff embrace the concept of resident-centered care and the right of the residents and their representatives to make informed choices about care and treatments including the right to determine bathing schedules (time of day), frequency, and type of bath	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 person physical assist with bathing, uses wheelchair for mobility, and frequently incontinent of urine. R57's care plan dated 7/31/17, identified self-care deficit related to need for assist with mobility, transfers and activities of daily living, approach with assist of 1 with bathing. Further identified potential for alteration in skin integrity with an approach to monitor skin with weekly bath/weekly skin check form to be completed. R57's, "bathing preference form," dated 7/31/17, revealed R57 would like a shower, and did not identify how many times a week R57 would like a shower. Facility bath sheets reviewed for the month of March, 2018, and revealed R57 was given 12 showers out of possible 31 days. Reviewed for the month of April with R57 receiving 7 showers out of 17 days. Requested bath schedule and was not provided. During observation on 4/16/18, at 9:06 a.m., R57 was sitting in her recliner dressed and well-groomed watching television. During observation on 4/17/18, at 5:46 p.m., R57 is sitting in her recliner wearing a blue shirt and black pants watching television. During interview on 4/16/18, at 8:46 a.m., when queried about frequency of bathing R57 stated, "They don't seem to think bathing every day is a requisite, the bath people don't have enough time to bathe me every day like I would like. I come from Hawaii where I am used to bathing 2-3 times	F 561	(tub/shower/sponge/bed bath). The residents are encouraged to participate to the greatest extent possible in the care planning process and the staff assists them in exercising their rights by discussing with the resident (or the resident□s representative) the resident□s condition and care needs, treatment options, personal preferences, and potential consequences of declining recommended cares and treatments. The facility□s polices and procedure for determining the residents□ bathing preferences were reviewed and found appropriate. The residents are asked about their bathing preferences at the time of admission. As part of the ongoing assessment process, at least quarterly, the residents are asked about their preferred bathing schedule and frequency as well as type of bath. The residents are also asked about the importance of choosing what to wear, having snacks available, locking up their personal belongings, choosing arise/bedtime, having access to reading material, listening to favorite music, keeping up with the news, participating in religious services/practices, etc. The residents□ preferences are included in their plan of care and the staff attempts to follow preferences for cares and services to the greatest extent possible. The resident and/or their legal representative are routinely asked about satisfaction with cares/services during the quarterly care conferences, with significant condition changes, and more often, if indicated.	

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	245153	A. BUILDING _____ B. WING _____	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

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F 561	Continued From page 3 a day. The rest of the people don't seem to mind it, but I do. I have told them I like to bathe every day and they have me down for twice a week." During interview on 4/17/18, at 6:04 p.m., R57 stated, "Wouldn't you want a bath if you sat in diapers all day? Well I do!" R57 further stated she gets a bath on Tuesdays and Fridays and if the bath aide has time she will give me an extra one on Thursday out of the goodness of her heart. If they have 50 people here and if they do 10 baths a day, Monday through Friday, that means everyone gets 1 bath a week, "So, I guess I better not complain, I get 2 and sometimes 3 (showers per week), I don't want to get kicked out of here for being so picky." At 6:43 p.m., R57 further stated, "I would like a bath every day, but I guess if they only have time to do two a week I don't have a choice." During interview on 4/18/18, at 9:42 a.m., nursing assistant (NA-A) verified she works Monday through Friday as the bath aide and stated, we typically do one bath a week unless the resident wants more, "they fill out that form on admission." R57 does want a daily bath, "with my schedule I just can't do it every day." NA-A verified R57 wants a daily bath because she itches from sitting in her urine. During interview on 4/18/18, at 9:46 a.m., registered nurse (RN-B) stated she asks residents their bathing preferences upon admission and verified the frequency of bathing on the form was not identified for R57. During interview on 4/18/18, at 10:25 p.m., director of nursing (DON) verified she was aware that R57 wanted a daily shower. "My expectation	F 561	During the mandatory staff meetings May 8 and 10, 2018, the nursing staff were informed of the residents right to make choices regarding heath care services consistent with their interests and assessed needs including the right to have their bathing preferences respected. The facility s policies and procedures for determining and communicating the residents preferences for personal cares were reviewed with the staff. The Director of Nursing met with resident number 57 on March 27, 2018 to discuss her satisfaction with cares including her bath schedule. Several bathing options were offered. At that time she expressed agreement with two to three baths per week and her preference for a specific staff member to assist with bathing. The Director of Nursing again met with the resident May 3, 2018, to review her bathing preferences. The resident expressed satisfaction with the plan for a shower every Tuesday and Friday morning and an additional shower Sunday evening. The resident chooses to independently perform daily perineal care. A new Bathing Preference form has been completed; the care plan and nursing assistant care guides have been updated accordingly. The resident will continue to be asked about her satisfaction with personal cares during the quarterly care conferences and the one-to-one social worker visits. Changes in her preferences will be communicated to the nursing staff.	

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F 561	Continued From page 4 for a resident with a preferred bathing preference, their choice should be respected." Further stated, we are aware of the situation and we have asked to have an evening bath aide added to our budget to accommodate resident preferences with bathing. A policy for bathing and resident choices /preferences was requested and was not received.	F 561	Compliance will be monitored by the Social Workers through resident interviews to verify that the residents bathing regimen is consistent with their preferences. Random interviews of residents with decision making capabilities will be conducted for fourteen days to determine the residents satisfaction with bathing schedules, frequency and type of bath. If noncompliance is noted, additional auditing and staff training will be done. Respect for the resident s right to self-determine and participate in health care decisions as well as their satisfaction with cares, including bathing, will continue to be monitored by the Social Workers during one-on-one interviews, during the quarterly care conferences, and through feedback from Resident Council meetings. Any care concerns will be communicated to the appropriate department manager/supervisor and additional staff training/counseling will be done as necessary. Compliance will be reviewed at the July 2018 quarterly Quality Assurance and Performance Improvement Committee meeting. Completion date: May 27, 2018	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after	F 640		5/27/18

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F 640	Continued From page 5	F 640		

a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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F 640	Continued From page 6 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to transmit a Discharge Return Not Anticipated (DCRNA) Minimum Data Set (MDS) assessment for 1 of 1 resident (R1) reviewed for resident assessment. Findings include: According to the face sheet, R1 was admitted to the facility on 11/20/17, with a postoperative coronary artery bypass. Nursing progress note dated 11/20/17, indicated R1 admitted for rehabilitation with a goal of returning home after completion of therapy. Physician order dated 12/07/17, indicated R1 may discharge to home on 12/8/17. Nursing progress note dated 12/8/17, at 9:48 a.m., indicated R1 discharged from the facility accompanied by his family member (FM)-A. On 4/18/18, at 11:11 a.m. during a review of the electronic health record (EHR) the DCRNA-MDS had been completed and electronically signed. The EHR identified the DCRNA-MDS as in progress. During an interview on 4/18/18, at 12:07 p.m., with registered nurse (RN)-C she verified the	F 640	Madonna Towers of Rochester has policies and procedures for complying with regulatory requirements for encoding data from the resident assessment instrument within seven days after completion, including completion of the subset of items completed upon a resident□s discharge. Within fourteen days after a resident□s assessment is completed, the facility electronically transmits the encoded data to the State. The minimum data set (MDS) Coordinator who responsible for encoding and transmitting the data to the state agency is aware of the submission requirements; the causal factors for lack of submission of discharge MDS data for one resident have been investigated. The data from the Discharge Return Not Anticipated MDS assessment for resident number one has been successfully transmitted to the state. To monitor MDS submissions/transmissions the MDS Coordinator will run a Matrix Resident MDS 3.0 Status Report every Monday. The report which lists MDS data that was received by the state agency will be compared with the data that was transmitted. Any discrepancies will be	

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F 640	Continued From page 7 DCRNA-MDS was completed but not submitted in a timely manner. RN-C attributed the oversite to a human factor, stating that it was a matter of volume and did not have an assistant at that time. A facility policy "Comprehensive Assessments and Care Planning" dated 11/20/17, was received but did not address the DCRNA procedure.	F 640	investigated. Compliance will be further monitored by the Director of Nursing who will be sent a copy of the Status Report and will verify state acknowledgment of the transmitted assessment/census data. Compliance will be reviewed at the July 2018 quarterly Quality Assurance and Performance Improvement Committee meeting. Completion date: May 27, 2018	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow orders and assist/encouraged brushing teeth after meals for 1 of 1 resident (R5) reviewed for activity of daily living (ADL). Findings include: R5's admission form included a diagnosis include unspecified acute lower respiratory infections and dysphasia (difficulty in swallowing). R5's significant change Minimum Data Set (MDS) an assessment dated 1/18/18, indicate a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment), and requires extensive assistance with personal hygiene such as brushing teeth. MDS also indicates a	F 677	Madonna Towers of Rochester, Inc. provides the necessary services to maintain good nutrition, grooming, personal care and oral hygiene. Based on the comprehensive resident assessment, the staff provides cares which assist the resident to maintain and enhance his/her self-esteem and self-worth including assistance with oral care. The residents need for assistance with personal hygiene/grooming is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary. The policies and procedures for oral care were reviewed and found appropriate. The Speech Language Pathologist, Director of Nursing and Staff Development Director	5/27/18

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F 677	Continued From page 8 swallowing disorder coughing or choking during meals or when swallowing medications. R5's current care plan reads oral care; assist with set up, R5 at times requires reminders/encouragement to perform oral care. R5 nutritional status is to have nectar thick liquids. May have thin coconut milk and water between meals per free water protocol, monitor for signs of aspiration or choking. A physician order dated 9/6/17, reads a general diet with nectar thick liquids with regular coconut milk. May have plain, thin water between meals. R5's Speech therapy referral dated 8/21/17, indicates evaluation is due to chronic cough when eating and frequent respiratory infections. R5 has had a functional decline in swallow safely. R5's discharge note from therapy dated 9/22/17, and will remained on nectar thick liquids with plain water between meals, to use both verbal and written cues with an ongoing assessment and patient education. During an observation R5 had been in her room on 4/16/18, at 12:04 p.m. R5's teeth had a debris built up on front upper teeth. There were two notes visible to staff posted on R5's wall one said, "RESIDENT TEETH MUST BE BRUSHED AFTER EVERY MEAL." The second note included, resident is allowed THIN water between meals, resident must have teeth brushed after meal, resident must be sitting up when drinking and no thin water in bed, with medications or with food. Interview with family member (FM)-B on 4/17/18	F 677	met May 7, 2018, to discuss implementation of the Free Water Protocol; a policy and procedure for communication and implementation of the Free Water Protocol has been developed. The speech language pathologist will notify the nurse clinical manager when a free (thin) water protocol has been ordered for a resident who otherwise receives thickened liquids at meal time and with medications. The care plan and nursing care guides will be updated accordingly. During the mandatory meetings May 8 and 10, 2018, the nursing staff will be 1) reinstructed on the facility□s policies for providing personal hygiene including oral care 2) reminded that their job description requires knowledge of and responsibility for following the residents□ plans of care and 3) instructed on the Free Water Protocol policies and procedures including the importance of good oral care after meals and prior to ingesting free water. Resident number five has an order for thickened liquids at meal time, regular coconut milk, and free water protocol. The care plan and the nursing assistant care guides have been updated to reflect the free water protocol which includes oral care after each meal prior to free water consumption. The nursing assistants have been instructed on the protocol and the importance of oral care after meals. Compliance will be monitored by the Staff Development Director through	

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F 677	Continued From page 9 at 2:46 p.m. at which time stated in regards to teeth being brushed after each meal, "Felt teeth get done once a day if lucky." As FM-B pointed to the signs on the wall. Following supper meal on 4/17/18, at 5:47 p.m. observed the administrator assisted R5 back to his room from dining room and gave R5 the call light and turned on television, before leaving the room. At 5:55 p.m. heard R5 cough like clearing of the throat. At 6:01 p.m. writer visited R5 in room asked about supper and photos on walls. At 6:10 p.m. R5 turned on call light and at 6:11 p.m. staff went in, asked what he needed, R5 said wanted to go to bed, staff stated they had to get help first and then staff turned call light off. At 6:21 p.m. R5 again turned on call light for help. At 6:24 p.m. staff went in room and took R5 to the bathroom, then left the room while R5 was in bathroom. At 6:37 p.m. staff went in room to ask if done in the bathroom, R5 stated to staff he needed help wiping self, staff said ok and assisted R5 as requested. Interview on 4/17/18, at 6:49 p.m. nursing assistant (NA)-B stated they had completed R5 cares to get ready for bed and that R5 brushed his own teeth. R5 was observed on 4/18/18, at 9:19 a.m. R5 sitting at the breakfast table with hospice nurse (HN)-E sitting with R5 and after R5 completed his meal HN-E assisted R5 to his room and connected oxygen to the concentrator. HN-E visited with R5 for a short time then left the room. At 9:38 a.m. activity (A)-A staff took R5 to an activity. It was observed no staff assisted R5 brush his teeth following his meal.	F 677	observation and staff/resident interviews to verify that oral cares are provided according to the plan of care. Random audits of oral care will be conducted for at least two weeks with focus on residents participating in the free water protocol and those who are dependent in oral cares. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the July 2018 quarterly Quality Assurance and Performance Improvement Committee meeting. Completion date: May 27, 2018	

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F 677	Continued From page 10 On 4/18/18 at 9:55 a.m. licensed practical nurse (LPN)-A was questioned about the two notes for brushing teeth after each meal that were located on R5's wall. LPN-A said the notes are a request from the family and was not sure why they were there. On asking when the residents teeth should be brushed after meal time, LPN-A said the expectation would be to brush within 15 minutes of a meal. At 10:00 a.m. while interviewing LPN-A, NA-C brought R5 back from activities to use the bathroom and NA-C said that registered nurse (RN)-D had told her to brush R5's teeth. On 4/18/18, at 10:15 a.m. with director of nursing (DON) stated the expectation is to brush teeth right away after meals. On 4/18/18, at 10:27 a.m. interview with speech therapist (ST)-F, ST-F said that R5 was seen due to swallowing concerns and history of respiratory infection including aspiration pneumonia. R5 gets nectar thick liquids and has free water protocol (Your doctor has ordered the Frazier Free Water Protocol for you. In this program, you will be allowed drink "free" (un-thickened) water. When provided along with good mouth care, water does not increase the risk for developing aspiration pneumonia). Sign with this information will be posted in resident room. ST-F said we follow the Fraizer free water protocol and you would need a doctors order for this to be implemented. When asked, the therapist said the reason why the teeth needs to be cleaned or mouth needs to be rinsed out, because if food is still in mouth, R5 can aspirate the food, he has history of this and that is why I originally became involved and evaluated and treated him.	F 677		

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F 677	Continued From page 11 Interview with FM-C on 4/18/18 at 12:07 p.m. who said notes on walls were from ST-F. Also FM-C did not think the brushing of the teeth after each meal was completed. FM-C recalled 2-3 times since admitted R5 had gotten aspiration pneumonia. FM-C said it was told to me by SP-F it is mandated to brush teeth after meals. On 4/18/18 at 12:41 p.m. the director of nursing was interviewed regarding R5's teeth brushing schedule. She said it was her expectation the teeth are to be brushed after each meal as ordered. Policy reviewed titled Physician Orders-Transcription of dated 11/17 reads: physicians orders, transcribe order, make necessary changes on care plan, document and make changes in medical record.	F 677		

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	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2018**

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K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 17, 2018. At the time of this survey Madonna Towers of Rocheter, Inc was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

Health Care Fire Inspections
State Fire Marshal Division

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	**4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Madonna Towers of Rochester is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (111) construction. In 1979, addition was constructed and was determined to be of Type V(111) construction. In 1998, an addition was added and was determined to be Type II (111). In 2002, an addition was added and was determined to be Type V (111). Because the original building are a Type II(111) and the 2 additions are of the type V (111) of construction and meet the construction type allowed for existing buildings, the facility was surveyed as a V (111) building. This will be surveyed as one building under LSC 2012. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2018**

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K 000	Continued From page 2 full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to, maintain the proper sprinkler head clearances and general maintenance of ceiling tiles in accordance with NFPA 13, 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4 This deficient	K 351	The items stored above acceptable levels in the oxygen storage room and the two hallway closets have been removed. Signs will be posted to alert staff to the maximum height of stored items. During	5/27/18

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K 351	Continued From page 3 practice could affect the safety of all (96) the residents, staff and visitors within the facility. Findings Include: On facility tour between 0900 AM and 12:00 PM on Date 04/17/2018, observations and staff interview revealed the following: 1) High storage found in the following locations: a) O2 storage room b) 1967 structure - hallway closets c) 1980 structure - hallway closets 2) Ceiling tile penetrations - holes in tiles and tiles not properly seated in the 1967 structure (Activities Room) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351	the mandatory meetings May 8 and May 10, 2018, the staff will be informed of proper storage procedures. Observation of the storage areas will be added to the monthly task list. The unseated tiles in the Activity Room have been repaired/replaced. The holes in the tiles will be closed/repaired by the Summit Fire Protection Company. The Environmental Services Director/designee will be responsible for monitoring compliance with appropriate storage procedures and repair/placement of ceiling tiles. Completion date: May 27, 2018	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		5/27/18

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K 372	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain properly 1 of 3 Smoke Barriers in accordance with 19.3.7.3, 8.6.7.1(1) This deficient practice could affect the safety of (24) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 0900 AM and 12:00 PM on Date 04/17/2018, observation revealed the following: horizontal penetration above the ceiling tile around data cabling was missing proper fire chalking. Proximal location was the Smoke Barrier door by RM 50 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372	The horizontal penetrations above the ceiling tile around the data cabling will be sealed with intumescent fire barrier caulk. The Environmental Services Director will monitor compliance by inspecting smoke barriers after construction projects which pose a risk of penetrating the smoke barriers with cables, wires, pipes, etc. Date of completion: May 27, 2018	