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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: E5K3

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 **10/25/2013** (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Marietta Lee, HFE NE II — 10/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 02/07/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
09/27/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5153

On July 26, 2013 we completed an abbreviated standard survey. Deficiencies were found, the most serious at a S/S level of G. On August 1, 2013 a standard survey was completed at this facility. Deficiencies were found, the most serious at a S/S level of F.

Since the facility was found to be not in substantial compliance at the time of the standard survey, we recommended the following to the CMS RO for imposition and CMS concurred:

- Mandatory DOPNA, effective October 26, 2013

If Mandatory DOPNA goes into effect the facility would be subject to a two year loss of NATCEP, effective October 26, 2013.

Post Certification Revisits were completed on September 19, 2013 for both the abbreviated standard survey and the standard survey. At the time of the revisits, health deficiencies were found uncorrected at a S/S level of D. As a result, the Mandatory DOPNA, effective October 26, 2013 continued.

Second PCRs were completed on October 23, 2013 and October 25, 2013. The facility was found in substantial compliance, effective October 9, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

- Mandatory DOPNA, effective October 26, 2013 be rescinded.

The facility would not be subject to the loss of NATCEP since DOPNA is rescinded.

See attached CMS-2567B forms from the revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5153

February 7, 2014

Ms. Beth Redalen, Administrator
Madonna Towers of Rochester, Inc
4001 19th Avenue Northwest
Rochester, Minnesota 55901

Dear Ms. Redalen:

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 October 9, 2013 the above facility is certified for:

2 Skilled Nursing Facility Beds

60 Skilled Nursing Facility/Nursing Facility Beds

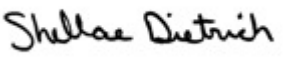
Your facility's Medicare approved area consists of all 62 skilled nursing facility beds.

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,



Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245153	A. Building B. Wing	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
MADONNA TOWERS OF ROCHESTER, INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**10/09/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**10/09/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GN/sd	Date: 10/29/13	Signature of Surveyor: 15425	Date: 10/23/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/1/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245153	A. Building B. Wing	10/25/2013

Name of Facility	Street Address, City, State, Zip Code
MADONNA TOWERS OF ROCHESTER, INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	**10/08/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**10/08/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KL/mm	Date: 10/29/13	Signature of Surveyor: 31591	Date: 10/25/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/26/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 29, 2013

Ms. Beth Redalen, Administrator
Madonna Towers of Rochester, Inc.
4001 19th Avenue Northwest
Rochester, Minnesota 55901

RE: Project Number H5153015 and S5153022

Dear Ms. Redalen:

On August 16, 2013 and September 30, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of August 16, 2013 and September 30, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2013.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on July 26, 2013 and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 19, 2013. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

This was also based on the deficiencies cited by this Department for a standard survey completed on August 1, 2013 and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 19, 2013. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 23, 2013 and October 25, 2013, the Minnesota Department of Health completed PCR's to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to PCR's, completed on September 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 9, 2013. Based on our visits, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR's, completed on September 19, 2013, as of October 9, 2013.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letters of August 16, 2013 and September 30, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 26, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 26, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 26, 2013, is to be rescinded.

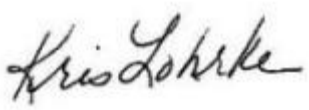
In our letters of August 16, 2013 and September 30, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 26, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 9, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Kris Lohrke, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
Telephone: (651) 201-4215 Fax: (651) 281-9796

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 29, 2013

Ms. Beth Redalen, Administrator
Madonna Towers of Rochester, Inc
4001 19th Avenue Northwest
Rochester, Minnesota 55901

Re: Enclosed Reinspection Results - Project Number H5153015 and S5153022

Dear Ms. Redalen:

On October 23, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program, and October 25, 2013, investigators of the Minnesota Department of Health, Office of Health Facility Complaints completed a reinspection of your facility, to determine correction of orders found on the abbreviated survey completed on July 26, 2013, the standard survey completed on August 1, 2013 and the revisits completed September 19, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Kris Lohrke

Kris Lohrke, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
Telephone: (651) 201-4215 Fax: (651) 281-9796

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00419	A. Building B. Wing	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
MADONNA TOWERS OF ROCHESTER, INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **10/09/2013**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **10/09/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GN/sd	**Date:** 10/29/13	**Signature of Surveyor:** 15425	**Date:** 10/23/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/1/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00419	A. Building B. Wing	10/25/2013

Name of Facility	Street Address, City, State, Zip Code
MADONNA TOWERS OF ROCHESTER, INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	**10/08/2013**	ID Prefix **21810** Reg. # **MN St. Statute 144.651 Subd. 6** LSC	**10/08/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KL/mm	10/29/13	31591	10/25/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/26/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: E5K3

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 **09/19/2013** (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:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
RobinLewis, HFE NEII 08/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/27/2013 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
09/27/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5153

On September 19, 2013, the Office of Health Facility Complaints and the Minnesota Department of Health completed PCRs to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard survey completed on July 26, 2013 and the standard survey completed on August 1, 2003. We presumed, based on their plan ofcorrection, that your facility had corrected these deficiencies. Based on our visit, we have determined the facility has not obtained substantial compliance. as a result of this visit, We recommended the following to the CMS Region V Office:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2013 remain in effect. (42 CFR 488.417 (b))

In addition, the Madonna Towers of Rochester Inc is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2013. Refer to the CMS 2567, CMS 2567b along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5421

September 30, 2013

Ms. Beth Redalen, Administrator
Madonna Towers of Rochester, Inc.
4001 19th Avenue Northwest
Rochester, Minnesota 55901

RE: Project Number S5153022 and H5153015

Dear Ms. Redalen:

On August 16, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2013. (42 CFR 488.417 (b))

We also notified you in our letter of August 16, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2013.

This was based on the deficiencies cited by the Office of Health Facility Complaints for an abbreviated standard survey completed on July 26, 2013, and failure to achieve substantial compliance at the time of the Standard survey completed on August 1, 2013. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 19, 2013, the Office of Health Facility Complaints and the Minnesota Department of Health completed PCRs to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard survey completed on July 26, 2013 and the standard survey completed on August 1, 2003. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCRs completed on September 19, 2013. The deficiencies not corrected are as follows:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services by Qualified Persons/Per Care Plan
F0314 -- S/S: D -- 483.25(c) Treatment/Services to Prevent/Heal Pressure Sores

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567s, whereby corrections are required.

This Department is recommending to the CMS Region V Office the following actions related to the imposed remedies in our letter dated August 16, 2013:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2013 remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of August 16, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2013.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to Kris Lohrke for the reissued deficiencies for F157 and F315 and to Gary Nederhoff for reissued deficiencies for F282 and F314:

Kris Lohrke, Assistant Director
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651)201-4215 Fax: (651)281-9796

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731 Fax: (507) 206-2711

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 January 26, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245153	A. Building B. Wing	9/19/2013

Name of Facility	Street Address, City, State, Zip Code
MADONNA TOWERS OF ROCHESTER, INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/19/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/19/2013**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/19/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/19/2013**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/19/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/cbl	09/30/2013	30238	09/19/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/1/2013			

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 _____	R 09/19/2013

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 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care interventions for prevention of pressure ulcers for 1 of 1 resident (R31) who was assessed to be at risk for developing pressure ulcers. Findings include: R31 was not provided repositioning every two hours according to the assessed needs on 9/18/13, from 12:50 p.m. to 3:50 p.m. (a total of three hours). R31 had diagnoses that included a carbuncle (deep-seated infection of the skin) on left hip. Review of the care plan dated 3/29/12, identified R31 as at risk for skin breakdown. A care plan intervention dated 5/6/13, directed staff to "turn and reposition R31 every two hours and PRN" (as needed). During continuous observations from 12:50 p.m. to 3:50 p.m. on 9/18/13, R31 was observed lying in bed positioned on the right hip the entire three hours. During interview on 9/18/13, at 3:31 p.m. nursing assistant (NA)-C indicated they had been working	{F 282} 10-17-13 KPN	See attachment 1	10-9-13

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

Beth Reddon, Admin / Health Serv, — 10/8/13

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 _____	R 09/19/2013

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 282}	Continued From page 1 with R31 on the second shift (from 2:00 p.m. to 10:00 p.m.) and had not provided any cares for R31 since shift began. NA-C indicated they had been waiting for the nurse to look at R31's left hip (has a stage two ulcer present) before getting the resident up into a chair. At 3:51 p.m., NA-C was asked when the last time R31 had been repositioned and NA-C responded that she assumed R31 had been repositioned before day shift left which would had been "around 2:00 p.m." NA-C verified R31 had not been repositioned yet on the evening shift. NA-C also confirmed R31 was supposed to be turned and repositioned every two hours. At 3:50 p.m. on 9/18/13, the resident was observed to receive care by NA-C. When the resident was repositioned off the right hip, the hip was observed to be reddened. At that time, NA-C verified R31's right hip was red after the resident had been lying on the right side for three hours. During interview on 9/18/13, at 3:54 p.m. registered nurse (RN)-C stated "when the nursing assistants come to me I direct them to the care guides". RN-C stated R31 was to be turned every two hours and that staff were to try to avoid positioning the resident on the left hip. R31 was to be repositioned from her right side to her back only. RN-C also stated the nursing assistants received report by going room to room so the next shift would be aware of anything going on with the residents. During interview on 9/19/13, at 11:15 a.m. the director of nursing (DON) verified R31's care plan interventions directed staff to turn and reposition R31 every two hours and PRN. The DON stated she would expect staff to follow each resident's	{F 282}		

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 _____	R 09/19/2013

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 282}	Continued From page 2 plan of care. The DON stated she was not sure how staff communicated to the next shift, but stated the nursing assistants would report to the nurse and the nurse would report to next shift, any changes in a resident's condition. In addition, the DON stated there was a face to face occurring with the nursing assistants at the change of shift.	{F 282}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure skin interventions, including timely repositioning, were implemented to prevent the development of pressure ulcers in accordance with individualized skin assessments for 1 of 3 residents (R31) who had been assessed to be at risk for developing pressure ulcers. Findings include: R31 was not provided repositioning every two hours according to the assessed needs on 9/18/13, from 12:50 p.m. to 3:50 p.m. (a total of	{F 314}	See Attachment 2	10-09-13

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 _____	R 09/19/2013

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 314}	Continued From page 3 three hours). R31 had diagnoses that included a carbuncle (deep-seated infection of the skin) on left hip. Review of the care plan dated 3/29/12, identified R31 as at risk for skin breakdown. A care plan intervention dated 5/6/13, directed staff to "turn and reposition R31 every two hours and PRN" (as needed). The Minimum Data Set assessment dated 6/22/13, indicated R31 had short and long term memory deficit, required extensive assistance of two staff for transfers and bed mobility, and was at risk for developing pressure ulcers. During continuous observations from 12:50 p.m. to 3:50 p.m. on 9/18/13, R31 was observed lying in bed positioned on the right hip the entire three hours. During interview on 9/18/13, at 3:31 p.m. nursing assistant (NA)-C indicated they had been working with R31 on the second shift (from 2:00 p.m. to 10:00 p.m.) and had not provided any cares for R31 since shift began. NA-C indicated they had been waiting for the nurse to look at R31's left hip (has a stage two ulcer present) before getting the resident up into a chair. At 3:51 p.m., NA-C was asked when the last time R31 had been repositioned and NA-C responded that she assumed R31 had been repositioned before day shift left which would had been "around 2:00 p.m." NA-C verified R31 had not been repositioned yet on the evening shift. NA-C also confirmed R31 was supposed to be turned and repositioned every two hours. At 3:50 p.m. on 9/18/13, the resident was observed to receive care by NA-C. When the	{F 314}		

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 _____	R 09/19/2013

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 314}	Continued From page 4 resident was repositioned off the right hip, the hip was observed to be reddened. At that time, NA-C verified R31's right hip was red after the resident had been lying on the right side for three hours. During interview on 9/18/13, at 3:54 p.m. registered nurse (RN)-C stated "when the nursing assistants come to me I direct them to the care guides". RN-C stated R31 was to be turned every two hours and that staff were to try to avoid positioning the resident on the left hip. R31 was to be repositioned from her right side to her back only. RN-C also stated the nursing assistants received report by going room to room so the next shift would be aware of anything going on with the residents. RN-C verified NA-C should have been informed by the day NA that R31 was last repositioned at a specific time so R31 could be repositioned every two hours. During interview on 9/19/13, at 11:15 a.m. the director of nursing (DON) verified R31's care plan interventions directed staff to turn and reposition R31 every two hours and PRN. The DON stated she would expect staff to follow each resident's plan of care. The DON stated she was not sure how staff communicated to the next shift, but stated the nursing assistants would report to the nurse and the nurse would report to next shift, any changes in a resident's condition. In addition, the DON stated there was a face to face occurring with the nursing assistants at the change of shift.	{F 314}		

Attachment 1

Regulation 483.20(k)(3)(ii) Tag F282
Services by Qualified Personnel per Care Plan

Madonna Towers of Rochester is committed to provide care and services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care.

The interdisciplinary care planning team 1) comprehensively assesses each resident and develops an individualized care plan that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. Interventions to manage skin risk are routinely addressed in the plan of care.

The policies and procedures for managing skin risk were reviewed. The *Care Guide* tool used to communicate the resident's care needs to the nursing assistants will be modified to include a designated space to record the last time the resident was repositioned prior to the end of the nursing assistant's shift. The time of the last repositioning prior to shift change will be communicated to the oncoming shift by verbal report or by referencing the previous *Care Guide* sheet. The *Care Guide* for residents that need assistance with repositioning will be reviewed to assure the repositioning schedule is accurate. To verify that the resident's repositioning interval is appropriate, the tissue tolerance of residents who require assistant with chair/bed mobility will be reevaluated as part of the next quarterly care assessment. At the present time there is only one resident with skin issues related to pressure–a pin point area that continues to improve.

Resident number 31 – The Minnesota Department of Health Summary Statement of Deficiencies erroneously states that the resident has a Stage II pressure ulcer on the left hip. She does have a chronic carbuncle on her left hip, but she has no skin problems related to pressure. A skin reassessment was completed September 27, 2013. The care plan was reviewed and found to appropriately reflect an every two-hour repositioning schedule. When in bed the resident will be positioned off her left hip. The nursing assistant Care Guide tool was updated to reflect the resident's repositioning schedule; the nursing assistants were instructed on the resident's skin-related plan of care. The resident's left hip will continue to be monitored daily by a licensed nurse; observation of the resident's skin condition is part of the bathing protocol.

During the mandatory meeting October 1, 2013, the nursing staff were reminded/ instructed that the residents' plans of care must be followed and that job performance

expectations include being aware of and following the individualized plan of care. The importance of timely repositioning of residents with mobility impairments was stressed.

To monitor compliance, the DON/clinical managers/designee will conduct random observations to monitor timely resident repositioning for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.

Completion date: October 9, 2013

Attachment 2

Regulation 483.25(c) Tag F314
Prevent/Heal Pressure Sores

Madonna Towers of Rochester has policies and procedures to ensure that residents who enter the facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure areas from developing.

Based on the comprehensive skin assessment, care plans are developed that address and minimize the risks of skin breakdown. The resident's repositioning schedule is based on an analysis of the skin risk assessment, the results of the Bradens Scale for Predicting Pressure Ulcer Risk tool, and the tissue tolerance evaluation. The plans of care focus on services that maintain skin integrity and prevent pressure sores.

For residents who have open skin lesions, a licensed nurse assesses the resident 's skin condition on a weekly basis. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol. If skin issues are noted, the resident's repositioning schedule is reassessed and the physician/nurse practitioner notified as appropriate. At the present time there is only one resident with skin issues related to pressure–a pin point area that continues to improve.

To verify that the resident's repositioning interval is appropriate, the tissue tolerance of residents who require assistant with chair/bed mobility will be reevaluated as part of the next quarterly care assessment. The *Care Guide* tool used to communicate the resident's care needs to the nursing assistants has been modified to include a designated space to record the last time the resident was repositioned prior to the end of the nursing assistant's shift. The time of the last repositioning prior to shift change will be communicated to the oncoming shift by verbal report or by referencing the previous *Care Guide* sheet. The *Care Guide* for residents that need assistance with repositioning will be reviewed to assure the repositioning schedule is accurate.

Resident number 31 – The Minnesota Department of Health Summary Statement of Deficiencies erroneously states that the resident has a Stage II pressure ulcer on the left hip. She does have a chronic carbuncle on her left hip, but she has no skin problems related to pressure. A skin reassessment was completed September 27, 2013. The care plan was reviewed and found to appropriately reflect an every two-hour repositioning schedule. When in bed the resident will be positioned off her left hip.

The nursing assistant *Care Guide* tool was updated to reflect the resident's repositioning schedule; the nursing assistants were instructed on the resident's skin-related plan of care. The resident's left hip will continue to be monitored daily by a licensed nurse; observation of the resident's skin condition is part of the bathing protocol.

During the mandatory meeting October 1, 2013, the nursing staff were reminded/ instructed that the residents' plans of care must be followed and that job performance expectations include being aware of and following the plan of care. The importance of timely repositioning of residents with mobility impairments was stressed.

To monitor compliance, the DON/clinical managers/designee will conduct random observations to monitor timely resident repositioning for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.

Completion date: October 9, 2013

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245153	A. Building B. Wing	9/19/2013

Name of Facility	Street Address, City, State, Zip Code
MADONNA TOWERS OF ROCHESTER, INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0272 Reg. # 483.20(b)(1) LSC	09/03/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KL/cbl	Date: 09/30/2013	Signature of Surveyor: 28229	Date: 09/19/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/26/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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 _____	R 09/19/2013

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 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care interventions for prevention of pressure ulcers for 1 of 1 resident (R31) who was assessed to be at risk for developing pressure ulcers. Findings include: R31 was not provided repositioning every two hours according to the assessed needs on 9/18/13, from 12:50 p.m. to 3:50 p.m. (a total of three hours). R31 had diagnoses that included a carbuncle (deep-seated infection of the skin) on left hip. Review of the care plan dated 3/29/12, identified R31 as at risk for skin breakdown. A care plan intervention dated 5/6/13, directed staff to "turn and reposition R31 every two hours and PRN" (as needed). During continuous observations from 12:50 p.m. to 3:50 p.m. on 9/18/13, R31 was observed lying in bed positioned on the right hip the entire three hours. During interview on 9/18/13, at 3:31 p.m. nursing assistant (NA)-C indicated they had been working	{F 282}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	R 09/19/2013

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 282}	Continued From page 1	{F 282}		

with R31 on the second shift (from 2:00 p.m. to 10:00 p.m.) and had not provided any cares for R31 since shift began. NA-C indicated they had been waiting for the nurse to look at R31's left hip (has a stage two ulcer present) before getting the resident up into a chair. At 3:51 p.m., NA-C was asked when the last time R31 had been repositioned and NA-C responded that she assumed R31 had been repositioned before day shift left which would had been "around 2:00 p.m." NA-C verified R31 had not been repositioned yet on the evening shift. NA-C also confirmed R31 was supposed to be turned and repositioned every two hours.

At 3:50 p.m. on 9/18/13, the resident was observed to receive care by NA-C. When the resident was repositioned off the right hip, the hip was observed to be reddened. At that time, NA-C verified R31's right hip was red after the resident had been lying on the right side for three hours.

During interview on 9/18/13, at 3:54 p.m. registered nurse (RN)-C stated "when the nursing assistants come to me I direct them to the care guides". RN-C stated R31 was to be turned every two hours and that staff were to try to avoid positioning the resident on the left hip. R31 was to be repositioned from her right side to her back only. RN-C also stated the nursing assistants received report by going room to room so the next shift would be aware of anything going on with the residents.

During interview on 9/19/13, at 11:15 a.m. the director of nursing (DON) verified R31's care plan interventions directed staff to turn and reposition R31 every two hours and PRN. The DON stated she would expect staff to follow each resident's

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 _____	R 09/19/2013

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 282}	Continued From page 2 plan of care. The DON stated she was not sure how staff communicated to the next shift, but stated the nursing assistants would report to the nurse and the nurse would report to next shift, any changes in a resident's condition. In addition, the DON stated there was a face to face occurring with the nursing assistants at the change of shift.	{F 282}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure skin interventions, including timely repositioning, were implemented to prevent the development of pressure ulcers in accordance with individualized skin assessments for 1 of 3 residents (R31) who had been assessed to be at risk for developing pressure ulcers. Findings include: R31 was not provided repositioning every two hours according to the assessed needs on 9/18/13, from 12:50 p.m. to 3:50 p.m. (a total of	{F 314}		

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 _____	R 09/19/2013

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 314}	Continued From page 3 three hours). R31 had diagnoses that included a carbuncle (deep-seated infection of the skin) on left hip. Review of the care plan dated 3/29/12, identified R31 as at risk for skin breakdown. A care plan intervention dated 5/6/13, directed staff to "turn and reposition R31 every two hours and PRN" (as needed). The Minimum Data Set assessment dated 6/22/13, indicated R31 had short and long term memory deficit, required extensive assistance of two staff for transfers and bed mobility, and was at risk for developing pressure ulcers. During continuous observations from 12:50 p.m. to 3:50 p.m. on 9/18/13, R31 was observed lying in bed positioned on the right hip the entire three hours. During interview on 9/18/13, at 3:31 p.m. nursing assistant (NA)-C indicated they had been working with R31 on the second shift (from 2:00 p.m. to 10:00 p.m.) and had not provided any cares for R31 since shift began. NA-C indicated they had been waiting for the nurse to look at R31's left hip (has a stage two ulcer present) before getting the resident up into a chair. At 3:51 p.m., NA-C was asked when the last time R31 had been repositioned and NA-C responded that she assumed R31 had been repositioned before day shift left which would had been "around 2:00 p.m." NA-C verified R31 had not been repositioned yet on the evening shift. NA-C also confirmed R31 was supposed to be turned and repositioned every two hours. At 3:50 p.m. on 9/18/13, the resident was observed to receive care by NA-C. When the	{F 314}		

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 _____	R 09/19/2013

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 314}	Continued From page 4 resident was repositioned off the right hip, the hip was observed to be reddened. At that time, NA-C verified R31's right hip was red after the resident had been lying on the right side for three hours. During interview on 9/18/13, at 3:54 p.m. registered nurse (RN)-C stated "when the nursing assistants come to me I direct them to the care guides". RN-C stated R31 was to be turned every two hours and that staff were to try to avoid positioning the resident on the left hip. R31 was to be repositioned from her right side to her back only. RN-C also stated the nursing assistants received report by going room to room so the next shift would be aware of anything going on with the residents. RN-C verified NA-C should have been informed by the day NA that R31 was last repositioned at a specific time so R31 could be repositioned every two hours. During interview on 9/19/13, at 11:15 a.m. the director of nursing (DON) verified R31's care plan interventions directed staff to turn and reposition R31 every two hours and PRN. The DON stated she would expect staff to follow each resident's plan of care. The DON stated she was not sure how staff communicated to the next shift, but stated the nursing assistants would report to the nurse and the nurse would report to next shift, any changes in a resident's condition. In addition, the DON stated there was a face to face occurring with the nursing assistants at the change of shift.	{F 314}		

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 _____	R-C 09/19/2013

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 000}	INITIAL COMMENTS A follow-up visit was conducted to verify correction of deficiencies cited on 07/26/2013 for complaint # H5153015. As a result, F157 and F315 are re-issued.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	{F 157}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	R-C 09/19/2013

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 157}	Continued From page 1	{F 157}		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the physician regarding urinary changes for 1 of 2 residents (R2) reviewed for bladder function who received intermittent catheterizations, experienced urinary changes and developed a urinary tract infection (UTI).

Findings include:

R2's Resident Admission Record revealed a diagnosis of urinary retention. Review of R2's hospital Dismissal Summary dated 08/16/2013, showed R2 required several in and out urinary catheterizations. R2's urinalysis results of 08/16/2013 revealed normal findings without bacteria.

R2's General Order, signed by R2's physician on 09/04/2013, showed an order start date of 09/04/2013 for R2 to have a post void residual (PVR) (amount of urine remaining in the bladder after urination) every four hours while awake and every six hours at night and to have a straight (intermittent) catheterization done if the PVR is greater than 250 cc's.

R2's Resident Progress Notes revealed the following documentation: on 09/03/2013 no signs or symptoms of UTI were present and R2's urine was clear; on 09/04/2013 at 12:01 p.m. R2's urine was light yellow and free of any sedimentation.

R2's Primary Care Internal Med Nursing Home report (identified by the facility as PCIM) dated 09/04/2013, showed the facility's Nurse

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 _____	R-C 09/19/2013

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 157}	Continued From page 2 Practitioner (NP) ordered urine tests for 09/05/2013. R2's Resident Progress Note dated 09/04/2013 and entered at 8:37 p.m. showed R2's urine was cloudy with sediment and the NP was aware. R2's Resident Progress Note dated 09/05/2013 at 8:00 a.m., showed sediment was noted at the end of the catheterization. A urine specimen was collected during this time and sent with the lab staff person who was present at the time. R2's urinalysis results, with a test and results date of 09/05/2013, showed abnormal findings that included the presence of bacteria. R2's PCIM dated 09/05/2013 and signed on 09/05/2013 by an NP (not the facility's regular NP) indicated the lab results of 09/05/2013 would be forwarded to the facility NP for follow-up; R2's record showed no evidence of this follow-up. R2's Resident Progress notes dated 09/05/2013 and entered at 9:36 p.m. showed R2's urine continued to be cloudy. R2's Resident Progress Notes dated 09/06/2013 and entered at 12:13 p.m. by licensed practical nurse (LPN)-B showed the following: at 11:00 a.m., bladder scan results were zero, R2 requested an intermittent catheterization due to feeling full with the inability to void and an intermittent catheterization was done, resulting in 150 mL of urine that contained sediment and a strong odor. R2's record contained no evidence that LPN-B notified the physician or NP regarding the new change of the strong odor or R2's request for a catheterization, following the bladder scan results of zero.	{F 157}		

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 _____	R-C 09/19/2013

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 157}	Continued From page 3 R2's Resident Progress Note dated 09/06/2013 and entered at 6:16 p.m. by Registered Nurse (RN)-C, showed the following changes with R2: R2's urine was dark, R2 felt full and uncomfortable and R2 complained of being thirsty. This progress note also showed that the nurse informed the NP, however, there was no documentation regarding the NP's response, or if the NP was made aware of the earlier change that day of the strong odor. R2 expressed frustration as R2 had feelings of needing to void. R2's Resident Progress Notes for Saturday, 09/07/2013 and entered by RN-C, showed R2's urine continued to be concentrated with sediment. RN-C's progress note for R2 entered on Sunday, 09/08/2013, showed R2 "expressed frustration with fluid restriction" and R2 reported "I'm thirsty, my urine is dark and I feel stopped up". R2's urine was cloudy and R2 was unable to void. R2's Resident Progress Notes dated 09/09/2013 at 4:47 a.m. showed R2 experienced urinary frequency, urinary urgency and had very foul smelling urine with sediment. This progress noted showed R2 is to be catheterized every six hours at night (scheduled at 2 a.m.). R2 received two intermittent catheterizations during this eight hour night shift, without any evidence of results of a bladder scan prior to these catheterizations. This documentation also indicated an SBAR (a communication tool used by the facility to notify the physician/NP of the resident's condition) would be completed for the NP to review for recommendations. R2's Resident Progress Notes for Monday, 09/09/2013 and entered by RN-D showed a	{F 157}		

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 _____	R-C 09/19/2013

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 157}	Continued From page 4	{F 157}		

urinalysis and urine culture were ordered for signs/symptoms of a UTI and R2's urine continued to be cloudy with sediment. An addition progress note for 09/09/2013, entered by RN-A at 2:28 p.m., showed R2 was allowed 300 mL more of fluids to drink.

R2's Resident Progress Notes for 09/11/2013 at 12:13 p.m. showed R2's urine was dark yellow, contained increased sediment and now contained pus. There was no evidence that R2's physician or NP was notified regarding the new symptom of pus in R2's urine and there was no evidence that the facility's nursing staff knew of the results of R2's urinalysis of 09/09/2013 at this time or the NP's follow-up.

R2's PCIM dated 09/11/2013 (received by the facility on 09/16/2013) revealed the following: R2's diagnosis of a UTI, the facility's NP electronically signed this PCIM on 09/11/2013 at 8:53 a.m., susceptibilities for the urine culture were still pending and the NP planned to go ahead with initiating an antibiotic. Seven hours later, R2's nursing progress note indicated R2 was started on an antibiotic medication for the UTI.

When interviewed on 09/19/2013 at 9:03 a.m. RN-A verified R2's record did not include any follow-up from the facility's NP regarding the abnormal urinalysis of 09/05/2013 or the information provided by RN-C regarding R2's condition on the afternoon/evening of Friday, 09/06/2013. RN-A indicated if no response from the NP is provided, the licensed nurses should immediately follow-up on this and described immediate as following up the next day. RN-A added that the NP should have been notified first

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 _____	R-C 09/19/2013

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 157}	Continued From page 5	{F 157}		

regarding the resident's request for catheterization (at 11:00 a.m.) for an approved one time order to move forward with the catheterization.

When interviewed on 09/18/2013 at 3:05 p.m., RN-B indicated if the nurse is not hearing back from the NP/provider, the nurse should follow up again within one day; RN-B reviewed R2's record and stated "it doesn't look like that happened in this situation" and was unsure why not. RN-B also stated that the nurses find out lab results from the NP via a PCIM or written orders. RN-B stated that on evenings, weekends or times when the facility NP is not available, the nurse has contact numbers to notify the resident's primary doctor or on-call doctor regarding any abnormal lab or condition change.

When interviewed on 09/18/2013 at 3:18 p.m., the Director of Nursing (DON) verified there were no SBAR documents for R2 that had not yet been uploaded into R2's electronic record. The DON indicated that if the staff or NP communicates verbally and an SBAR is not used, the nurse's notes should still reflect the information from the verbal notification/response.

Review of the facility's policy titled "Change of Condition-Clinical Protocol", last revised 08/2013, included the following information: the provider or NP will respond in a timely manner and the staff will notify the Medical Director for any guidance and consultation if a timely or appropriate response is not received. R2's record contained no evidence that the Medical Director was notified.

Review of the facility's policy titled "Urinary Tract

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 _____	R-C 09/19/2013

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 157}	Continued From page 6 Infection Protocol", last revised 08/2013, included the following information: notify the NP or physician with signs or symptoms of a UTI and bladder scanning for PVR as ordered.	{F 157}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services regarding prevention of a urinary tract infection (UTI) for 1 of 2 residents (R2) reviewed for bladder function who received intermittent catheterizations, experienced urinary changes and developed a UTI. Additionally, based on interview and record review, the facility failed to comprehensively and accurately complete a resident bladder assessment for 1 of 2 residents (R3) reviewed for bladder function, who experienced urinary incontinence. Findings include: R2's Resident Admission Record revealed a	{F 315}		

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 _____	R-C 09/19/2013

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 315}	Continued From page 7	{F 315}		

diagnosis of urinary retention. Review of R2's hospital Dismissal Summary dated 08/16/2013, showed R2 experienced urinary retention with post void residuals (PVR) (amount of urine remaining in the bladder after urination) of approximately 800 milliliters/cubic centimeters (mL/cc). R2 needed several in and out (intermittent) urinary catheterizations to drain the urine left in the bladder. This report showed R2's discharge instructions for urinary management included bladder scanning with an intermittent catheterization if PVR is greater than 500 cc's. Additionally, R2's urinalysis results of 08/16/2013 revealed normal findings without bacteria.

R2's Brief Interview for Mental Status (BIMS) (a cognitive impairment screening test) dated 09/06/2013 showed R2's memory was cognitively intact.

R2's Licensed Nurse Flowsheet for September 2013 showed R2 was on a fluid restriction from 09/01/2013 until 09/12/2013 (due to being overloaded with fluid intake causing a decrease in blood sodium levels).

R2's General Order, electronically signed by R2's physician on 09/04/2013, showed an order start date of 09/04/2013 for R2 to have a PVR every four hours while awake and every six hours at night and to have a straight (intermittent) catheterization done if the PVR is greater than 250 cc's (which is a lower PVR compared to R2's discharge report).

When interviewed on 09/19/2013 at 9:03 a.m. Registered Nurse (RN)-A indicated R2 was a resident assigned to RN-A's caseload. RN-A identified R2's General Order dated 09/04/2013

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 _____	R-C 09/19/2013

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 315}	Continued From page 8	{F 315}		

as current and correct and stated it is very clearly spelled out. RN-A explained that this order directed nursing staff to check R2's PVR, perform a bladder scan and then, based on the bladder scan results, determine if R2 needed to be catheterized to empty the bladder. RN-A stated the facility's process for doing a PVR included having R2 urinate first and then do a bladder scan.

R2's Licensed Nurse Flowsheet for September 2013 showed R2's PVR/catheterization order change dated 09/04/2013, which corresponded exactly with R2's General Order electronically signed by the physician on 09/04/2013, and included documented instructions to do a PVR and perform a straight catheterization if the PVR is greater than 250 cc's. R2's Resident Progress Note dated 09/04/2013 and entered at 11:01 a.m., also corresponded exactly with R2's General Order dated 09/04/2013 (as described above).

Continued review of R2's Licensed Nurse Flowsheet from 09/04/2013 through 09/18/2013, showed 55 times where no urine cc's were identified for the bladder scan results; these sections contained either a blank space, straight line or a check mark. When interviewed on 09/19/2013 at 9:03 a.m., RN-A did not know what the straight line and check mark meant and added that if no bladder scan was done, the nurse is to circle the section and add a note to explain the reason for this.

R2's Resident Progress Notes revealed the following documentation: 09/03/2013-no signs or symptoms of UTI present and 650 cc's clear urine with an intermittent catheterization, 09/04/2013 at

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 _____	R-C 09/19/2013

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 315}	Continued From page 9	{F 315}		

12:01 p.m.-bladder scan results of 565 mL, followed by intermittent catheterization results of 550 mL and R2's urine was light yellow and free of any sedimentation.

R2's Resident Progress Notes revealed the following: a note dated 09/04/2013 and entered at 8:37 p.m. showed R2's urine was cloudy with sediment and the NP was aware; a note dated 09/05/2013 at 8:00 a.m., showed bladder scan results of 290 cc's, intermittent catheterization results of 250cc's and sediment was noted at the end of the catheterization-a urine specimen was collected during this time and sent with the lab staff person who was present at the time.

R2's urinalysis results, with a test and results date of 09/05/2013, showed a normal appearance with abnormal findings that included the presence of bacteria. R2's record did not show any evidence of an order or test for a culture analysis of this bacterium (used to identify the bacterial organism). This report showed the facility received these results via fax on 09/05/2013.

R2's PCIM dated 09/05/2013 and signed on 09/05/2013 by an NP (not the facility's regular NP) indicated the lab results of 09/05/2013 would be forwarded to the facility NP for follow-up.

Continued review of R2's Resident Progress Notes read as follows: dated 09/05/2013 entered at 9:36 p.m. showed R2's urine continued to be cloudy; dated 09/06/2013 and entered at 12:13 p.m. by LPN-B showed that at 6:45 a.m., bladder scan results were 23 (twenty-three) and an intermittent catheterization was done with 150 mL of urine; at 11:00 a.m., bladder scan results were zero, R2 requested an intermittent catheterization

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 _____	R-C 09/19/2013

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 315}	Continued From page 10 due to feeling full with the inability to void and an intermittent catheterization was done, resulting in 150 mL of urine that contained sediment and a strong odor (LPN-B had not notified the physician or NP about the strong odor, R2's sensation of feeling full or R2's request for the catheterization that was outside of the parameters of the physician's order); dated 09/06/2013 and entered at 6:16 p.m. by RN-C, showed R2's urine was dark, cloudy and contained sediment, R2 felt full and uncomfortable and R2 complained of being thirsty (this progress note also showed that the nurse informed the NP, however, there was no documentation regarding the NP's response, or if the NP was made aware of the earlier change that day of the strong odor)-additionally, there was no evidence of a bladder scan being done prior to the intermittent catheterization at 4:00 p.m., R2 was unable to void and was catheterized with urinary output results of 100 mL-RN-C then scanned R2's bladder four times and found 20 mL in R2's bladder-R2 expressed frustration as R2 had feelings of needing to void; dated 09/07/2013 and entered by RN-C, showed R2's urine continued to be concentrated with sediment; dated 09/08/2013 and entered by RN-C, showed R2 "expressed frustration with fluid restriction" and R2 reported "I'm thirsty, my urine is dark and I feel stopped up"-R2's urine was cloudy, R2 was unable to void and there was no evidence of a bladder scan done prior to an intermittent catheterization (to determine a PVR greater than 250 mL), with catheterization results being 150 mL; dated 09/09/2013 at 4:47 a.m. showed R2 experienced urinary frequency, urinary urgency and had very foul smelling urine with sediment-R2 received two intermittent catheterizations during this eight hour night shift, without any evidence of results of a bladder scan	{F 315}		

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 _____	R-C 09/19/2013

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 315}	Continued From page 11	{F 315}		

prior to these catheterizations or reason for performing an additional catheterization outside of the ordered parameters; dated 09/09/2013 and entered by RN-D showed a urinalysis and urine culture were ordered for signs/symptoms of a UTI and R2's urine continued to be cloudy with sediment; dated 09/09/2013 and entered by RN-A at 2:28 p.m., showed R2 was allowed 300 mL more of fluids to drink; dated 09/10/2013 showed an intermittent catheterization was done at 4:00 p.m. with results of 200 cc's urine (there was no evidence of any bladder scan results prior to this catheterization); dated 09/11/2013 at 12:13 p.m. showed R2's urine was dark yellow, contained increased sediment and now contained pus. There was no evidence that R2's physician or NP was notified regarding the new symptom of pus in R2's urine and there was no evidence that the facility's nursing staff knew of the results of R2's urinalysis of 09/09/2013 at this time.

R2's PCIM dated 09/11/2013 (received by the facility on 09/16/2013) revealed the following: R2's diagnosis of a UTI, the facility's NP electronically signed this PCIM on 09/11/2013 at 8:53 a.m., susceptibilities for the urine culture were still pending and the NP planned to go ahead with initiating an antibiotic. Seven hours later, R2's nursing progress note indicated R2 was started on an antibiotic medication for the UTI.

R2's Resident Progress Notes dated 09/15/2013 showed orders from a Physician Assistant (PA-C) that indicated R2 had a new diagnosis of urinary retention and the current orders for the intermittent catheterization were to be continued.

Review of R2's Urology Consult report dated

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 _____	R-C 09/19/2013

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 315}	Continued From page 12 09/13/2013 (received in the facility on 09/19/2013) showed that sitting in a warm bath or shower may relax R2 and allow R2 to void. It was also discussed with R2 that once R2's bowel function improves to a normal state, the urinary retention may improve as well. R2's care plan with a problem start date of 09/06/2013 showed R2 was admitted for short-term placement and lacked any information regarding R2's urinary retention and UTI. There was no evidence of care-planned interventions to reduce the risk of R2 developing a UTI. R2's Short Term Resident Plan of Care (a care plan initiated on admission and replaced with a comprehensive care plan that is to be done by the 21st day after admission) dated 08/16/2013 also lacked this information. When interviewed on 09/18/2013 at 11:33 a.m., licensed practical nurse (LPN)-A reviewed R2's care plan with the investigator and verified R2's care plan lacked information related to R2's urinary retention, interventions to reduce the risk of a UTI and R2's recent UTI. LPN-A verbalized uncertainty regarding the reason that R2's care plan did not contain this information and stated R2's urinary retention and intermittent catheterizations was one of the main reasons for R2 being admitted to the facility. LPN-A indicated the nurse clinical managers develop the resident's care plan and any nurse can handwrite revisions onto the care plan. LPN-A recalled that R2 had a urology appointment on 09/13/2013, felt the 09/15/2013 progress note referring to the PA-C orders was from this visit (but was not certain), and could not locate any visit note in R2's record from this appointment. LPN-A further explained that the NA's have a care guide, which	{F 315}		

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 _____	R-C 09/19/2013

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 315}	Continued From page 13	{F 315}		

is used to know information about a resident's needs and condition. LPN-A showed the investigator the location where the care guides are kept and was not able to locate a copy of the care guide that included R2's information. LPN-A identified NA-A as the NA assigned to care for R2 on 09/18/2013 and it was learned that NA-A did not have a copy of the current care plan for R2 until 12:48 p.m., when RN-E printed a copy for staff use.

When interviewed on 09/18/2013 at 3:23 p.m., the MDS Coordinator indicated the care plans done for short-term placement residents are different than the care plans done for long-term care placement residents. The MDS Coordinator indicated the full care plan is not developed for the short-term placement residents as many are not at the facility longer than two weeks; however, the MDS Coordinator verified R2 had resided at the facility longer than this (approximately five weeks). The MDS Coordinator indicated the full care plan that is developed for a short-term placement resident only includes the areas of social work and activities. The MDS Coordinator stated the nurse who is first informed of a resident's condition change would update the care plan. The MDS Coordinator could not provide a reason for R2's care plan not being updated with information regarding R2's urinary retention or UTI.

When interviewed on 09/19/2013 at 9:52 a.m., R2 indicated the nurses do not always do a bladder scan prior to the catheterization. R2 stated the nurses should not catheterize R2 if the bladder scan result is less than 250 (mL) and expressed that the lowest amount that R2 is aware of has been around 240 (mL). R2 indicated last having

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 _____	R-C 09/19/2013

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 315}	Continued From page 14 a bladder infection forty to fifty years ago. R2 also talked of all the times R2 has required intermittent catheterizations, stated "my daughter catheterized me" and "I had no infection whatsoever; my daughter was very meticulous." R2 stated "(a facility nurse) blames me" for the UTI "because I didn't wipe front to back" (referring to removal of the lubricant jelly from R2's body following the catheterization). R2 told this nurse "I'm not the only one who wipes me" and "you should see all the different ways the staff wipe me." R2 stated not all the nurses allow R2 to independently wipe the lubricant jelly off. R2 recalled over the weekend of 09/06/2013 that R2's urine "was a little strong." When interviewed on 09/19/2013 at 9:03 a.m. RN-A verified R2's record did not include any follow-up from the facility's NP regarding the abnormal urinalysis of 09/05/2013 or the information provided by RN-C on the afternoon/evening of Friday, 09/06/2013, regarding R2's sensation of feeling full, urinary changes and feeling thirsty. RN-A indicated if no response from the NP is provided, the licensed nurses should immediately follow-up on this and described immediate as following up the next day. RN-A further stated "it shouldn't have been done" regarding the above intermittent catheterizations on 09/06/2013 and added that the NP should have been notified first regarding the resident's request for catheterization (at 11:00 a.m.) for an approved one time order to move forward with the catheterization. RN-A stated the protocol/order of doing a PVR first was not followed. RN-A added that the staff 's actions can increase R2's risk for a UTI. When interviewed on 09/18/2013 at 3:05 p.m.,	{F 315}		

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 _____	R-C 09/19/2013

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 315}	Continued From page 15	{F 315}		

RN-B indicated if the nurse is not hearing back from the NP/provider, the nurse should follow up again within one day; RN-B reviewed R2's record and stated "it doesn't look like that happened in this situation" and was unsure why not. RN-B also stated that the nurses find out lab results from the NP via a PCIM or written orders. RN-B stated that on evenings, weekends or times when the facility NP is not available, the nurse has contact numbers to notify the resident's primary doctor or on-call doctor regarding any abnormal lab or condition change.

When interviewed on 09/18/2013 at 3:18 p.m., the Director of Nursing (DON) verified there were no SBAR documents (a form used by the nursing staff to communicate resident information to the physician/NP) for R2 that had not been uploaded into R2's electronic record. The DON indicated that if the staff or NP communicates verbally and an SBAR is not used, the nurse's notes should still reflect the information from the verbal notification/response.

Review of the facility's policy titled "Change of Condition-Clinical Protocol", last revised 08/2013, included the following information: the provider or NP will respond in a timely manner and the staff will notify the Medical Director for any guidance and consultation if a timely or appropriate response is not received. R2's record contained no evidence that the Medical Director was notified.

Review of the facility's policy titled "Urinary Tract Infection Protocol", last revised 08/2013, included the following information: the purpose of the policy included identifying residents at risk for a UTI, ensuring that residents receive appropriate

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 _____	R-C 09/19/2013

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 315}	Continued From page 16	{F 315}		

treatment and services for prevention of UTI's and to restore as much normal bladder function as possible; risk factors for UTI's are noted in the plan of care; notify the NP or physician with signs or symptoms of a UTI and bladder scanning for PVR as ordered.

R3 lacked a comprehensive bladder assessment, which should include all pertinent diagnoses.

R3's hospital Dismissal Summary dated 08/29/2013 showed that R3 had a past history of stroke and required limited assistance with toileting. R3's BIMS dated 09/12/2013 showed R3's memory was cognitively intact.

R3's admission Minimum Data Set (MDS) (a resident assessment and screening tool) with an observation end date of 09/12/2013 and signed as complete by the MDS Coordinator on 09/19/2013, showed R3 was always continent of bladder.

When interviewed on 09/18/2013 at 3:54 p.m., NA-B indicated that sometimes R3's brief is a little wet and felt the reason for this was due to R3's age. NA-B stated R3 knows when the brief is wet. NA-B added that R3 is mostly continent of urine and uses the call light to request assistance to the bathroom.

When interviewed on 09/18/2013 at 4:25 p.m., R3 indicated having episodes of urinary incontinence for years, was unsure if this started after R3's stroke and recalled it getting worse after the stroke. R3 stated that initially the urinary incontinence was only happening once in a while and occurs mainly at night. R3 verbalized not ever talking to R3's physician about this and that

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 _____	R-C 09/19/2013

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 315}	Continued From page 17 R3's spouse feels R3 should have this checked out. R3 stated "it probably is treatable" and indicated has not had urinary incontinence "to this extent." R3 indicated needing help to get to the toilet and that staff is not always timely in assisting R3 to the bathroom. R3 also notices the urinary incontinence when changing positions from the recliner to the wheelchair. Review of R3's Bladder Assessment completed on 09/10/2013 by RN-A indicated R3 is currently incontinent of bladder and experiences urine leakage on the way to the bathroom. Section 3 of this form (which identifies diagnoses that apply to R3) contained a section for CVA/stroke that was not marked. Section 6, which includes identification of symptoms that may correlate with certain types of incontinence, included a symptom of "urine loss on way to toilet room" that was not marked (marking this would indicate possible urge urinary incontinence), urinary incontinence in small amounts (drops, spurts) that was not marked (which could possibly indicate stress incontinence (incontinence associated with impaired urethral closure) and leakage with physical activity (also indicative of stress incontinence) that was not marked. Areas marked for Section 6 included mobility/manual dexterity impairments and medications, both indicative of possible functional urinary incontinence. R3 was identified as having functional incontinence (unable to remain incontinent due to external factors). This assessment did not include any information regarding whether or not R3 would be appropriate for a toileting or retraining program and the rationale for this. The Bladder Assessment Summary contained the following documentation: "Resident has occasional dribbling of urine" and	{F 315}		

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 _____	R-C 09/19/2013

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 315}	Continued From page 18 lacked an analysis of the identified symptoms/risk factors and a summary of the facility's three day voiding diary. When interviewed on 09/19/2013, RN-A agreed the stroke section should have been checked, indicated it was human error and added that R3's stroke history was not considered in any way during R3's bladder assessment. RN-A stated the three day voiding diary is used during the assessment, could not provide any information regarding R3's voiding diary and was uncertain whether or not this information is kept as RN-A thought the facility was phasing these diaries out. When asked about the analysis of this information, RN-A expressed uncertainty for possible causes of R3's urinary incontinence and replied that R3 wears a pad in R3's underpants to manage the dribbling. Review of the facility's policy titled "Incontinence", last revised 08/2013, provided the following information: the goal of the assessment is to determine the history and pattern of incontinence to detect and treat possible reversible causes; the bladder assessment consists of the resident's history, potential transient causes of urinary incontinence, contributing diagnosis or medical conditions and evaluation for bladder rehab programs and an individualized care plan will be developed. Review of the facility's policy titled "Bladder and Bowel Policy and Procedure", last revised 08/2013, included the following information: each resident will be assessed for 72 hour bladder voiding patterns; the licensed nurse will gather information from review and analysis of the 72 hour voiding patterns; assessments will be	{F 315}		

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 _____	R-C 09/19/2013

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 315}	Continued From page 19 completed to evaluate for feasibility in retraining for bladder control and based on the assessment, the resident's plan of care will be developed to address the issues, goals and appropriate interventions. Review of R3's Care Area Assessment information for the assessment date of 09/05/2013, showed R3 had urinary urgency and need for assistance in toileting, the type of incontinence showed no type applied to R3 and it was determined that R3 required a care plan for urinary incontinence. Review of R3's Short Term Resident Plan of Care dated 08/29/2013 showed R3 had bladder incontinence. R3's care plan lacked any other information or interventions regarding R3's urinary incontinence.	{F 315}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E5K3

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: **2** (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 **08/01/2013** (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:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michelle McFarland, HFE NEII 08/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 09/27/2013 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
09/27/2013
(L33)

DETERMINATION APPROVAL

CCN: 24-5153

On July 26, 2013 an abbreviated standard survey was completed by the Office of Health Facility Complaints as a result of complaint number H5153015. On August 1, 2013 the Minnesota Departments of Health and Life Safety Code completed a standard survey. This Department recommended to the Region V Office of CMS to impose denial of payment for new admissions. If substantial compliance is not acheived by October 26, 2013, the remedy of denial of payment for new admissions and loss of NATCEP would go into effect. Refer to the CMS 2567 forms for both health and life safety code along with the providers plan of correct for the standard survey completed on August 1, 2013. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5254

August 16, 2013

Ms Beth Redalen, Administrator
Madonna Towers Of Rochester, Inc
4001 19th Avenue Northwest
Rochester, Minnesota 55901

RE: Project Number H5153015, S5153022

Dear Ms. Redalen:

On August 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Office of Health Facility Complaints for an abbreviated standard survey, completed on July 26, 2013. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), whereby corrections were required.

On August 1, 2013, a standard survey was completed at your facility by the 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, where by corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 26, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 26, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 26, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Madonna Towers Of Rochester, Inc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 26, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the August 1, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731
Fax: (507) 206-2711

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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

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 January 26, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

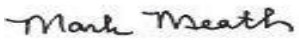
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5153s13LcOhfcltr.rtf

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 _____	08/01/2013

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 000	INITIAL COMMENTS The facility's plan of correction (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 form 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	F 000	AUG 29 2013 MN Dept of Health Rochester	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote dignity and respenct for each resident during activities of daily living for 1 of 4 residents(R31) who was observed to be isolated from other residents in the facility. Findings include: R31 was observed to eat in the dining room alone at a table and also when in the hallway she was isolated by herself and no other residents in the immediate area. This was the routine activity observed for R31. R31 was admitted to the facility on 6/13/2006 with a diagnosis of Alzheimer's disease with associated behaviors, depression, anxiety,	F 241	See Attachment 1 08/30/2013 sph	9-10-13

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

Beth Redalen / Admin / Health Serv. | 8/29/13

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.

Attachment 1

Regulation 483.15(a) Tag F241
Resident Dignity

Madonna Towers of Rochester promotes care for residents in a manner and an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The staff routinely interact with residents and encourage/provide activities which assist the resident in experiencing the highest possible quality of life and which maintain and enhance his/her self-esteem and self-worth.

During the August 22, 2013 mandatory meeting with the certified nursing assistants, the residents' right to dignified and respectful treatment as well as the importance of continuing to interact with and provide stimulating opportunities for residents with cognitive and sensory deficits were addressed. Discussion during the September 5, mandatory all-staff meeting will address the need to 1) be sensitive to the residents' psychosocial well-being 2) recognize and respect the residents' leisure pursuit preferences and 3) provide opportunities for interaction with the staff and other residents. During the September 5, 2013 mandatory all-staff meeting, the above issues were reviewed as well as the facility's policy, *Quality of Life-Dignity*, which addresses the right of cognitively impaired residents to be treated with dignity and sensitivity and the need to address the underlying motives or root causes for behaviors that negatively impact others. As part of the orientation process, new employees are instructed on the resident's right of dignity and respect.

Resident number 31, a 101-year-old female with the diagnosis of blindness, hearing impairment, and advanced dementia was admitted to the facility March 13, 2006. Over the years she has developed a very positive relationship with many staff members who are aware of her preferences, often initiate conversation with her, and provide frequent therapeutic touch. Due to her sensory impairments which increase the risk of social isolation, she is provided with one-on-one visits by the activity staff several times per week and is visited routinely by the social worker.

Due to a history of socially inappropriate/disruptive behaviors (spitting, yelling out, smearing feces) when in the common areas of the facility and her increased agitation when exposed to a noisy, active environment, her plan of care includes placing the resident in a quiet setting which tends to be calming for her. She enjoys sitting near the nursing station with a fleece throw around her shoulders. Her immediate environment has been modified to include objects that provide multiple opportunities for tactile stimulation. When queried, her son expressed satisfaction with the social and activity interventions provided by the facility staff.

To verify appropriateness of activity plan of care, the resident's behaviors will be tracked every shift for one month. For two weeks, the resident will be invited to various group activities on a daily basis. Her behavior and participation level will be documented. After a review of the above data, the resident's psychosocial needs and behaviors exhibited during the activities will be reassessed and the plan of care reviewed and revised as necessary to promote maximum involvement in therapeutic/recreational leisure activities.

The resident continues to frequently spit and throw eating utensils during meal time which increases the risk of negative reactions from other residents (including verbal and physical abuse); therefore, she will be provided a private table for dining. As part of the ongoing comprehensive assessment and care planning process, the resident's behaviors, leisure pursuits, and activity participation will be reviewed quarterly and after any significant changes in condition. Revisions to the care plan will be made as appropriate.

The Madonna Living Community Wellness Director will monitor compliance for resident 31 through review of the appropriateness of the activity plan care developed after the assessment of the collected behavior data. During the quarterly care conference process, the Wellness Coordinator for the skilled care unit will review the plans of care and related documentation for residents at risk for social isolation due to sensory impairments and/or limited participation in activity programs. Activity/leisure related care plans will be revised as needed to promote the highest practicable psychosocial well-being. Compliance will be reviewed during the October Quality Council meeting.

Date of completion: September 10, 2013

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 _____	08/01/2013

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 241	Continued From page 1 blindness and kidney disease. The quarterly Minimum Data Set (MDS) assessment dated 6/19/2013 indicated R31 has severely impaired vision and minimal difficulty hearing. In addition, it also indicated R31 having behavioral symptoms not directed towards others that occurred 1-3 days. The resident requires extensive assistance with activities of daily living (ADL). During the dining observation at 6:00 p.m. on 7/29/13 R31 was observed seated in the dining room at a table by herself with a plastic mat under her wheelchair. When R31 had finished eating she was taken out of the dining room and placed in the hallway facing a glass window which looked into the activities room and again she was by herself. During the dining experience on 7/29/13 at 6:00 p.m. the dietary director had been interviewed and said R31 had behaviors such as spitting and yelling out and these had been disruptive to the other residents. During observation of the dining experience there were no behaviors such as spitting or yelling noted during the meal time. During observations at 3:30 p.m. on 7/30/13 R31 was again observed sitting facing the glass window into the activities room by herself. There was a bright colored bedside table in front of R31 this time with some small sensory items attached and in reach of R31. At 7:27 a.m. on 7/31/13 R31 was again observed sitting facing the glass window which looked into the activity room with the bright colored bedside table in front of her. R31 had a glass of liquids on the table. R31 was observed to be spitting and yelling out "Take me home, I want to go home." At 8:06 a.m. the resident was brought into the	F 241		

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 _____	08/01/2013

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 241	Continued From page 2 dining room form the hallway and placed at a dining room table alone; a staff member sat down by R31 and started assisting her to eat. During this time there were no behaviors observed when staff was with R31. At 8:30 a.m. R31 was removed from the dining room and placed in the same place as before the meal. At 8:40 a.m. on 7/31/13 nursing assistant (NA)-A brought the resident from the hallway to her room to lay her down. At 7:20 a.m. on 8/1/13 the resident was observed in her room. At 8:00 am R31 was still in her room. At 9:27 a.m. R31 was in her wheel chair located in the hallway with the sensory side table. The resident was not observed to have any behaviors during these observations. During an interview at 7:30 am on 7/31/13 R31 stated, "I don't mind sitting here." In reference to being in her bedroom. On further interview it was noted that R31 did have confusion to where she was currently living. R31 then said that she did not have breakfast and didn't know when she was going, just that she wanted a little bit to eat. At 7:40 a.m. on 7/31/13 during an interview RN-C said R31 sits by the activity window because she gets agitated when around a bunch of people. When asked why R31 had been faced towards the glass window rather than facing the other direction so she can interact with others that are in the area RN-C said that the resident is blind. During an interview with NA-B at 8:00 a.m. on 7/31/13 in regards to whey R31 is placed facing the window, NA-B said the resident sits this way because she disturbs the other residents and spits. At 8:01 a.m. on 7/31/13 during an interview with RN-D it was learned that R31 ' s routine is by herself in the dining room during the meal and	F 241		

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 _____	08/01/2013

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 241	Continued From page 3 then moved to the hallway and looks into the activity room. RN-C also said R31 does well when staff sits with her with not having spitting and yelling episodes. At 12:27 p.m. on 7/31/13 during an interview the director of nursing (DON) she said R31 ' s behaviors have gotten better and said she does not always sit in front of the window by the activities room. The DON stated the resident did have a behavioral evaluation on December 10th, 2012 with the DBART (behavioral team to assess unwanted behaviors) team through the Mayo Clinic that recommended textile sensory for the resident and her spitting may be due to a habit. The resident was on Seroquel (antipsychotic) and Remeron (psychoactive medication) in the past; however it was discontinued due to no improvement in the resident's behaviors. At 9:52 a.m. on 8/1/13 during an interview with the social service director and the activity director it was verified R31 had been seated in front of the sensory table a great deal of her time. Activity director said they do more 1:1 visits as the resident has behaviors that are disruptive towards the other residents when in group activities. When asked if the behaviors were documented that R31 was disruptive in activities the activity director verified it was not documented. Both the social service director and the activities director had seen an improvement in R31's behaviors since the DBART team evaluated R31. The activity director said that she had not attempted to include R31 in group activities after noting an improvement in R31's behavior. R31's nursing notes and behavior monitoring reports were reviewed from December 2012	F 241		

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 _____	08/01/2013

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 241	Continued From page 4 through July 2012 which showed intermittent behaviors by the resident; however it had not indicate daily occurrences of behaviors such as spitting or yelling. For the month of July 2013, only one behavior was documented on the behavior tracking tool. The care plan dated 1/7/13 addressed the resident at risk for reduced social interaction related to impaired vision, Alzheimer's disease and depression. The approaches indicate the resident enjoys visiting with others, to invite and escort resident to a variety of activities, attend sensory visits twice per week. On 7/13/13 the following information was added: the resident frequently becomes overstimulated and benefits from a quieter setting, faced away from the general traffic area. On 2/2/13 the care plan addresses the resident ' s spitting behaviors and indicates to not always face the resident outwards towards residents or visitors in the common areas. There is no documentation that states to keep the resident sitting at the dining table alone or sitting alone in the common areas.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to	F 248	See Attachment 2	9-10-13

Attachment 2

483.15(f)(1) Tag F248
Activities to Meet Interests/Needs

Madonna Towers of Rochester provides for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. An activity interest assessment is completed at the time of admission and is used to develop activity programming with care plan goals and approaches that are individualized to match the skills, abilities, interests and preferences of each resident. The comprehensive assessment is used to 1) identify residents who would benefit from one-to-one visits by the activity staff and 2) determine the frequency and focus of the visits. Members of the Resident Council are queried whether they are satisfied with the types and scheduling of activities that are available.

The appropriateness of the resident's activity support/leisure programming is reassessed during the quarterly care conference and more often if indicated. The residents are asked about their preferences and their satisfaction with the current programming. To the greatest extent possible, modifications are made to meet the residents' preferences and requests; care plans are revised to reflect changes.

During the mandatory training meeting September 5, 2013, the staff will be/were instructed on the need for awareness of the residents' 1) leisure time preferences 2) ability to participate in recreational/leisure activities and 3) need for assistance in pursuing/attending the leisure activities pursuits of their choice. The need to report changes in the resident's condition which may alter his/her ability to participate in recreational/leisure activities was also addressed.

Resident number 31, a 101-year-old female with the diagnosis of blindness, hearing impairment, and advanced dementia was admitted to the facility March 13, 2006. Over the years she developed a very positive relationship with many staff members who are aware of her preferences, often initiate conversation with her, and provide frequent therapeutic touch. Several staff members have taken the initiative to personally hand-craft fabric sensory objects for her calming and comfort. Due to her sensory impairments and risk for social isolation, she is provided one-on-one visits by the activity staff several times per week and is visited routinely by the social worker.

Due to a history of socially inappropriate/disruptive behaviors (yelling out, smearing feces, spitting) in the dining room and other common areas of the facility and increased agitation when exposed to a noisy, active environment, her plan of care includes placing the resident

in a quiet setting which tends to be calming for her. She enjoys sitting near the nursing station with a fleece throw or modified jacket around her shoulders. Her immediate environment has been modified to include objects that provide opportunity for tactile stimulation. When queried, her son expressed satisfaction with the social/activity interventions provided by the facility staff.

The resident's behaviors will be tracked every shift for one month. For two weeks, the resident will be invited to various group activities on a daily basis. Her behavior and participation level will be documented. After review of the above data, the resident's psychosocial needs and responses/behaviors exhibited during the activities will be re-assessed and the plan of care reviewed and revised as necessary.

The resident continues to frequently spit and throw eating utensils during meal time which increases the risk of negative reactions from other residents (including verbal and physical abuse); therefore, she will be provided a private table for dining. As part of the ongoing comprehensive assessment and care planning process, the resident's behaviors, leisure pursuits, and activity participation will be reviewed quarterly and after any significant changes in condition. Revisions to the care plan will be made as appropriate.

The Madonna Community Wellness Director will monitor compliance for resident 31 through review of the appropriateness of the activity plan care developed after the assessment of the collected behavior data. During the quarterly care conference process, the Wellness Coordinator for the skilled care unit will review the plans of care and related documentation for residents at risk for social isolation due to sensory impairments and/or limited participation in activity programs. Activity/leisure related care plans will be revised as needed to promote the highest practicable psychosocial well-being. Compliance will be reviewed during the October Quality Council meeting.

Date of completion: September 10, 2013

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 _____	08/01/2013

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 248	Continued From page 5 meet the needs of the resident for 1 of 4 residents (R31) reviewed for activities. Findings include: R31 had not been included in group activities and other activities that would decrease the amount of time spent alone whether it was in her room, during the meal, and in the common areas where other staff, visitors, and residents congregate. Even though a recommendation for a less stimulating environment was suggested the resident was kept isolated from any activity with other residents. The resident was admitted to the facility on 6/13/2006 with a diagnosis of Alzheimer ' s disease with associated behaviors, depression, anxiety, blindness and kidney disease. The quarterly Minimum Data Set (MDS) assessment dated 6/19/2013 indicated R31 has severely impaired vision and minimal difficulty hearing. In addition, it also indicated R31 having behavioral symptoms not directed towards others that occurred 1-3 days. The resident requires extensive assistance with activities of daily living (ADL.) The annual Minimum Data Set dated 12/27/2012 assessed R31 to like to listen to music, being around animals such as pets and participation in favorite activities. At 6:00 p.m. on 7/29/13 R31 was observed sitting in the dining room at a table by herself. When R31 finished eating she was taken out of the dining room and placed facing the glass window facing into the activities room. During the meal the dietary director was interviewed and said the resident has behaviors such as spitting and yelling out that is disruptive to the other residents. There were no behaviors noted during the meat time. At 3:30 pm on 7/30/13 R31 again was	F 248		

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 _____	08/01/2013

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 248	Continued From page 6 observed sitting facing the glass window into the activities room by herself. Also a bright colored bedside table was placed in front of her with some small sensory items attached. During observations, at 7:27 a.m. on 7/31/13 the resident was again observed sitting facing the glass window into the activity room with the bright colored bedside table in front of her and drinking a glass of liquid. R31 was observed spitting and yelling out " Take me home, I want to go home." At 8:06 a.m. on 7/31/13 the resident was brought into the dining room and placed at a table alone; a staff member sat down by R31 and started assisting. There were no behaviors of spitting or yelling observed when she was assisted to eat by staff. At 8:30 a.m. on 7/31/13 R31 was brought back t to beside table facing the window by the activities room from the dining room. At 8:40 a.m. on 7/31/13 nursing assistant (NA-A) brought R31to her room to lie her down. At 7:20 a.m. on 8/1/13 R31 was observed in her room. At 8:00 a.m. R31 was still in her room. At 9:27 a.m. R31 was observed at the sensory side table. The resident was not observed to have any behaviors during these observations. During an interview at 7:30 a.m. on 7/31/13 R31 said, " I don't mind sitting here." This was in reference to her being in her room alone. At 12:27 pm on 7/31/13 during an interview the director of nursing (DON) stated the resident's behaviors have gotten better since being seen by a team at the Mayo Clinic for behaviors. R31 was seen by the Mayo Clinic behavior unit in December 2012.	F 248		

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 _____	08/01/2013

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 248	Continued From page 7 At 9:52 a.m. on 8/1/13 during an interview with both the social service director and the activity director concerning R31 activity during the day it was learned that R31 did spend a great deal of her time at the sensory table located by the activity window alone. The activity director said they do 1:1 visits as the resident has behaviors that are disruptive towards the other residents. When asked if these behaviors were documented the activity director said that it was not always documented. It was verified by the social service director and the activities director the resident's behaviors have improved since the behavior team at Mayo Clinic had evaluated the resident and it was also verified they did not make any attempts to have the resident sit with other residents during dining or attend group activities. However, following this interview R31 was observed to be placed in group activities. During review of R31 ' s nursing notes and behavior monitoring reports from December 2012 through July 2013 it was noted R31 had intermittent behaviors; however it did not indicate daily behaviors. July 2013 note had only one behavior documented on the behavior tracking tool. The nursing notes and behavior monitoring tool does not reflect the behaviors the resident was exhibiting according to the variety of staff interviews. The care plan dated 1/7/13 category activities addresses the resident risk for reduced social interaction related to impaired vision Alzheimer's disease and depression. The approaches indicate the resident enjoys visiting with others, encourage music programs, to invite and escort resident to a variety of activities, and attend sensory visits twice per week. On 7/13/13 it is noted on the care	F 248		

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 _____	08/01/2013

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 248	Continued From page 8 plan the resident frequently becomes overstimulated and benefits from a quieter setting, faced away from the general traffic area. On 2/2/13 the care plan addresses the resident ' s spitting behaviors and indicates to not always face the resident outwards towards residents or visitors in the common areas. There is no documentation in the care plan that R31 was to neither eat alone for meals nor sit alone in the common areas.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 279	See Attachment 3	9-10-13

Attachment 3

Regulation 483.20(d), (k)(1) Tag F279
Develop Comprehensive Care Plans

The Madonna Towers of Rochester staff do not believe there has been a deviation from this regulation. This plan of response regarding Tag F279 is written solely to maintain certification in the Medicare and Medical Assistance Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety. This plan of correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all state and federal regulatory requirements and constitutes the facility's allegation of compliance.

Madonna Towers of Rochester uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services.

The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented; the interdisciplinary care plan is developed within seven days after completion of the comprehensive assessment.

During the mandatory training meeting September 5, 2013, the nursing staff will be informed of the surveyor concerns and reminded 1) of the facility policies for care plan implementation/reviews/ updates 2) that the residents' care plans must be current at all times and 3) that care plans must continue to address oral/dental needs that impact the residents' hygiene, intake, and quality of life.

Resident Number 32 was admitted to the facility May 31, 2013. The admission nurse's note states, that the resident is alert and oriented to time and place. The resident reports that she wears upper and lower partials which fit well; she denied chewing or swallowing problems. The resident was seen by a registered dental hygienist from Apple Tree Dental on June 6, 2013. The hygienist reported, "Significant wear attrition abrasion from end to end bite. Teeth clean. Doing OK for now. Should stay current on regular check up/cleaning." In response to the facility staff recommendation, the family agreed to an assessment by Apple Tree Dental for repair/replacement of a broken upper partial; the resident was seen by the Apple Tree Dental hygienist July 3, 2013. The hygienist noted the broken upper partial (stored at the nursing station). The hygienist further noted that the

resident had "both partials in, which would suggest that she has 2 sets (of partials). Significant chipping and tooth wear of natural and denture teeth." The hygienist categorized the visit as "Routine dental referral. Resident has non-urgent dental needs."

The resident's oral/dental condition was reassessed August 1, 2013. When queried, the resident denied discomfort from the chipped lower front teeth. The nurse reports, "I had her put them in (upper and lower partials) while I was in the room setting and she easily placed them in her mouth. I asked her if they fit her comfortably and she stated 'yes'. She denied discomfort from her chipped lower front teeth when eating . . . Resident currently denies any difficulty with eating due to teeth." In addition, an August 1, 2013, a note by the RN clinical manager states, "Resident will be seen by Apple Tree Dental on Friday September 6, 2013 r/t oral assessment that was completed 07/03/2013. Family was updated . . . "

The reference to broken teeth in the regulatory audit report was based on a positive response to the quarterly Minimum Data Set Section L 0200A (Oral/Dental Status) question which asks if the resident has "Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)." As clarification, this question refers to partials/dentures, not natural teeth. Since the resident had a broken partial, the assessor's response to the question was affirmative. Subsequently, the resident was found to have a second partial in good repair that is now being used.

The facility policies and procedures for developing a plan of care for oral hygiene/dental services were followed for Resident Number 32. The resident had no mouth pain, mouth sores, weight loss, anorexia, or difficulty chewing. The chipped teeth did not impact the resident's oral care or quality of life. Therefore, not addressing the chipped teeth in the plan of care was an objective decision by the interdisciplinary care plan team. Due to investigation and recommendation by the regulatory auditors, the care plan was revised to address the chipped teeth.

Comprehensive care planning by the interdisciplinary team will continue. At the time of admission, quarterly, and with significant change in condition, the care plan team will continue to review residents' oral care dependencies and need for dental services. Referrals will be made for dental care as appropriate. The regulatory concern for care plan content will be reviewed at the Quality Council meeting.

Completion Date: September 10, 2013

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 _____	08/01/2013

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 279	Continued From page 9 review, the facility failed to develop a comprehensive care plan related to the comprehensive dental assessment for 1 of 3 residents (R32) reviewed for dental needs. Findings include: R32's care plan identified they had partial dentures and needs assist with oral hygiene, a comprehensive care plan had not been developed that identified timely interventions related to broken teeth. Observation on 7/29/13, at 2:21 p.m., revealed R32 had broken natural teeth on right upper side, missing teeth upper and no upper partial denture in place. During interview on 7/31/13, at 11:02 a.m., R32 said they had both an upper partial and lower partial dentures. Visual observation of mouth at this time revealed a few broken natural teeth right upper side. R32 stated partial dentures fit o.k., denied oral pain, chewing or eating problems. Observation on 7/31/13, at 11:58 a.m., R32 was sitting in dining room eating independent, no signs of discomfort chewing and no swallowing issues noted. Review of R32's quarterly Minimum Data Set (MDS) dated 6/19/13, identified oral/dental broken teeth. Review of R32's oral/dental assessment form dated 7/3/13; indicated upper metal partial is broken into three pieces (stored at nursing station) but has both partials in, which would suggest that she has two sets. Significant chipping and tooth wear natural and denture teeth. Routine dental referral, resident has	F 279		

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 _____	08/01/2013

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 279	Continued From page 10 non-urgent dental care needs, family request's Apple Tree Dental visit to assess and repair/replacement of upper partial. R32's care plan dated 6/16/13, identified problem, self-care deficit related to overall debility, requires assistance with activities of daily living (ADL's.) Goal, will maintain ability to participate in cares through staff encouragement and intervention. Approach, requires staff assistance with oral hygiene and brushing of teeth and partial dentures. Set up and assist her to complete this task as needed. During interview on 8/1/13, at 10:32 a.m., director of nursing verified R32 ' s care plan did not identify broken teeth. Director of nursing stated she would expect problem of broken teeth to be on care plan. Document review of facility CARE PLANNING PROCESS dated 7/13, revealed STANDARD, " A comprehensive care plan must be: c. Periodically reviewed and revised by a team of qualified persons after each assessment." INTERDISCIPLINARY CARE PLAN AND CONFERENCE PROCESS, " 7. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs [Care Area Assessment]. " PROCEDURE, " 5. The Care Plan will be: c. Updated following any changes in status or as resident condition/orders change or following hospitalization. All changes are made in ink and accompanied with date of change, and person making change."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	See Attachment 4	9-10-13

Attachment 4

Regulation 483.20(k)(3)(ii) Tag F282
Services by Qualified Personnel per Care Plan

Madonna Towers of Rochester assures that services are provided that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. Interventions to manage skin risk and safe resident transfers are routinely addressed in the plan of care.

The policy, *Safe Resident Handling and Movement,* was reviewed and found appropriate; the procedures for repositing residents were reviewed and updated. During the mandatory meeting August 22, 2013, the certified nursing assistants were reminded/instructed that the residents' plans of care must be followed and that job performance expectations include being aware of and following the plan of care. The importance of timely repositioning of residents with mobility impairments, appropriate use of mechanical transfer devices, and techniques for reducing the risk of injuries/falls was stressed. The above issues will again be addressed during the September 5, 2013 mandatory all-staff meeting.

Use of the Hoyer mechanical lift continues to be appropriate for transferring Resident Number 14. The care plan and nursing assistant care guide were reviewed and found to accurately reflect use of the Hoyer lift. The direct care staff have been counseled on the risks of not following the resident's care plan and that the care plan specifies use of the Hoyer lift for transfers.

A skin reassessment for Resident Number 14 was completed August 23, 2013. The resident does not have any open skin areas on the buttocks or coccyx. The care plan has been revised to reflect every two-hour repositioning. Pressure reduction devices are used in the bed and chair. The staff have been informed of the care plan revision. The resident's skin condition will continue to be monitored weekly by a licensed nurse; observation of the resident's skin condition is part of the bathing protocol.

To monitor compliance, the licensed nurses will conduct random observations to monitor timely resident repositioning and proper use of mechanical lift devices for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the quarterly Quality Council Committee meeting.

Completion date: September 10, 2013

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 _____	08/01/2013

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 282	Continued From page 11 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for appropriate use of a transfer device for 1 of 1 resident (R14) observed during an EZ stand device transfer and the facility failed to follow the care plan for positioning for 1 of 1 resident (R14) reviewed for stage III pressure ulcer. Findings include: R14 was not transferred from chair to bed according to the care plan and care guide. R14 was admitted on 1/11/08 with diagnoses that included but not limited to gait abnormality, osteoporosis and macular degeneration. R14's care plan dated 1/13/13 directed staff to transfer resident with the assistance of Hoyer lift and two staff members. Nursing assistant care guide dated 7/29/13, directed staff to use a HOYER for all transfers. During observation on 7/31/13, at 9:24 a.m. nursing assistant (NA)-C and NA-D was observed transferring R14 from wheelchair to bed. NA-C brought EZ stand (device used to transfer a person who is able to bear weight from bed to chair and chair to bed) into room and lined up with R14's wheelchair. R14's feet were placed on the EZ stand base and the strap applied around	F 282		

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 _____	08/01/2013

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 282	Continued From page 12 the legs. The sling was placed behind R14's back and buckled across chest of resident. Both NA-C and NA-D attempted to pry R14's fingers open to hold on to handles to assist with standing position. NA-C began to lift R14 from the sitting position to a standing position. R14's head was leaning against the left side of the EZ stand, upper extremities were hanging by the EZ stand strap and right leg was fully lifted and non-weight bearing. R14 had not physically participated in the transfer. During interview on 7/31/13, at 9:24 a.m. NA-C indicated staff was able to use either the EZ stand or the Hoyer lift. During interview on 7/31/13, at 1:06 p.m. NA-D identified transfers are written on the assignment sheet. NA-D indicated would use the Hoyer with R14 due to them not being able to hold on to the handles. NA-D indicated it was not safe to use the EZ stand for R14 and would use the Hoyer. During interview on 7/31/13, at 1:51 p.m. registered nurse (RN)-B indicated R14 was to be transferred with the Hoyer with assist of two staff. RN-B identified there had not been any assessment completed on any safe transfer device. RN-B indicated if the residents were not able to weight bear they would not use EZ stand. RN-B indicated the nursing assistant care guides were updated by the management staff on a daily basis and as needed. During interview on 7/31/13, at 3:13 p.m. the director of nursing (DON) said their expectation would be for staff to follow the resident care guide. The DON indicated if nursing assistants identified a problem they needed to address it	F 282		

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 _____	08/01/2013

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 282	Continued From page 13 with DON or clinical manager and change the care sheet. The DON also indicated they would get therapy involved if needed to assess the appropriate transfer device and make sure the staff followed the care guide as the parameter for cares. R14 was not provided repositioning every hour according to the assessed needs on 7/31/13, from 6:55 a.m. to 9:24 a.m. a total of 2 hours and 29 minutes. R14 had diagnoses that included but not limited to stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) and olecranon bursitis an inflammation of the olecranon at the back of the elbow. During review of the care guide sheet dated 7/29/13, identified R14 was assessed to be high risk for skin breakdown, directed staff to keep right elbow relieved of pressure at all times and to turn and reposition every one hour. During observation on 7/31/13, R14 was continuously observed sitting in wheelchair in the hall outside the dining room from 6:55 a.m. to 7:44 a.m., when nursing assistant wheeled R14 to the dining room without changing position. R14 remained in wheelchair in the dining room from 7:44 a.m. to 8:28 a.m. when R14 was wheeled to room and was not offered or changed position. At 9:24 a.m. resident was transferred from wheelchair to bed. During interview on 7/31/13, at 9:24 a.m. NA-C	F 282		

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 _____	08/01/2013

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 282	Continued From page 14 indicated R14 was to be repositioned before and after meals. During interview on 7/31/13, at 1:35 p.m. RN-B indicated R14 should be repositioned every hour according to the care guide sheets. The care guide sheets are the most accurate as they are updated on a daily basis and as needed. During interview on 7/31/13 at 3:13 p.m. DON indicated they would have expected the staff to follow the care guide for positioning. The DON indicated the clinical managers, DON or house charge update the care sheets daily. If the care guide should be interchangeable and if the care guide indicated every hour for repositioning they would expect staff to follow that care guide and assessed need if not able to complete the repositioning as scheduled would expect staff to call another staff member to help with positioning.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions to	F 314	See Attachment 5	9-10-13

Attachment 5

Regulation 483.25(c) Tag F314
Prevent/Heal Pressure Sores

Madonna Towers of Rochester has policies and procedures to ensure that residents who enter the facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure areas from developing.

Based on the comprehensive skin assessment, care plans are developed that address and minimize risks of skin breakdown. The resident's repositioning schedule is based on an analysis of the skin risk assessment, the results of the Bradens Scale for Predicting Pressure Ulcer Risk tool, and the tissue tolerance evaluation. The plans of care focus on services that maintain skin integrity and prevent pressure sores.

For residents who have open skin lesions, a licensed nurse evaluates the resident 's skin condition on a weekly basis. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol. If skin issues are noted, the resident's repositioning schedule is reassessed and the physician/nurse practitioner notified as appropriate.

During the mandatory meeting August 22, 2013, the certified nursing assistants were reminded/instructed that the residents' plans of care must be followed and that job performance expectations include being aware of and following the plan of care. The importance of timely repositioning of residents with mobility impairments was stressed. The above issues will again be addressed during the September 5, 2013 mandatory meeting for all nursing staff.

A skin reassessment for Resident Number 14 was completed August 23, 2013. The resident does not have any open skin areas on the buttocks or coccyx. The care plan has been revised to reflect repositioning at least every two-hours. Pressure reduction devices are used in the bed and chair. The staff have been informed of the care plan revision. The resident's skin condition will continue to be monitored weekly by a licensed nurse.

To monitor compliance, the licensed nurses will conduct random observations to assure timely resident repositioning for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.

Completion date: September 10, 2013

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 _____	08/01/2013

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 314	Continued From page 15 prevent or promote healing of pressure ulcers was provided for 1 of 1 resident (R14) reviewed for stage III pressure ulcer. Findings include: R14 was not provided reposition every hour according to their assessed needs. On 7/31/13, from 6:55 a.m. to 9:24 a.m. a total of 2 hours and 29 minutes R14 had not been repositioned. R14 had diagnoses that included but not limited to stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) and olecranon bursitis (inflammation of the olecranon at the back of the elbow). The quarterly Minimum Data Set (MDS), (resident assessment and care screening tool) dated 7/5/13, indicated R14 required extensive assistance with bed mobility, transfers and toileting needs. The MDS also revealed R14 had short and long term memory deficit and stage III pressure ulcer. The Braden skin risk assessment dated 7/20/13 indicated R14 was at moderate risk for skin breakdown and staff to assist with hourly turning and repositioning. R14 was to have right elbow floated with a pillow while in bed to relieve pressure on right elbow pressure ulcer, Geri sleeves apply to bilateral upper and lower extremities to promote skin integrity. During review of the care guide sheet dated 7/29/13, identified R14 was at high risk for skin breakdown, directed staff to keep right elbow relieved of pressure at all times and to turn and reposition everyone hour.	F 314		

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 _____	08/01/2013

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 314	Continued From page 16 During observation on 7/31/13, R14 was continuously observed sitting in wheelchair in the hall outside the dining room from 6:55 a.m. to 7:44 a.m., when nursing assistant wheeled R14 to the dining room without changing position. R14 remained in wheelchair in the dining room from 7:44 a.m. to 8:28 a.m. when R14 was wheeled to room and was not offered or changed position. At 9:24 a.m. resident was transferred from wheelchair to bed. During interview on 7/31/13, at 9:24 a.m. nursing assistant (NA)-C indicated R14 was to be repositioned before and after meals. During interview on 7/31/13, at 1:35 p.m. registered nurse (RN)-B indicated R14 should be repositioned every hour according to the care guide sheets. The care guide sheets are the most accurate as they are updated on a daily basis and as needed. During interview on 7/31/13 at 3:13 p.m. the director of nursing (DON) indicated their expectation would be to follow the care guide for positioning. The DON indicated the clinical managers, DON or house charge update the care sheets daily. If the care guide indicated every hour they would expect staff to follow that care guide and if they cannot for some reason they need to have another staff help.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	See Attachment 6	9-10-13

Attachment 6

483.25 (h) Tag F323
Accidents, Supervision, Devices

Madonna Towers of Rochester has policies and procedures to ensure that the residents' environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues with interventions to enhance mobility and promote safety.

The resident's use of and need for enabling/transfer devices are assessed at the time of admission and reassessed quarterly and whenever there is a change in the resident's behavior, physical condition, and/or cognition that impacts safety and functional status. The resident's care plan is modified as necessary to assure maximum function with minimal risk of injury.

During the mandatory training meeting August 22, 2013, the nursing assistants were instructed on 1) the importance of providing services that enhance resident function/safety 2) the need for interventions to reduce the risk of injury 3) the importance of following the plan of care for safe transfers and 4) job performance expectations that include being aware of and following the resident's plan of care. The above issues as well as the facility's policy, *Safe Resident Handling and Movement,* will be addressed during the September 5, 2013 mandatory all-staff meeting.

Use of the Hoyer mechanical lift continues to be appropriate for transferring Resident Number 14. The care plan and nursing assistant care guides were reviewed and found to accurately reflect the resident's care needs. The direct care staff have been counseled on the risks of not following the resident's care plan and that the care plan specifies use of the Hoyer lift for transfers.

The licensed nurses will conduct random observations to monitor proper use of mechanical transfer devices for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.

Completion date: September 10, 2013

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 _____	08/01/2013

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 323	Continued From page 17 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents had received the correct transfer device to provide a safe transfer depended on the residents ability to participate for 1 of 1 resident (R14) who had been transferred with the EZ stand lift device and the resident did not participate in the transferring process making this an unsafe device for this resident. Findings include: R14 was not transferred from the chair to the bed in an EZ stand lift vs. Hoyer lift which is used when residents do not assist with transfers. R14 was admitted on 1/11/08 with diagnoses that included but not limited to gait abnormality, osteoporosis and macular degeneration. R14's quarterly Minimum Data Set (resident assessment and care screening tool) dated 7/5/13, identified R14 was rarely-never understood, severely impaired decision making skills, required extensive assistance with transfers with two plus person physical assist and was identified as not steady during surface to surface transfers (between bed and chair.) Care area assessment (CAAs) summary dated 1/13/13, indicated R14 required extensive to dependence upon staff for all areas of activities of daily living. R14 transferred with assistance of	F 323		

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 _____	08/01/2013

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 323	Continued From page 18 HOYER lift. This area of care was not likely to change due to overall debility and progressive disease process. R14's care plan dated 1/13/13 directed staff to transfer resident with the assistance of Hoyer lift and two staff members. Nursing assistant care guide dated 7/29/13, directed staff to use a HOYER for all transfers. During review of physical therapy therapist progress and discharge summary dated 12/20/11, indicated EZ stand transfer assessed with resident on four different occasions. R14 was unable to stand completely upright in stand secondary to joint limitations and postural restrictions. R14 presented with increased lean towards left and kyphotic (Abnormal rearward curvature of the spine) posture limiting ability to use sling from stand lift correctly. Safety concerns and concerns for injury were noted during each attempt with use of EZ stand. Nursing staff were notified of above and verbalized agreement of concerns noted above. Hoyer lift performed with resident and nursing aide. Transfer completed safely, resident appeared well supported in lift, and resident offered no complaint of pain or discomfort during transfer with use of Hoyer lift. During observation on 7/31/13, at 9:24 a.m. nursing assistant (NA)-C and nursing assistant NA-D was observed transferring R14 from wheelchair to bed. NA-C brought EZ stand into room and lined up with R14's wheelchair. R14's feet were placed on the EZ stand base and the strap applied around the legs. The sling was placed behind R14's back and buckled across chest of resident. Then both NA-C and NA-D attempted to pry R14's fingers open to hold on to handles to assist with standing position but failed. NA-C began to fully lift R14 from sitting position to	F 323		

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 _____	08/01/2013

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 323	Continued From page 19 a standing position. R14's head was leaning against the left side of the EZ stand, upper extremities were hanging by the EZ stand strap and right leg was fully lifted as R14 made no attempt to assist with transfer. During interview on 7/31/13, at 9:24 a.m. NA-C indicated staff was able to use either the EZ stand or the Hoyer lift. During interview on 7/31/13, at 1:06 p.m. NA-D identified transfers are written on the assignment sheet. NA-D indicated would use the Hoyer with R14 due to not being able to hold on to the handles. NA-D indicated it had not been safe to use the EZ stand and would use the Hoyer instead. During interview on 7/31/13, at 1:51 p.m. registered nurse (RN)-B indicated R14 was to be transferred with the Hoyer and assist of two staff. RN-B identified there had not been any assessment completed on safe transfer device. RN-B indicated if residents were not able to weight bear would not use EZ stand. RN-B indicated the nursing assistant care guides were updated by the management staff on a daily basis and as needed. During interview on 7/31/13, at 3:13 p.m. with the director of nursing (DON) who said they expected staff to follow the resident care guide. The DON indicated if nursing assistants identified a change in resident needs/cares they need to inform the DON or clinical manager and change the care sheet. The DON also indicated they would get therapy involved if needed to assess the appropriate transfer and make sure the staff followed the care guide as the parameter for	F 323		

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 _____	08/01/2013

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 323	Continued From page 20 cares.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to attempt a gradual dose reduction for 1 of 1 resident (R64) who utilized psychoactive medications, and the facility failed to monitor potassium blood levels while taking Lasix which has an averse consequence of lowereing	F 329	See Attachment 7	9-10-13

Attachment 7

483.25(l) Tag F329
Unnecessary Drugs

Madonna Towers of Rochester staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible.

During the consultant pharmacist's monthly medication audits and the quarterly care planning process, the resident's medications will continue to be reviewed to assure that the resident is receiving the lowest effective medication dose and that appropriate laboratory tests have been done. The procedures for communicating the consulting pharmacist's recommendations to the physician in a timely manner were reviewed and revised. Since the Olmsted Medical Center practitioners do not have an office at the facility, the *Note To Attending Physician/ Prescriber* form outlining the pharmacist's findings will be faxed to the Olmsted Medical Center attending physicians/nurse practitioners. During the September 5, 2013 mandatory meeting, the nursing leadership team will be instructed on the procedural changes.

Resident number 64 - The pharmacist's recommendation for consideration of a Celexa dose reduction was filed in the designated folder for review by the Olmsted Medical Center physician/nurse practitioner. The May 30, 2013 recommendation for a dose reduction was not reviewed by the physician until August 1, 2013. The physician subsequently ordered a reduction in the daily Celexa dose from 20 to 10 milligrams.

Resident number 15 – The order for a laboratory test to check potassium level may have been part of the clinic record, but could not be found in the facility's medical record. The nurse practitioner that works with the resident's attending physician was informed of the Minnesota Department of Health expectation for a laboratory test to check the potassium levels when a resident is receiving Lasix. The nurse practitioner indicated that the test was unnecessary and declined the nurse's request for a potassium check. The consulting pharmacist reviewed the medical record and was also of the opinion that the test was not indicated. To avoid further negative impact from the Minnesota Department of Health investigators, the facility staff contacted another practitioner who reviewed the clinic records and agreed to order a potassium check.

The normal potassium range is 3.6-5.2 mmol/L. The resident's potassium level has been stable and within normal limits as follows: 4.1 on August 1, 2013; 4.6 on October 7, 2011; 4.4 on June 23, 2011.

The Consultant Pharmacist will continue to monitor the timeliness of the physician's response to his recommendations during his monthly consultation visits. The clinical manager will monitor that the Olmsted Medical Center practitioners are informed of the consultant pharmacist's recommendation in a timely manner on an ongoing basis. Compliance will be reviewed during the October quarterly Quality Council meeting.

Completion Date: September 10, 2013

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 _____	08/01/2013

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 329	Continued From page 21 potassium in the blood for 1 of 1 resident (R15) newly admitted to the facility and had been reviewed for unnecessary medications. Findings include: R64 had been on Celexa an antidepressant for more than one year and a tapering of the medication or a physician ' s justification as to why a tapering of the medication was contraindicated at this time. R64 had diagnoses that included depression and dementia. Review of the medical record revealed R64 had been receiving Celexa 20 milligrams (mg) daily since 6/28/12. Further review of the record confirmed no tapering had been attempted nor had the physician documented a justification to continue at the current dose. Review of pharmacy recommendations from 5/30/13 to 7/30/13, indicated the pharmacist had recommended a dose reduction for the use of the Celexa. However, there was no documented response from the physician regarding the recommendations. Review of the facility's PSYCHOTROPIC MEDICATION policy, revised 8/13, included residents who are receiving psychotropic medications receive gradual dose reductions unless clinically contraindicated. During interview with the director of nursing (DON) on 8/1/13, at 7:32 a.m., it was learned that the physician had not been notified of the pharmacy recommendations from 5/30/2013. R15 received daily Lasix medication. The physician requested a potassium blood level as Lasix depletes the potassium in the blood stream,	F 329		

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 _____	08/01/2013

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 329	Continued From page 22 however,the blood level had not been done in June 2013 but after it was brought to the facilities attention by this surveyor. R15 had diagnoses that included congestive heart failure, chronic kidney disease. Review of physician orders dated 7/29/2013, revealed R15 was receiving Lasix (furosemide) 80 milligrams, two tablets once every morning and one tablet at noon, which was originally ordered on 6/8/13 for congestive heart failure. Review of physician progress note dated 8/1/13; revealed R15 was to have potassium checked in June 2013. There was an oversight and this blood work was never obtained. During interview on 8/1/13, at 1:14 p.m., the director of nursing verified blood work to check potassium level had not been done in June 2013 and had been drawn today.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	See Attachment 8	9-10-13

Attachment 8

Regulation 483.35(l) Tag F371
Sanitary Conditions

Madonna Towers of Rochester stores, prepares, distributes, and serves food under sanitary conditions.

The policies and procedures related to sanitary food storage and meal service were reviewed. A minor modification was made to the procedures for storing/serving cold food. The cart storing clean dishes has been moved away from the hand wash sink to the clean dish area in the main dining room kitchenette. Sandwiches in the food service area will be placed on an ice bath to maintain safe serving temperature.

The culinary service staff will be educated on food service techniques to minimize the risk of infection on August 28, 2013. Applicable policies/procedures will be reviewed and the instruction will specifically address 1) labeling containers with the date it was opened 2) storage of clean utensils/food service items in a manner to prevent contamination including the new location for parking the storage cart for clean dishes 3) glove use when handling food items and 4) techniques to assure sandwiches in the food service area are kept at a safe temperature. New employees are provided with infection control/safe food handling training and infection control practices/procedures are included as part of the required annual inservice training.

Compliance will be monitored by the Director of Culinary Services/designee through random daily observations for two weeks of proper dating of open food storage containers, sanitary storage of dishes, appropriate glove use, and techniques for maintaining proper serving temperature of cold foods. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.

Completion Date: September 10, 2013

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 _____	08/01/2013

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 371	Continued From page 23 Based on observation, interview and document review, the facility failed to date foods that can cause food borne illness when opened; failed to store clean dishes in a manner to prevent contamination, failed to serve foods using sanitary practices; failed to maintain safe cold food temperature before serving residents. This had the potential to affect 62 of 62 residents residing in the facility. Findings Include: FOOD THAT COULD CAUSE FOOD BORNE ILLNESS THAT WAS NOT DATED WHEN OPENED: During tour of the main dining room kitchenette on 8/1/13, at 10:59 a.m., one milk shake stored in the refrigerator had been opened and not dated. During interview on 8/1/13, at 2:00 p.m., culinary services supervisor -F said one milk shake container had been opened and not dated but should have had the date put on it when opened. Document review of facility STORAGE OF LEFTOVERS dated 08/2013, revealed PROCEDURE, " 8. Bulk products (cookies, crackers, pasta) will be removed from unsealed cardboard boxes and will be stored in original bag, food grade vinyl bags, or in NSF approved containers that is sealed with date of opening indicated." SANITARY STORAGE OF DISHES: During entrance of the main dining room kitchenette on 7/29/13, at 11:35 a.m., a cart with clean dishes on the top and second shelf had been observed located next to the hand washing sink and when staff washed hands the water could splash on the dishes. This was also observed on 8/1/13, at 10:58 a.m. During interview on 8/1/13, at 2:00 p.m., culinary services supervisor -F verified the clean dishes	F 371		

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 _____	08/01/2013

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 371	Continued From page 24 sitting on the cart next to the hand washing sink in the main dining room kitchenette had the potential to be contaminated when hands were washed. Document review of facility Dishwashing Procedures dated 08/2013, revealed PROCEDURE, " u) Clean and sanitized portable equipment and utensils are to be stored above the floor in a clean, dry location so that food contact surfaces are protected from splash, dust and other contaminants. " The facility had not maintained sanitary conditions when serving food. During meal service observation with culinary services supervisor -F in the main dining room kitchenette on 8/1/13, at 10:59 a.m., culinary services aide-A was observed picking up sandwiches with the same soiled pair of gloves they wore when handling the food cart and handles of a drawer. During interview on 8/1/13, at 2:00 p.m., culinary services supervisor -F verified culinary services aide-A had picked up sandwiches while wearing the same gloves that were soiled after handling the food cart and handles of a drawer. Culinary services supervisor-F stated she expected the staff person to use tongs to handle sandwiches when serving them to residents. Document review of facility Standard Precautions dated 08/2013, revealed PROCEDURE PROTECTIVE BARRIERS, " A. Gloves must be worn: 6. hen serving food without a utensil E. Change gloves between residents and as necessary (i.e., torn or contaminated). Do not use contaminated gloves on clean areas. Always work clean to dirty." COLD FOOD ITEMS WERE NOT KEPT AT 40 DEGREES OR LESS BEFORE SERVING TO	F 371		

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 _____	08/01/2013

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 371	Continued From page 25 THE RESIDENTS TO PREVENT FOOD BOURNE ILLNESS: During food temperature checks of the main dining room kitchenette on 8/1/13, at 10:59 a.m., observation revealed temperature of cold chicken salad sandwiches 48 degrees, temperature of cold cheese sandwiches 50 degrees, verified at the time by culinary service aide-A. Sandwiches were sitting in metal trays with no ice underneath to maintain temperature. Culinary services aide-A started to serve sandwiches. Food service stopped when surveyor intervened. During interview on 8/1/13, at 11:51a.m., culinary services aide-A stated temperatures of cold foods should be 40 degrees or below to serve. Culinary services aide stated when temperatures of food are not appropriate kitchen should be notified to bring more food. During interview on 8/1/13, at 2:00 p.m., culinary services supervisor-F verified the sandwiches had not come on ice from the main kitchen. Culinary services supervisor-A stated she expected staff to notify her right away if food temperatures are not right when checking food temperatures, before serving the food. Document review of facility Sanitary Food Handling Guidelines dated 08/ 2013, read STANDARDS, " 16. Cold food prepared for the serving line or salad bars must be at 40 degrees Fahrenheit (four degrees centigrade) or below." Document review of facility FOOD STORAGE - MAINTAING PROPER FOOD TEMPERATURE DURING FOOD SERVICE dated 08/2013, revealed PROCEDURE, " 2. The temperature of potentially hazardous cold foods will be no greater than 40°F during tray assembly. Pre-preperation of cold items a day in advance, placing items in freezer 45 minutes prior to service, and the use of ice baths are suggested."	F 371		

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 _____	08/01/2013

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 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired insulin was unavailable for use for one of two residents (R9) observed during medication storage review. Findings include: R9 had an outdated insulin vial available for use and should have been removed to prevent use. The 100 medication cart was observed on 7/29/13, at 7:13 p.m. with registered nurse (RN) -E. During the observation an open vial of Novolin Humulin insulin (medication used for diabetes)	F 425	See Attachment 9	9-10-13

Attachment 9

Regulation 483.60(a)(b) Tag F425
Pharmacy Services

Madonna Towers of Rochester provides pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services within the facility and to guide development and implementation of pharmaceutical services and procedures. The facility utilizes only persons authorized under state requirements to administer medications.

All medication storage areas were checked for outdated/expired pharmaceuticals. No irregularities were found. The expired medication for resident number 9 was immediately discarded.

During the mandatory meeting September 5, 2013, the nurses and trained medication aides will be reinstructed on the need to check expiration dates of medications prior to administration and to discard insulin twenty-eight days after the first penetration date.

To monitor compliance, the Clinical Manager/designee will check the medication storage areas for expired medication weekly for four weeks. The consultant pharmacist will continue conduct ongoing audits for outdated/expired medications. Compliance will be reviewed at the October quarterly Quality Council meeting.

Completion Date: September 10, 2013

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 _____	08/01/2013

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 425	Continued From page 27 with an order to give 24 units subcutaneous in a.m. The vial had a hand written date of 6/25/13. According to manufacturer Novolin insulin expired 28 days after having been opened which indicated expired date of 7/23/13. The physician order indicated R9 received Novolin 24 units subcutaneous once in morning. Review of medication administration record for July 2013, identified R9 had received the outdated insulin injection four times since 7/23/13. During interview on 7/29/13 at 7:13 p.m., RN-E verified there was no other insulin bottle available for R9. As the outdated bottle was currently being used. During interview on 7/29/13 at 7:15 p.m., the director of nursing (DON) verified the date open on R9's insulin vial was 6/25 and confirmed good for 28 days once opened. The DON Indicated nursing staff was responsible for checking for expired medication. During interview on 7/30/13 at 9:03 a.m., the facility Pharmacy consultant indicated nursing staff were responsible for identifying expired medications. During interview on 7/31/13 at 10:49 a.m., the administrator indicated the facility followed Weber and Judd pharmacy policy on expired medications and if no specific policy would follow manufacturer's recommendations. During review of an undated policy titled expiration dates of medications it directed staff that once injectable were opened, expiration was based on manufacturer recommendations or facility policy.	F 425		

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 _____	08/01/2013

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 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure that drug regimen irregularities reported by the pharmacist had been reported to the director of nursing or attending physician for 1 of 1 resident (R64) who had a pharmacist recommendation to attempt a gradual dose reduction and the facility failed to ensure the facility pharmacist consultant monitored physician recommended blood labs for 1 of 1 resident (R15) who received Lasix to treat congestive heart failure. This was noted during the unnecessary medications review. Findings include: R64 had not had the physician and director of nursing respond to the consulting pharmacists recommendations for a gradual dose reduction (GDR) for R64 for the use of the antidepressant medication Celexa. R64 had diagnoses that included depression, and dementia. Review of R64's medical record identified a physician's order for Celexa 20 milligrams (mg) by mouth daily (QD) with a start	F 428	See Attachment 10	9-10-13

Attachment 10

Regulation 483.60(c) Tag F428
Drug Regimen Review

The goal of Madonna Towers of Rochester is to prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least monthly by a licensed pharmacist. The pharmacist routinely reports irregularities to the attending physician, and the director of nursing, and these reports are routinely acted upon.

The Director of Nursing and Consultant Pharmacist reviewed the surveyor concerns regarding the dose reduction for Celexa and the routine checking of potassium levels; procedures for communicating and acting on the Consultant Pharmacist's recommendations were reviewed. Since the Olmsted Medical Center (OMC) staff do not have designated office space at the facility, the Consultant Pharmacist's recommendations may not be reviewed in a timely manner by the OMC physicians/nurse practitioner. To facilitate timely review, the *Note To Attending Physician/ Prescriber* form which outlines the pharmacist's findings will be faxed to the OMC practitioners. During the September 5, 2013 mandatory meeting, the nursing leadership team will be instructed on the procedural changes.

Resident number 64 - The pharmacist's recommendation for consideration of a Celexa dose reduction was filed in the designated folder for review by the Olmsted County Medical Center physician/nurse practitioner. The May 30, 2013 recommendation for a dose reduction was not reviewed by the physician until August 1, 2013. The physician subsequently ordered a reduction in the daily Celexa dose from 20 to 10 milligrams.

Resident number 15 – The order for a laboratory test to check potassium level may have been part of the clinic record, but could not be found in the facility's medical record. The nurse practitioner that works with the resident's attending physician was informed of the State Department of Health expectation for a laboratory test to check the potassium levels when a resident is receiving Lasix. The nurse practitioner indicated that the test was unnecessary and declined the nurse's request for a potassium check. The consulting pharmacist reviewed the medical record and was also of the opinion that the test was not indicated. To avoid further negative impact from the Minnesota Department of Health investigators, the facility staff contacted another practitioner who reviewed the clinic records and agreed to order a potassium check.

The normal potassium range is 3.6-5.2 mmol/L. The resident's potassium level has been stable and within normal limits as follows: 4.1 on August 1, 2013; 4.6 on October 7, 2011; 4.4 on June 23, 2011.

The Consultant Pharmacist will continue to monitor the timeliness of the physician's response to his recommendations during his monthly consultation visits. The clinical manager will monitor that the Olmsted Medical Center practitioners are informed of the consultant pharmacist's recommendation in a timely manner on an ongoing basis. Compliance will be reviewed during the October Quality Council meeting.

Completion Date: September 10, 2013

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 _____	08/01/2013

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 428	Continued From page 29 date of 6/28/12. A review of the consulting pharmacist's recommendations dated 5/30/13 for R64 read "This resident [R64] has a history of depression for which she currently receives treatment with Celexa 20mg QD. Consideration for a gradual dose reduction (GDR) attempt was last addressed 6/28/12 at which time she was successfully reduced from 30mg/day dosing. Based on federal skilled-care regulations she now requires another assessment for a possible gradual dose reduction (GDR) attempt at this time. To ensure regulatory compliance please address her annual required assessment for possible GDR to, eg. Celexa 10mg QD, to see if she could be maintained on a lower dosage. As a dose reduction attempt is not mandated, if you feel a reduction would not be appropriate at this time, please document as to why you feel an attempt would likely "impair the residents function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder" (i.e. justify why a GDR would be clinically contraindicated or, in other words, if she is doing well/stable on the current regime then justify why you would not attempt a GDR to see if she could maintain stability on a reduced dose.)" Further review of the consulting pharmacist's recommendations from 6/24/13, and 7/30/13 indicated the consulting pharmacist identified follow-up had been pending for the GDR of the Celexa. Review of R64's record indicated there was no documented response from the physician regarding the recommendations. During interview with the director of nursing	F 428		

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 _____	08/01/2013

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 428	Continued From page 30 (DON) on 8/1/13, at 7:32 a.m., it was revealed the physician had not been notified of the pharmacy recommendations because it had been miss filed. The DON verified neither she nor the physician had been aware of the recommendations. Review of the facility's policy, CONSULTANT PHARMACIST REPORTS DOCUMENTATION AND COMMUNICATION OF CONSULTANT PHARMACIST RECOMMENDATIONS undated, included comments and recommendations concerning medication therapy are communicated in a timely fashion. Recommendations are acted upon and documented by the facility staff. R15 lacked a pharmacist irregularity finding to the director of nursing and physician in regards to the lack of having a potassium blood level being done in June 2013. This should have been found during the July 2013 monthly pharmacist review. R15 had diagnoses that included congestive heart failure, chronic kidney disease. Review of physician orders dated 7/29/2013, revealed R15 was receiving Lasix (furosemide) 80 milligrams, two tablets once every morning and one tablet at noon, which was originally ordered on 6/8/13 for congestive heart failure. Review of consultant pharmacist medication regimen review dated 6/24/13 and 7/30/13, revealed no recommendation for potassium level to be checked. Review of physician progress note dated 8/1/13; revealed R15 was to have potassium checked in June. There was an oversight and this blood work was never obtained. Blood work ordered and to	F 428		

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 _____	08/01/2013

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 428	Continued From page 31 be drawn at this time. During interview on 8/1/13, at 2:37 p.m., the facility pharmacist verified had not recommended to check potassium level. During interview on 8/1/13, at 1:14 p.m., the director of nursing verified blood work to check potassium level had not been done in June 2013 and had been drawn today. Document review of facility CONSULTANT PHARMACIST REPORTS IIIA2: DOCUMENTATION AND COMMUNICATION OF CONSULTANT PHARMACIST RECOMMENDATIONS undated, revealed "Policy The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents ' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. Procedures 3) The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review."	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	See Attachment 11	9-10-13

Attachment 11

Regulation 483.65 Tag F441
Infection Control

Madonna Towers of Rochester has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has policies and procedures reflecting an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control.

During the mandatory meeting August 22, 2013, the certified nursing assistants were instructed not to place personal care items such as wash basins on the floor without a barrier between the utensil and the floor.

During the September 5, 2013 mandatory meeting, all staff will be instructed to observe for sanitary storage of personal care equipment. The licensed nurses will be instructed on the infection control policies and standards of practice for skin treatments. Infection control techniques are addressed during the new employee orientation and are included in the annual mandatory staff training.

Resident number 14 – The nurse who allowed the elbow wound to come in contact with the cushioned bolster on the wheel chair arm rest has been counseled. She was required to observe a dressing change using correct technique and successfully performed a return demonstration. The infection control procedures related to the resident's dressing change will be reviewed with the licensed staff during the September 5, 2013 meeting.

The Director of Housekeeping/designee will monitor compliance with sanitary storage of personal care items through random observations of patient care areas weekly for one month. If noncompliance is noted, additional observations and staff training will be done. Compliance with infection control policies/techniques will be reviewed during the October quarterly Quality Council meeting and ongoing.

Completion Date: September 10, 2013

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 _____	08/01/2013

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 441	Continued From page 32 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow infection control techniques during wound care to promote healing for 1 of 1 resident (R14) reviewed for pressure ulcers, and the facility failed to store resident personal care equipment in a sanitary manner to prevent possible cross contamination for 6 of 35	F 441		

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 _____	08/01/2013

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 441	Continued From page 33 residents (R15, R32, R35, R56, R64 and R162) who had their personal care items stored directly on the bathroom floor. Findings include: R14 had a dressing change done by a licensed person and during the procedure the licensed staff put the cleaned open wound directly on the soiled arm bolster located on the wheel chair. The bolster was not changed or sanitized nor was the open wound treatment done again. R14 was admitted to the facility 1/11/08, and had diagnoses that included but not limited to stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) and olecranon bursitis (inflammation of the olecranon at the back of the elbow) on right elbow and olecranon bursitis. R14 had a physician order that directed staff to cleanse area with wound cleanser, skin prep to peri-wound area, collagen to be folded and applied over wound bed, then covered with small foam border, secured with roll gauze and to change daily. During observation on 7/30/13, at 4:35 p.m. licensed practical nurse (LPN)-B set up supplies in R14's room and set the supplies on R14's personal table. LPN-B washed hands, applied gloves. LPN-B picked up supplies off the table and placed a paper towel under the supplies and proceeded to set the supplies back on the table. R14 ' s sweater and Geri sleeve removed from right arm and towel was placed under the right arm as barrier from cushioned bolster on wheelchair arm rest. LPN-B removed soiled gloves and put on new gloves. LPN-B then	F 441		

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 _____	08/01/2013

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 441	Continued From page 34 removed the old dressing which had visible brown colored drainage. The barrier towel had fallen off the arm rest of the wheelchair and LPN-B continued to cleanse the wound and around the wound area. LPN-B then placed the arm with the open wound that had been cleaned set directly on the soiled arm bolster while getting supplies ready to complete the wound care. LPN-B picked up the arm then applied the new collagen ointment and a foam dressing and wrapped with roll gauze. During interview on 7/30/13, at 4:45 p.m. LPN-B verified the wound had touched the pillow bolster on the right arm rest of wheelchair and had not cleansed the wound after the potential contamination of the wound. LPN-B confirmed should have cleaned the wound area again. During interview on 7/31/13 at 3:13 p.m. DON indicated my expectation would be for clean technique and a barrier between the wound and potential contaminated area and if the wound became contaminated during the treatment she would expect the nurse to redo the wound treatment. During facility tour on 7/29/13 at 6:45 p.m., and again on 8/1/13 at 8:06 a.m., the following was observed: R15's bathroom had been observed to have their wash basin stored on the floor without a barrier between the floor and the basin. R32's bathroom had been observed to have their wash basin, incontinent wipes, and incontinent products stored on the floor without a barrier between the floor and the items listed. R35's bathroom had been observed to have their wash basin stored on the floor without a barrier between the floor and the basin.	F 441		

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 _____	08/01/2013

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 441	Continued From page 35 R56's bathroom had been observed to have their wash basin stored on the floor without a barrier between the floor and the basin. R64's bathroom had been observed to have their wash basin stored on the floor without a barrier between the floor and the basin. R162's bathroom had been observed to have their wash basin stored on the floor without a barrier between the floor and the basin. During the environmental tour on 8/1/13, at 8:06 a.m. with the administrator, plant operations director, and housekeeping director the above findings were verified. During the tour the administrator stated, "Storing basins on the floor or anything like that on the floor is not acceptable." The administrator reported wash basins were to be stored in the resident ' s bedside table drawers. During interview on 8/1/13, at 10:34 a.m. Quality Assurance and infection control registered nurse (RN)-E verified the storing reusable resident equipment on a floor was not an acceptable practice. RN-E stated, "That's and infection control concern." RN-E indicated the facility did not have a policy for storage of resident personal equipment related to infection control practice.	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	See Attachment 12	9-10-13

Attachment 12

Regulation 483.70(h) Tag F465
Safe, Sanitary, Comfortable Environment

It is the policy of Madonna Towers of Rochester to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

As part of an ongoing process to provide a pleasant, home-like environment, Madonna Towers has a schedule for routine cleaning, repairs, and maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/ supervisory staff.

An additional maintenance check list has been implemented for inspection of resident rooms at the time of discharge and at least yearly for all long term residents. The condition of the walls, ceilings, bathroom fixtures, and resident care equipment will be checked. A checklist has also be developed to facilitate at least quarterly inspections of the common areas of the facility. Damaged equipment and furnishings will be repaired/replaced as needed.

During the September 5, 2013 mandatory meeting, all staff will be reminded to observe for equipment/furnishings/structures that need to be repaired, cleaned, or replaced. The procedures for reporting work items to the Director of Maintenance by phone and email will be reviewed.

Compliance will be monitored by the administrator through direct observation and review of the maintenance checklists.

Completion date: September 10, 2013

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 _____	08/01/2013

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 465	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for maintenance repair had been followed for ceiling tile stain in 5 of 35 resident rooms (107, 108, 113, 116, and 200) observed during facility environmental tour. Finds include: On 8/1/13, at 8:06 a.m. an environmental tour of the facility was conducted with the administrator, plant operations director and housekeeping director. During the tour the following observations were noted: Resident rooms 107, 108, 113, and 116 had stained ceiling tiles located by the bathroom doorways. Resident room 200 had a stained ceiling tile located along a wall. The administrator, plant operations director and housekeeping director observed the findings with the surveyor. During the observations the plant operations director stated he was unaware of the ceiling tile stains and reported the staff should have reported the stains so they could have been replaced. Procedure for reporting work repairs dated 1/5/13 was reviewed and revealed staff had been directed to report any equipment or repairs observed to be defective to maintenance.	F 465		

STATEMENT OF COMPLIANCE

Madonna Towers of Rochester has been providing nursing services to the community for past 44 years. Its policies and procedures have been developed in accordance with the law and the community standard of practice.

Madonna Towers of Rochester objects to and disagrees with both the findings of noncompliance and the level of deficiencies cited. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this State of Deficiency was correctly cited, and is also not to be construed as an admission against interest against Facility, its Administrator or any employees, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by this Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.

Accordingly, we are submitting the Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegation of noncompliance or admissions by Facility.

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 _____	**07/31/2013**

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	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Madonna Towers of Rochester was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility will be surveyed as two separate buildings. 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. The building is fully sprinklered. The facility has a fire alarm system with 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	K 000		

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

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 **01 - MAIN BUILDING 01** B. WING _____	**07/31/2013**

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 census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	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 **02 - 2008 ADDITION** B. WING _____	**07/31/2013**

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	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Madonna Towers of Rochester Inc. was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. This facility will be surveyed as two separate buildings. Madonna Towers of Rochester Inc. new additions were constructed at 2 different times. A 1-story addition was constructed in 2008 and was determined to be of Type V (111) construction. In 2011, a 1-story addition was constructed and was determined to be of Type V (111) construction. Because the 2 additions are of the same type of construction and meet the construction type allowed for new buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with 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 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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 **02 - 2008 ADDITION** B. WING _____	**07/31/2013**

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 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		