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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EEGV

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 **6/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **62** (L18)

13.Total Certified Beds **62** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 06/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/15/2016 (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 **06/01/2016** (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245153

June 14, 2016

Ms. Elizabeth Redalen, Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 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 June 3, 2016 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

An equal opportunity employer

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2016

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

RE: Project Number S5153025

Dear Ms. Redalen:

On May 11, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 28, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 3, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 3, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 28, 2016, effective June 3, 2016 and therefore remedies outlined in our letter to you dated May 11, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245153		6/11/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0332 Reg. # 483.25(m)(1) LSC	Correction Completed 06/03/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 06/03/2016	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	6/14/2016	10160	6/11/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**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
4/28/2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245153 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/3/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	05/13/2016	LSC K0048	06/03/2016	LSC K0050	05/13/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0144	05/13/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	6/14/2016	37008	6/3/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/28/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245153 Y1	A. Building 02 - 2008 ADDITION B. Wing Y2	6/3/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 06/03/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 05/13/2016	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 (INITIALS) TL/kfd	DATE 6/14/2016	SIGNATURE OF SURVEYOR 37008	DATE 6/3/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/28/2016	☐ 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: EEGV

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 **04/28/2016** (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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NE II 05/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/01/2016 (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
06/01/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 11, 2016

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

RE: Project Number S5153025

Dear Ms. Redalen:

On April 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 7, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 7, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	04/28/2016

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication was administered without errors for 3 of 7 residents (R51, R43, R70) observed for medication administration. Findings include: R51's Physician Order Report included scheduled potassium chloride tablet extended release 20 miliequivalents twice daily (given for low potassium) and Occuvite two tablets twice daily (supplement). Administration Record (MAR) included the administration notes "Medication	F 332	Madonna Towers of Rochester has policies and procedures requiring that the preparation and administration of drugs and biologicals are in accordance with 1) physicians' orders 2) manufacturers' specifications and 3) accepted professional standards and principles. The goal is to have a medication error rate of less than 5% and be free of all significant medication errors. The medication administration policies and procedures were reviewed and found appropriate. The RN Staff Development	6/3/16

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

Electronically Signed | 05/19/2016

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

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F 332	Continued From page 1 crushed in pudding." The MAR also included special instructions for the potassium chloride. "...Melt tablet in 10-15 mL [milliliters] of water to make slurry. DO NOT CRUSH." On 4/26/16 at 4:51 p.m. trained medication aid (TMA)-A was observed preparing R51's afternoon dose of potassium chloride and occuvite tablets. TMA-A crushed one tablet of Occuvite and one tablet of potassium chloride extended release 20 miliequivalents and mixed together in the medication cup with pudding. TMA-A walked to R51 and just as TMA-A was administering the medication to R51 the surveyor stopped TMA-A. The surveyor informed TMA-A of the special instructions not to crush the potassium. TMA-A then reviewed the MAR and prepared a second tablet of Occuvite; crushing and mixing in with the 1st Occuvite tablet and potassium. TMA-A then walked to R51's room to administer the medication. Just as TMA-A was administering the medication the surveyor once again stopped TMA-A and asked if the crushed potassium remained in the cup. TMA-A verified the crushed potassium remained in the cup. TMA acknowledged medication was not to be crushed. R51's Medication and Treatment Incident Report dated 4/26/16 8:00 p.m. included the same information as observed by surveyor. R43's Physician Order Report included scheduled brimonidine drops 0.2% (treatment for ocular hypertension) one drop in the right eye two times a day and dorzolamide drops 2% (to treat high pressure inside the eye) one drop in both eyes two times a day; both medications are used for the treatment of glaucoma.	F 332	Director provided education and oversight to the licensed practical nurse and trained medication assistant (TMA) addressing standards regarding accurate administration of medications. Medication administration techniques were observed and competency was evaluated. Both staff members demonstrated good techniques and best practices while being observed administering medications. They were able to articulate understanding of the principles of accurate medication administration. During the May 19, 2016 mandatory nursing/TMA meeting, the facility's policies and procedures addressing administering medication were reviewed. Instruction included following the "five rights" (right resident, medication, dose, route and time) of medication administration. The nurses and TMAs were reminded of the need to check for specific instructions for drug administration. The nurses and trained medication aides signed to verify receipt/review of the educational material. A registered nurse under contract with our consulting pharmacy has been/will be observing medication passes to determine whether facility policies and best practices are being followed during the medication administration process. All staff who regularly administer medications will be observed for competencies including appropriately crushing/dissolving medications and administering eye drops and insulin. Findings have been/will be reported to the nursing administrative	

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F 332	Continued From page 2 On 4/26/16 at 6:13 p.m. trained medication assistant (TMA)-A instilled one drop of dorzolamide 2% in each of R43's eyes. Five minutes later at 6:18 p.m. TMA-A returned to R43 and was stopped by the surveyor just prior to instilling additional drops of dorzolamide 2%. TMA-A returned to the medication cart and reviewed R43's medication administration record (MAR). At 6:43 p.m. TMA-A instilled brimonidine 0.2% one drop in both eyes. At 6:48 p.m. TMA-A stated, "It is suppose to be in the right eye and I gave it in both eyes. Yes, that is a med error. I will notify the nurse and fill out the sheet for the process." R43's Medication and Treatment Incident Report dated 4/26/16 8:12 p.m. included the same information as observed by surveyor. R70's Physician Order Report included scheduled Novolog Flexpen (insulin used to treat diabetes) administer 20 units three times a day before meals. On 4/27/16 at 11:02 a.m. licensed practical nurse (LPN)-A prepared R70's noon dose of Novolog insulin using the Flexpen. LPN-A opened the pen by removing the cap, applied the needle, and turned the Flexpen to 20 units. LPN-A injected the pen into R70's abdomen. LPN-A was asked if she primed the Flexpen or gave it an "air-shot" to remove any air from the chamber. LPN-A stated, "I guess I don't know what that is. I've never been taught that, I've never done that." Facility policy, Insulin Pen Use dated 11/2015, includes manufacturer instructions: "3. Giving the airshot before each injection. a. Before each injection small of amounts of air may collect in the	F 332	staff. The RN Staff Development Director will also monitor for compliance by conducting weekly random observations of medication passes for four weeks. Observations will include medication administration for residents number 43, 51, and 70. If an unacceptable medication error rate is noted, additional auditing and staff training will be done. Medication errors will continue to be tracked and evaluated for need for corrective action. Compliance will be reviewed, as customary, at the July quarterly Quality Council meeting and ongoing.	

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F 332	Continued From page 3 cartridge during normal use. To avoid injecting air and to ensure proper dosing: i. Turn the dose selector to select 2 units. ii. Hold your FlexPen with the needle pointing up. iii. Tap the cartridge gently with your finger a few time to make any air bubbles collect at the top of the cartridge. iv. Keep the needle pointing upwards, press the push-button all the way in. v. The dose selector returns to 0. vi. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. vii. If you do not see a drop of insulin after 6 times, do not use the Flexpen..." On 4/26/16 at 7:11 p.m. the director of nursing stated, "They [staff are expected to] read the instructions on the MAR and the container and follow the five rights of med administration." On 4/27/16 at 12:53 p.m. the DON added, "[LPN-A] was trained 11/3/15. She completed the training. They should follow the policy, they also have sheets out there on how to do it." Facility policy, Medication Administration by Licensed and Non-Licensed Personnel last revised 7/15 read, "...Medications are administered by a TMA or Licensed Nurse in accordance with the written orders of the attending physician or nurse practitioner...Prepare each dose of medication using appropriate measuring device....2. Read and follow any special instructions written on labels. 3. Crush medications only after checking with pharmacy and/or charge nurse since the medications may be time-release capsules or enteric-coated medications.	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		6/3/16

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F 441	Continued From page 4 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 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.	F 441		

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F 441	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent the spread of infection during open wound cares for 2 of 2 residents (R40 & R14) who had dressing changes to open wounds. Findings included: R40's right great toe wound dressing change observation on 04/27/16, at 10:05 a.m. with registered nurse (RN)-A completing the wound care as follows: RN-A washed hands donned gloves, measured normal saline in a small medication cup, put gauze in the saline, sterilized scissors, mixed the Iodasorb and Curasol in another medication cup, washed hands and donned gloves. RN-A removed the dressing and assistant director of nursing (ADON) measured the wound. RN-A donned a new pair of gloves without washing her hands, and washed off the wound with moistened saline gauze, removed and threw away gloves, donned new gloves without washing her hands, applied the skin prep to peri-wound area and applied the Iodasorb and Curasol mixture, then applied the dry gauze to cover the wound, removed gloves and applied R40 ' s sock. R40's physician's orders included; Iodosorb 0.9% gel apply 50:50 mixture of Iodosorb and Curasol to right great toe lesion once daily after cleaning wound. Apply skin prep to peri-wound and toe surface. Cover with gauze and netting. During an interview on 4/27/16, at 2:22 p.m. RN-A indicated she did not wash her hands after removing the soiled dressing and donning new gloves. During an interview on 4/27/16, at 3:50 p.m.	F 441	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 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control and 4) requires staff to clean their hands after each direct resident contact for which hand cleansing is indicated by accepted professional practice. The infection control policies and procedures were reviewed. The procedure for applying clean dressings has been reviewed and updated to include hand hygiene according to current accepted practice standards. During the mandatory meeting May 19, 2016, the licensed nurses and trained medication assistants will be instructed on infection control techniques related to dressing changes and the revised procedure for changing clean dressings. Infection control techniques including glove use are addressed during the new employee orientation and are included in the annual mandatory staff training.	

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F 441	Continued From page 6 director of nursing (DON) stated, she would expect the nurse at a minimum to wash hands between removal of the old dressing and application of the new dressing. Facility policy Dressing, Dry/Clean last reviewed 11/2015, included the following steps: "Wash and dry your hands, put on clean gloves, loosen tap and remove soiled dressing. Pull glove over dressing and discard into plastic or biohazard bag, wash and dry your hands. Open dry, clean dressing, touching only the exterior surface, using clean technique, open other products as ordered, wash and dry your hands. Put on clean gloves, assess the wound, cleanse the wound with ordered cleanser, apply the ordered dressing." R14 had been observed on 4/27/16 at 9:30 a.m., along with RN-C (hospice nurse) who performed the dressing change on R14's open wounds located on buttocks. ADON joined RN-C and ADON had measured the open areas on the left buttocks, right buttocks and a new open area on the coccyx. RN-C applied gloves gloves but had not washed hands after completing a left open wound dressing. RN-C then applied a pair of gloves and proceeded to take a wash cloth to wipe away visible stool from R14's rectal area. RN-C, without changing the pair of soiled gloves, then applied barrier cream to R14's buttocks, which included the open areas on R14's right buttocks. R14's physician order report, dated 4/18/16, instructed the nursing staff to treat wounds with Optilock. R14's licensed nurse administration history, reviewed from 4/20/16 through 4/28/16, indicated that the hospice nurse had been changing the dressings as ordered.	F 441	Resident number 40 – The nurse who completed the dressing change without cleansing hands between glove changes has been reeducated. During a subsequent return demonstration of a dressing change, the nurse was observed using the correct technique to minimize the risk of infection. The infection control procedures related to the resident's dressing change will be reviewed with the licensed staff during the May 19, 2016 meeting. Resident number 14 – The nurse from the hospice agency was counseled regarding the need to cleanse hands and apply clean gloves after performing resident hygiene and before applying topical creams/ointments. The hospice agency administrative staff has been made aware of the incident and the regulatory outcome. The hospice agency will counsel with their nurses regarding infection control practices and regulatory compliance. The hospice resident died at the facility May 2, 2016. Weekly for four weeks the RN Staff Development Director will monitor compliance with infection control techniques by direct observation of the staff completing dressing changes. Resident number 40 will be included in the observation sample. If noncompliance is noted, additional observations and staff training will be done. Compliance with infection control policies/techniques will be reviewed during the July quarterly Quality	

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F 441	Continued From page 7 When interviewed on 4/27/16 at 10:26 a.m., RN-C stated that she probably should have changed the soiled gloves after cleaning up the resident's stool prior to applying the barrier cream. When interviewed on 4/28/16 at 9:34 a.m., the director of nursing (DON) stated that once the dirty part of the process for cleaning a resident then the nursing staff should wash their hands and apply a new pair of gloves before applying any kind of cream or ointment to the resident. The DON stated that was intended in order to prevent any kind of potential infection that could occur. Review of the facility policy Infection Control Guidelines for All Nursing Procedures, (last revised 8/15) was reviewed and included standard precautions would be used in the care of all residents. Standard precautions would apply to body fluids, secretions and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. It stated that staff should wash their hands prior to contact with blood, body fluids, secretions, mucous membranes, or non-intact skin. Staff should also wash their hands after removing gloves. Review of the facility policy Dressings, Dry/Clean, (reviewed 11/2015) read, after a dressing had been applied staff were to wash and dry their hands.	F 441	Council meeting and ongoing.	

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

F5153024

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A 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 not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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		

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K 000	Continued From page 2 census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all 58 residents within the smoke compartments. Findings include: On facility tour between 09:00 AM and 12:30 PM on 04/28/2016, it was observed that between units 109-110 had penetration that the smoke barrier doors above ceiling tiles around wires.	K 025	K025 The penetrations in the smoke barrier between units 109 and 110 were sealed with fire stop caulk on April 29, 2016. On May 13, 2016, the maintenance staff were trained on how to inspect for penetrations in the smoke barriers and the procedures for sealing penetrations with fire caulk. When building alterations are made near a smoke barrier, the maintenance staff will inspect the barrier and seal any penetrations. Compliance will be monitored by the Director of Maintenance/designee.	5/13/16
K 048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by:	K 048		6/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2016**

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 048	Continued From page 3 On facility tour between 09:00 AM and 12:30 PM on 04/28/2016, observation and documentation reviewed revealed that there was no documentation was found for not allowing space heaters, building construction type.	K 048	K048 A policy will be developed regarding a ban on the routine use of space heaters in the resident care areas. Information about the facility's policy on the use of space heaters will be distributed to current residents/families through the facility's monthly newsletter. The facility's policy on space heater use will be included in the new resident admission packet. Compliance will be monitored by the Social Worker.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: On facility tour between 09:00 AM and 12:30 PM on 04/28/2016, observation and documentation reviewed revealed that documentation shows that fire drills are not space out more than 90 minutes apart through-out the year.	K 050	K050 Fire drills are held with sufficient frequency to familiarize staff with the drill procedures. A revised fire drill schedule had been made for 2016; drills will be conducted once per quarter on each shift at no less than two hour intervals. The fire drill schedule will be added to Tels PM Program to allow electronic tracking.	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2016**

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K 050	Continued From page 4	K 050	The Director of Maintenance will be responsible for scheduling fire drills to meet regulatory requirements. Compliance will be monitored by the Director of Maintenance through review of the Tels PM Program data. If noncompliance is noted, additional staff training will be done.	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: On facility tour between 09:00 AM and 12:30 PM on 14/28/2016, observation and documentation reviewed revealed that the generator log does not show a cool down period of at least 5 minutes on the log sheets.	K 144	K144 The generator logs have been modified to include tracking/verification of a thirty minute cool down period after the monthly tests. The generator automatically runs an additional 30 minutes to allow cool down after the monthly test. On May 13, 2016, the maintenance staff was trained on the procedures for monitoring the generator function and completing the weekly/monthly log sheets. The generator test has been added to the preventive maintenance tasks which are tracked electronically using the Tels PM Program software. The Director of Maintenance will routinely monitor the paper and electronic logs to ensure that the required generator tests and documentation are completed.	5/13/16

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 _____	**04/28/2016**

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 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A 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 not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/19/2016

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 _____	**04/28/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 048	NFPA 101 LIFE SAFETY CODE STANDARD	K 048		6/3/16

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 _____	**04/28/2016**

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

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K 048 SS=C	Continued From page 2 There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1 This STANDARD is not met as evidenced by: On facility tour between 09:00 AM and 12:30 PM on 04/28/2016, observation and documentation reviewed revealed that there was no documentation was found for not allowing space heaters, building construction type.	K 048	K048 A policy will be developed regarding a ban on the routine use of space heaters in the resident care areas. Information about the facility's policy on the use of space heaters will be distributed to current residents/families through the facility's monthly newsletter. The facility's policy on space heater use will be included in the new resident admission packet. Compliance will be monitored by the Social Worker.	
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K 050	Continued From page 3 apart through-out the year.	K 050	procedures. A revised fire drill schedule had been made for 2016; drills will be conducted once per quarter on each shift at no less than two hour intervals. The fire drill schedule will be added to Tels PM Program to allow electronic tracking. The Director of Maintenance will be responsible for scheduling fire drills to meet regulatory requirements. Compliance will be monitored by the Director of Maintenance through review of the Tels PM Program data. If noncompliance is noted, additional staff training will be done.	