



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 18, 2025

Administrator
MADONNA TOWERS OF ROCHESTER INC
4001 19TH AVENUE NORTHWEST
ROCHESTER, MN 55901

RE: CCN: 245153

Cycle Start Date: June 12, 2025

Dear Administrator:

On June 12, 2025, the Minnesota Department of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2025

Administrator
Madonna Towers of Rochester, Inc.
4001 19th Avenue Northwest
Rochester, MN 55901

RE: CCN: 245153
Cycle Start Date: June 12, 2025

Dear Administrator:

On June 12, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Madonna Towers of Rochester, Inc.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 September 12, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by December 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

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June 23, 2025

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<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 07/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2025	
NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 On 6/9/25 to 6/12/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. : H51536487C (MN00103769) H51536432C (MN00104312) H51536392C (MN00104346) H51536393C (MN00111890) H51536433C (MN00111888) H51536488C (MN00112677) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive			F 684			7/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2025

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 684	Continued From page 1 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively monitor and assess for edema (swelling) so intervention effectiveness could be determined, and new interventions developed if needed for 1 of 1 residents (R43) assessed for edema management. Findings include: R43's quarterly Minimum Data Set (MDS) assessment dated 5/31/25, indicated R43 had intact cognition and was diagnosed with heart failure and debility. R43's care plan dated 5/23/25, indicated R43 was receiving a diuretic, which placed her at "a high risk for adverse reactions" staff were to monitor for an infective dose such as an increase in edema. The care plan indicated R43 was at risk for skin alteration related to a history of lymphedema (swelling from an accumulation of protein-rich fluid usually drained by the body's lymphatic system). The care plan indicated staff were to apply R43's left upper extremity edema wraps in the morning, leave them on until the next morning, take off and assess the skin, and then re-apply. The care plan indicated that compression devices were to be applied to R43's bilateral lower extremities in the morning and taken off at nighttime.	F 684	R43's care plan was reviewed and revised as necessary to include edema management interventions for bilateral upper extremities. All facility residents currently receiving edema management services had care plans reviewed and revised as necessary to include resident-specific edema management interventions. All facility clinical staff received education on the Resident Examination and Assessment Policy. DON or designee will complete random audits on skin assessments to ensure edema management and monitoring compliance three times a week for six weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.		

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

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F 684	Continued From page 2 R43's Weekly Skin Checks dated: 4/9/25, 4/16/25, 4/23/25, 5/7/25, 5/14/25, 5/21/25, 5/29/25, and 6/4/25 were reviewed and indicated R43 had no edema at the time of assessment. R43's medical record dated 4/9/25 to 6/9/25 was reviewed and did not include further assessment of R43's left upper extremity edema. During an interview and observation on 6/9/25 at 4:14 p.m., R43 was observed sitting in her wheelchair in her room. R43's arm was observed with significant swelling to her left upper extremity, with her left hand puffy. R43 was observed attempting to use her left hand and did not appear to be able to fully bend her fingers towards her palms. R43 was observed wearing long pants and her lower extremities were unable to be fully visualized. R43 stated she has had the edema in her left hand for a long time, but it has overall improved since being at the facility, although never fully goes away. R43 stated the edema in her left hand had been worse the past couple of weeks. During an interview on 6/10/25 at 12:54 p.m., registered nurse (RN)-C confirmed she was the nurse for R43 for the shift and was familiar with the resident. RN-C stated R43 had a history of edema and shortness of breath, had gotten better since being at the facility but had never gone away. RN-C stated R43 no longer has edema in her lower extremities, so she has not been documenting R43 has any edema. RN-C stated R43 had chronic edema in her left upper extremity and a compression device was used. RN-C stated R43's left upper extremity was "pretty edematous" and thought it had been to this degree almost a month but RN-C stated she was unable to find this was being documented.	F 684			

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F 684	Continued From page 3 During an interview on 6/11/25 at 10:13 a.m., RN-B confirmed she was the nurse for R43 for the shift and was familiar with the resident. RN-B stated R43 had left upper extremity lymphedema "for a while" and "always" had some edema in that extremity. RN-B stated the edema R43 had in her upper extremity was normal for her but was unsure where they documented assessing this edema in her arm. RN-B stated R43's edema to her lower extremities had diminished and R43 usually only had trace edema or did not have any at all there. During an interview on 6/11/25 at 10:54 a.m., RN-A, stated R43's edema to her left upper extremity was a chronic issue for her and would have expected staff to document that in the weekly skin check form. RN-A stated it was important this edema was documented so staff and the provider could see if changes in her edema level had occurred and if the current interventions were still effective. The facility's Resident Examination and Assessment policy dated 10/2/23, indicated that a resident assessment would be completed on admission, with a change in physical function, or with an acute change in condition and documented in the electronic health record (EHR).	F 684			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis:	F 732			7/15/25

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F 732	Continued From page 4 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the required nurse staffing information was posted daily and contained the facility name. This had the potential to affect all 55 residents residing in the facility	F 732	No facility residents were directly affected with this deficient practice. During the survey process, the SNF Administrator posted the updated required		

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F 732	Continued From page 5 and/or visitors who may wish to view the information. Findings include: During observation, document review, and interview on 6/11/25 at 8:32 a.m., the nursing staff posting was observed in the main lobby near the entrance and was dated 6/9/25 with a resident population of 55 and did not have the facility name on it. The staff posting indicated the morning shift began at 6:00 a.m. The administrator confirmed the staff posting had not been updated since 6/9/25 as the staffing coordinator (SC) was on paid time off (PTO). The administrator stated she thought the health unit coordinator (HUC)-A would be the staff member in charge of updating the staff posting while the staffing coordinator was away. During an interview on 6/11/25 at 9:06 a.m., HUC-A stated the SC oversaw posting the staff posting and was not sure who oversaw completing this task while she was on PTO. During an interview on 6/12/25 at 8:54 a.m., the SC stated that she was unsure who oversaw posting the nurse staffing information while she was on PTO. The SC confirmed the staff posting did not have the facility name on it and stated after reviewing the staff postings that it had been like this since September of 2024. The SC stated she had not noticed the change in the form and would have to call cooperate to see why the form no longer had the facility name on it. The facility's Posting of Nursing Hours policy dated 9/20/22, indicated the nurse staffing information would be posted daily at the	F 732	staffing information in the designated area. Posting of nursing hours facility process updated to include role of backup for the staffing coordinator during any approved paid leave of absence. All facility administration staff were educated on the Posting of Nursing Hours Policy and facility-specific process for daily staffing postings; including the role of backup in the absence of the staffing coordinator. Facility administrator or designee will complete audit of posting of nursing hours three times a week for six weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.		

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F 732	Continued From page 6	F 732			
F 812 SS=F	beginning of each shift and would include the facility name. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators were labeled, dated and discarded properly. This deficient practice had the potential to affect all 55 residents, staff and visitors who received food from facility kitchen. Findings include: During the initial kitchen tour on 6/9/25 at 1:42 p.m., dietary manager (DM) stated the dates listed on the food was the date of opening or	F 812			7/15/25
			No facility residents were directly affected with this deficient practice. During the survey period, the Culinary Director immediately discarded food items that were identified as expired or had been opened without appropriate dating. Facility process was implemented to include a designated culinary associate responsible for checking cooler and freezer items for proper labeling during		

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F 812	Continued From page 7 when it was prepped and should be tossed after one week. The following items were observed in the fridge expired or undated food: -Mushrooms dated 5/30/25 -Undated, opened celery appearing soft and browning -Undated, opened lettuce -Undated, opened chopped celery appearing with browning spots -Undated, opened carrots During interview on 6/9/25 at 1:42 p.m., culinary director (CD) stated the normal practice they follow is once foods are opened, the opened date is written on the container. The dated food is good for one week; the staff on evening shift will throw undated and expired foods every evening. CD confirmed the mushrooms, celery, lettuce, and carrots should have been thrown out previously, due to being expired or undated. During interview on 6/11/25 at 11:02 a.m., cook (C)-A stated the practice for dating stored foods is to put the date on the container when it was opened, the food is then thrown out in one week. C-A stated the evening shift is responsible for going through the refrigerators and toss undated or expired foods. Per facility Food Storage policy dated August 2019, sanitary procedures will be maintained in perishable food storage to keep foods safe.	F 812	each shift. All culinary associates were educated on Food Storage – Perishable Policy and facility-specific process. The Director of Culinary Services or designee will complete audit of expired and unlabeled food products three times a week for six weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883			7/15/25

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(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 883	Continued From page 8 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883			

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F 883	Continued From page 9 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R43, R14, R22) reviewed for immunizations were offered and/or provided the pneumococcal conjugate vaccine (PCV)20 as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infections. Findings include: A CDC Shared Clinical decision-making document titled "PCV20 or PCV21 Vaccination for Adults 65 years or older" dated 9/11/24 indicated: "Adults 65 years of age or older have the option to receive supplemental PCV20 or PCV21 (not both) if they previously completed the pneumococcal vaccine series with both PCV13 and PPSV23 [pneumococcal polysaccharide vaccine] and meet the following criteria: -Previously received one dose of PCV13 (but not PCV15, PCV20, or PCV21) at any age, and -Previously received all recommended doses of PPSV23 (including 1 dose of PPSV23 at or after 65 years of age)	F 883	R14, R22, and R43 were offered and/or provided the pneumococcal conjugate vaccine (PCV20) as recommended by the Centers for Disease Control (CDC). All facility residents were reviewed to determine eligibility status for the PCV20 vaccine, in alignment with CDC recommendations. All eligible residents were offered PCV20. A vaccine tracking spreadsheet was developed to streamline documentation and will be reviewed in the facility's daily Clinical IDT Meeting. Ongoing, all newly admitted residents will be screened for PCV20 eligibility within five days of admission by the DON or designee. Facility Nursing Administration was educated on the Pneumococcal Vaccines for Residents Policy and facility-specific process. The facility DON or designee will complete		

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F 883	Continued From page 10 The determination to administer PCV20 or PCV21 is based on a shared clinical decision-making (SCDM) process between a patient and their healthcare provider. SCDM recommendations are optional and informed by the characteristics, values, and preferences of the patient, and the clinical discretion of the health care provider." It continues, "Increased risk of exposure to PCV20 or PCV21 serotypes may occur among people who are living in: nursing homes or other long-term care facilities. If exposed, people with one or more of the following health issues are at increased risk of developing severe pneumococcal disease: -immunocompromising condition, one or more of these chronic medical conditions: alcoholism, chronic heart, liver, or lung disease; cigarette smoking; or diabetes. Protection against disease from both PCV13 and PPSV23 is expected to decrease over time." It continues, "If you and your patient decide PCV20 or PCV21 is appropriate, give one dose of PCV20 or PCV21 at least 5 years after the patient's last pneumococcal vaccine dose". R43 R43's face sheet indicated she was 83 years of age. R43's facility preventative healthcare report dated 6/10/25 indicated R43 received the following vaccinations: -PPSV23 on 12/28/2012 -PCV13 on 12/19/16 R43's Minnesota Immunization Information Connection (MIIC) report indicated R43 received PCV13 on 12/19/2016 and PPSV23 on 10/24/2005 and 12/28/2012.	F 883	audit of resident vaccine status by conducting random audits of vaccinations in accordance with CDC recommendations three times a week for six weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.		

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F 883	Continued From page 11 R43's facility immunization review form dated 5/27/25 indicated R43's pneumococcal vaccinations were not up to date and the pneumococcal vaccines were not offered. R43's medical record lacked documentation of shared decision making with provider and resident/responsible agent regarding administration of PCV20 vaccination. R14 R14's face sheet indicated R14 was 87 years of age. R43's facility preventative health care report printed 6/10/25 indicated the following vaccinations: -PPSV23 on 12/13/2004 and 6/9/2015 -PCV13 on12/11/2014 R14's MIIIC report indicated R14 received PCV-3 on 12/22/14, PPSV23 on 6/9/15 and 12/13/2004. R14's immunization review form, dated 2/6/25, indicated R14's pneumococcal vaccinations were up to date. A facility immunization consent or refusal form dated and signed on 7/12/24, indicated consent to administration of pneumonia immunizations. Date of pneumonia vaccinations was left blank. R14's medical record lacked documentation of shared decision making with provider and resident/responsible agent regarding administration of PCV20 vaccination. R22 R22's face sheet indicated age of 77. R22's	F 883			

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F 883	Continued From page 12 facility preventative health care report dated 6/10/25 indicated: -PPSV23 on 12/5/2012 and 1/19/2018 -PCV13 on 2/11/2015 R22's MIIIC report indicated R22 received PCV13 on 2/11/2015, PPSV23 on 12/5/2012 and 1/19/2018. R22's facility vaccination review form dated 3/28/25, indicated R22's pneumococcal vaccinations were "up to date". R22's facility immunization consent or refusal form dated and signed by R22 on 7/12/24, indicated consent to administration of the pneumonia immunizations. Date of pneumonia vaccinations was left blank. R22's medical record lacked documentation of shared decision making with provider and resident/responsible agent regarding administration of PCV20 vaccination. During interview on 6/11/25 at 12:57 p.m., the regional nurse consultant confirmed there was no documentation of shared decision making or offer/administration of PCV20 vaccination for R14, R43, or R22. The infection preventionist stated residents were offered the PPSV23 vaccinations and confirmed the PCV20 vaccinations had not been offered to residents. A facility policy titled "Pneumococcal Vaccines for residents dated 3/18/22, indicated the policy purpose was: "To reduce the mortality and morbidity from pneumococcal disease by vaccinating all residents who meet criteria established by the	F 883			

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F 883	Continued From page 13 CDC." "It is the policy of [corporate owner] to provide education and administration of the PPSV23 and PCV13 to the residents of the facility according to CDC recommendations. CDC now recommends pneumococcal conjugate vaccine PCV15 or PCV20 for adults who have NEVER received a prior pneumococcal conjugate vaccine PCV13 if they are 65 years or older and have certain chronic medical conditions or other risk factors. For adults who have only received PCV13 but not PPSV 23, CDC recommends vaccine providers give PPSV23 as previously recommended." Line 6 under "Procedure" indicated "the type pf pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend upon the recipients age and susceptibility to pneumonia in accordance with current CDC guidelines and recommendations." Line 10 indicated "A pneumococcal vaccination is recommended for all adults 65 years and older and based on the following recommendations: A. For adults 65 years or older who have not previously received any pneumococcal vaccine, give 1 dose of PCV15 or PCV20. B. For adults 65 years or older who have only received a PPSV23 give 1 dose of PCV15 or PCV20. The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23."	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/10/2025. At the time of this survey, MADONNA TOWERS OF ROCHESTER, INC found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2025

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. MADONNA TOWERS OF ROCHESTER, INC 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	K 000			

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K 000	Continued From page 2 addition was added and was determined to be Type V (111). Because the original building is 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 Type V (111) building. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The building is protected by a full fire sprinkler system. 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 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.			K 346			7/15/25

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K 346	Continued From page 3 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2025 between 10:30 AM and 1:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy was incomplete in content and did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (regional point of contact and phone #). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	Our Fire Alarm Out of Service Policy has been amended on June 25, 2025, to include as our regional State Fire Marshal contact, Deputy State Fire Marshal Steven Jurrens, and his cell phone number 651-470-4416. All other contacts required by the policy have also been updated with accurate names and phone numbers. The Fire Alarm Out of Service Policy will be reviewed annually for completeness and accurate contact information. The Environmental Service Director will be responsible for implementing this plan of correction and monitoring compliance.		
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an	K 354			7/15/25

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K 354	Continued From page 4 approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2025 between 10:30 AM and 1:30 PM, it was revealed by a review of available documentation that the fire sprinkler system out-of-service policy was incomplete in content and did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (regional point of contact and phone #). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	Our Sprinkler system out of service policy has been amended on June 25, 2025, to include as our regional State Fire Marshal contact, Deputy State Fire Marshal Steven Jurrens, and his cell phone number 651-470-4416. All other contacts required by the policy have also been updated with accurate names and phone numbers. The Fire Alarm Out of Service Policy will be reviewed annually for completeness and accurate contact information. The Environmental Service Director will be responsible for implementing this plan of correction and monitoring compliance.		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.	K 372			7/15/25

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K 372	Continued From page 5 Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain and inspect smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.5, 8.3.5.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/10/2025 at 11:45 AM, it was revealed by observation, that above ceiling at smoke barrier door (# 4), there were unsealed and/or improperly sealed penetrations in the gypsum board of the smoke barrier construction. 2. On 06/10/2025 at 11:50 AM, it was revealed by observation, that above ceiling at smoke barrier door (# 7), there were unsealed and/or improperly sealed penetrations in the gypsum board of the smoke barrier construction. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 372	On 6/25/2025 3M 4 hour rated fire barrier sealant (MFG part# CP-25WB+) was ordered and a Work order entered into Tels assigned to Madonna Towers Maintenance staff (WO#2437) to seal penetrations above fire barrier door #4 and smoke barrier door #7. In addition to this work order another Work Order was created and assigned to maintenance staff to check all remaining smoke barriers in SNF for unsealed penetrations or inadequately sealed penetrations, and seal as necessary. These Work Orders have a due date of July 15, 2025, and will be monitored for timely completion and adequate sealing of the penetrations by the Environmental Service Director. In the future, the Environmental Service Director will check or assign staff to check any smoke barrier that has been penetrated due to construction or maintenance for proper sealing. The Environmental Service director will also be responsible for instructing contractors or maintenance staff to properly seal any penetrations and plan for this before any work crossing smoke barriers is permitted. This will include instructions on the proper sealant, either the 3M CP-25WB+, which will be		

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K 372	Continued From page 6			K 372	kept in stock in the maintenance department, or another compliant fire barrier sealant that is preapproved by the Environmental Service Director.		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/10/2025 at 11:55 AM, it was revealed by observation that smoke barrier door assembly (# 2) exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke.			K 374	On June 25, 2025, PEMKO Meeting Stile brush type (MFG part# 086682) smoke seals were ordered for Smoke barrier Door assemblies #2 and #9 and a work order (WO24739) was created in TEIs assigned to Madonna Towers Maintenance staff to replace the smoke seals on barrier doors #2 and #9. The Due date for this work is July 15, 2025, and will be monitored for timely completion by the Environmental Service Director. The Environmental service Director will also inspect the newly installed seals for compliance by		7/15/25

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K 374	Continued From page 7 2. On 06/10/2025 at 12:00 AM, it was revealed by observation that smoke barrier door assembly (# 9) exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K 374	observing that no light is visible between the closed doors, and to ensure the deficiency does not reoccur, he will look for visible light as the criteria on the door inspections moving forward, instead of using a measuring device as in the past, which could introduce a measurement error. Same as above		7/15/25
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document electrical receptacle testing in resident rooms per			K 914	The form we were using to document the results of the electrical outlet inspections was deficient in that there was no		

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K 914	Continued From page 8 NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2025 between 10:30 AM and 1:30 PM, it was revealed by a review of available documentation that documentation presented for review did not identify date(s) of completion and individual(s) that completed the inspection and documentation of the findings of each outlet. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	signature line or box that would indicate who performed the test. We reached out by email on June 25th, 2025, to Steven Jurrens, our Deputy State Fire Marshal for our region, and requested a form that would meet the standards. On June 26th, 2025, Steven Jurrens sent us a form titled: "Receptacle Tests (Patient Care Areas)". We downloaded the form and incorporated it into our Life Safety Binder and this form will be used going forward for receptacle tests required by the standard. The Environmental Service Director will be responsible for the form being correctly filled out with Testers Name, employed by, Test Date, Room number, Device number, and the results of the testing in the corresponding boxes on the form. The testing for this year will be automatically generated as a task in Tels in August. The entire maintenance staff participates in outlet testing. The Environmental Service Director will supervise the testing and ensure that each tech will have his own page of this form referenced above, with the rooms and devices indicated on the page along with his name and the date on which he performed the testing. The Environmental Service director will be responsible for supervising this process going forward to ensure future compliance.		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918			7/15/25

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K 918	Continued From page 9 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.4, 5.6.4. This deficient finding could have a widespread impact on the residents within the facility.			K 918	There was a discrepancy on our paperwork for our annual generator PM conducted by Pioneer Critical Power. On the paperwork dated February 28th, 2025, under the battery section of the report, it has the text that reads "Battery install		

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K 918	Continued From page 10 Findings include: On 06/10/2025 between 10:30 AM and 1:30 PM, it was revealed by a review of available documentation and visual inspection that there was a discrepancy as to the date which the battery was last changed. Vendor documentation indicated 2025, visual inspection identified 2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	date: Feb 28,2025". Upon physical inspection of the generator, the batteries were marked with 9/2022. We reached out by phone on June 20th, 2025, to Pioneer Critical Power for an explanation. Todd Meyer, service manager with Pioneer Critical Power, confirmed that the batteries were not replaced on February 28th, 2025, and that the service report on that date was an error. I had our business office pull all of our invoices for Pioneer Critical Power for the last three years, and it was discovered that the batteries were replaced by Pioneer Critical Power in September of 2022. This is consistent with what is marked on the batteries. We have requested that the service report be amended, and the corrected one sent to use for placement in our life safety maintenance binder. The Environmental Service Director will be responsible for ensuring that the amended report is sent, and the erroneous one is replaced in a timely manner. We also requested a quote from Pioneer Critical Power for the replacement of the batteries ASAP. In addition, we reached out to Ziegler Cat here in Rochester for a second quote for battery replacement. We are setting a target date of completion for battery replacement on or before July 15th, 2025. The Environmental Service Director will be responsible for ensuring that the batteries are replaced on or before July 15th, 2025, and that the date of replacement is clearly marked on the batteries and in the service report. The service report for the new battery		

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K 918	Continued From page 11	K 918	replacement will be placed in the Life Safety Binder.		