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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J7YX

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 **04/20/2017** (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 :
Sarah Strenke, HFE II 06/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/29/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245153 June 29, 2017

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 04/11/2017 the above facility is certified for or recommended for:

62 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 29, 2017

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

RE: Project Number S5153026

Dear Ms. Redalen:

On March 21, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 11, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2017, effective April 11, 2017 and therefore remedies outlined in our letter to you dated March 21, 2017, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
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Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 29, 2017

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

Re: Reinspection Results - Project Number S5153026

Dear Ms. Redalen:

On April 20, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 3, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J7YX

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2.STATE VENDOR OR MEDICAID NO.
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(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 **03/03/2017** (L34)

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

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FISCAL YEAR ENDING DATE: (L35)
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And/Or Approved Waivers Of The Following Requirements:
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___ 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

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(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Danette Bakken, HFE II 03/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/09/2017 (L20)

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

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B. Rescind Suspension Date:
(L45)

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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 21, 2017

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

RE: Project Number S5153026

Dear Ms. Redalen:

On March 3, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-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 April 12, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a 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:

- 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 June 3, 2017 (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 September 3, 2017 (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 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

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

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 _____	C 03/03/2017

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 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity for each resident according to needs for 1 of 1 resident (R75), who were dependent upon staff for toileting. Findings: R75's quarter Minimum Date Set (MDS) dated 2/16/17 identifies R75 functional status for toilet use is extensive assist of one person. R75 is moderately impaired with a score or 9 out of 15 on the Brief Interview for Mental Status (cognitive	F 241	Madonna Towers of Rochester staff treat and care for residents in a manner and an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility policies and procedures address, protect and promote the rights of all residents. The staff routinely interact with residents and provide care and services that support and enhance their self-esteem and self-worth including needed	4/11/17

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

Electronically Signed | 03/30/2017

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 _____	C 03/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 assessment), bowel and bladder assessment is frequently incontinent of bowel meaning at least once per week. R75's care plan reads alteration in elimination, is incontinent of bowel and bladder, R75 requires assistance to the toilet with one person and the stand aide (a device/machine that assist the resident to stand and transfer while on a platform). R75 also has an alteration in mobility, decreased strength and endurance with an intervention for prompt to toilet after meals and bedtime and on first night rounds. Nursing assistants care guide reads assist of one person with toileting, do not leave sitting in her room in her wheel chair and is incontinent of bowel and bladder. Observation on 3/2/17 at 8:03 a.m. noted R75 wheeling self from dining room out in the hall, activity aide (AA)-A came up behind R75 and offered to assist her to her room, once in room R75 said to (AA)-A she had to use the bathroom. (AA)-A said in response to request to use bathroom, "I have to get help." R75 repeated, "I have to go to the bathroom, I have to go bad!" (AA)-A said, "I'll go find someone. Twenty four minutes later at 8:27 a.m. R75 was observed in room crying and on entering her room there was a strong smell of stool. When R75 saw surveyor she lifted hand and asked for help. Surveyor immediately notified NA-H who had been standing by the nursing station. It was also noted that R75's call light was activated and staff had not responded to the light. At 8:30 a.m. NA-H and surveyors entered R75's room and R75 continued to cry. NA-H was observed to help	F 241	assistance with activities of daily living (grooming, dressing, bathing, eating, and toileting) as identified in the comprehensive assessment and outlined in the plan of care. The facility policy addressing dignity and quality of life was reviewed and found appropriate. The activity staff was immediately educated about individualized toileting plans and the need for prompt notification of the appropriate staff to respond to residents' care requests. During the April 4 and 6, 2017 mandatory educational meetings, all staff will be 1) reminded of the resident's right to dignified and respectful treatment 2) reinstructed on the need for timely response to care requests, especially urgent requests for toileting and 3) informed that the facility policy is to respond to requests as soon as possible with a prompt response time defined as ten minutes or less. The Staff Development Coordinator will continue to instruct new employees on residents' rights as part of the orientation process. The residents' right to respect and dignity is also addressed as part of the annual employee education/training. The care plan for resident number 75 was reviewed. The plan appropriately instructs staff to transport the resident to her room after meals when there is staff available to immediately assist her with toileting. The resident's plan of care will continue to be	

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 _____	C 03/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 remove R75's pants while seated on toilet. NA-H said R75 had soiled her pants with stool. R75 continued to cry from the time NA-H entered room to assist with toileting until NA-H had completed cleaning the incontinent episode. After helping R75 to bed, NA-H ask if "ok", R75 said "No" An interview with social worker (SW) on 3/2/17 at 1:44 p.m. included the sharing of R75's incontinent of stool and having to wait for assistance even though R75 had informed staff of urgent need to use toilet. SW would expect staff to assist right away. SW stated it would not be good if resident had an accident while waiting for help. Interview on 3/2/17 at 3:06 p.m. with director of nursing (DON) and administrator concerning incontinent episode for R75 yesterday and lack of timely assistance. The DON and administrator both said their goal for answering lights timely is 10 minutes if resident calls for help by activation call light. On asking how long residents should expect to wait when they verbally say to staff they need to use bathroom immediately. Again both DON and administrator agreed that the goal would still be 10 minutes maximum to respond to request. Policy review titled Quality of Life-Dignity dated 12/16 reads under the policies interpretation and implementation; Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: Promptly responding to the residents request for toileting assistance.	F 241	reviewed and revised at least quarterly and with changes in condition. The social worker/designee will monitor compliance by interviewing selected residents regarding their satisfaction with staff response to their toileting needs and requests. Residents who can communicate toileting needs and need assistance with the toileting process will be interviewed before April 11, 2017. If concerns about toileting are identified, additional interviews will be conducted and staff education provided. The residents/families will continue to be asked about their satisfaction with cares during the quarterly care conferences. Feedback regarding resident satisfaction with cares and services is also a standard agenda item for the resident council meetings. Resident's concerns are investigated and responded to in a timely manner. Compliance will be reviewed at the April quarterly Quality Council meeting and ongoing.	
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		4/11/17

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F 280 SS=D	Continued From page 3 PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280		

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F 280	Continued From page 4 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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F 280	Continued From page 5 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include frequency of brushing teeth for 2 of 3 residents (R33 and R75) reviewed for dental status. Findings Include: R33's Chart Progress Note from R33's dental provider dated 1/23/17, identified diagnoses/assessment: generalized recession related to early chronic periodontal disease. Treatment: encourage R33 to focus along gum line during twice daily brushing. R33's current electronic care plan identified: Problem: Dental needs related to dental assessment notation of xerostomia, gum line recession, extensive restoration and exposed bone (#21) with oral surgery consult opting to observe and treat if develops pain/symptoms. Approaches included: Dental consults as ordered. Has own teeth which are heavily restored and at risk for cavities. Oral care; A x 1 (assist of one). Report signs/symptoms of mouth pain, missing or chipped teeth for follow up with provider as needed. Problem: Self-care deficit related to right above knee amputation stump revision with prior left below knee amputation requires assistance with activities of daily living. Approaches included: Oral care assist of one (set up). However, it lacked dentist recommendation to brush teeth twice each day. R33's care guide sheets dated 2/27/17 lacked to include frequency of brushing teeth.	F 280	Madonna Towers of Rochester, Inc. staff develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their families/legal representatives are encouraged to participate in the care planning process and the quarterly care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. The care plan and dental services policies and procedures were reviewed and found appropriate. According to facility policy as a standard of care, residents are routinely assisted with oral care in the morning and evening. During the mandatory meetings April 4 and 6, 2017, the nursing staff will be 1) informed of the regulatory requirement that the residents' care plans be current at all times 2) reinstructed on the facility policies for care plan reviews and updates and 3) reminded of the importance of including care plan interventions that address oral care that is	

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F 280	Continued From page 6 On 3/2/17, at 8:58 a.m. R33 was observed to be sitting up in her wheelchair in her room. At the time nursing assistant (NA)-G stated she had assisted R33 with getting up this a.m. NA-G stated when queried if had assisted R33 with oral cares, NA-G stated usually R33 completes oral cares herself after we set up, when R33 asks for help. At the time, R33 stated she had not brushed her teeth. On 3/3/17, at 8:54 a.m., the director of nursing (DON) stated our care plans are not that specific in regards to including frequency of brushing teeth. Our expectation is nursing assistants are to do oral cares with a.m. and p.m. cares. When queried regarding treatment order from R33's dental provider to encourage R33 to focus along gum line during twice daily brushing to be included on the care plan, the DON stated I think that is how you should brush everybody's teeth. The DON confirmed frequency of brushing teeth was not included on R33's care plan. R75's significant Minimum Data Set (MDS) dated 9/15/16 reads obvious/likely cavity or broken natural teeth. R75's oral cavity assessment dated 2/16/17 reads obvious or likely cavity or broken natural teeth and inflamed or bleeding gums or loose natural teeth with an intervention of oral hygiene assistance and staff assist resident with oral cares. Summary of finding and plan of care describe last dental appointment on 6/6/16 showed multiple root tips, obvious decayed teeth and heavy plague. R75 needs assistant with oral cares twice a day. Dentist recommended dental evaluation of root tips for removal. Social services notified regarding these concerns.	F 280	in addition to the routine cares addressed in the facility's oral care policies and procedures (twice daily oral care is the standard of care). The facility's contract dental service sends a report of their findings/recommendations to the resident and/or the resident's legal representative. A licensed nurse routinely reviews the report. During the April meetings, the nurses will be instructed to ensure that 1) oral hygiene recommendations are added to the care plan and the certified nursing assistant care guides if they are in addition to the routine standard of care addressed in the facility policy and 2) that recommendations for additional dental care are discussed with the resident's legal representative and follow up appointments are arranged as necessary. Resident number 33 – The resident's care plan and the certified nursing assistant care guide were updated to reflect twice daily brushing with attention given to brushing along the gum line. The resident's oral hygiene/dental needs will be addressed during the quarterly care conferences and more often if needed. The care plan will be updated with changes in the resident's oral hygiene needs. Resident number 75 – The June 6, 2016 dental report for follow up care includes twice daily brushing and evaluation of root tips for removal. The social worker discussed the dentist's recommendation	

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F 280	Continued From page 7 R75's review of dentist oral dental form dated 6/6/16, please see that R75's teeth get brushed twice daily and needs a dental visit to evaluate root tips for removal and follow up dental visit to evaluate root tips. R75's care plan had been reviewed and had not included the dentist recommendation to brush teeth twice daily. Interview with social worker (SW) on 3/2/17 at 1:33 p.m. the facility has a contracted dentist who comes to the facility to perform dental services for the residents. Families updated with dental recommendation if any during the care conferences. Review of the last dental appointment dated 6/6/16 assessment with SW and verified that there was to be a follow up recommendations from the dentist. At 2:16 p.m. social worker updated the last care conference was 2/22/17 and verified that there was no mention of follow up dental services for R75's to resident or family. The facility failed to update care plan with recommendations from dentist including not following through with a follow up appointment. Facility policy review titled Dental Services dated 6/2016 reads; routine and emergency services are available to meet the resident's oral health services in accordance with the residents assessment and plan of care. Policy review titled Assessment, Comprehensive dated 12/2016 reads the purpose; is to develop consistent quality care that will attain or maintain, the facility will complete a comprehensive assessment of the resident's needs. The assessment must include the following but not	F 280	to "evaluate root tips for removal" with the resident's daughter. The daughter reports she is not interested in any further dental work unless the resident is having mouth pain. The resident's oral/dental care needs will be reviewed during the quarterly care conferences and more often as necessary. A dental referral will be made if the resident is experiencing mouth discomfort. To monitor compliance the Assistant Director of Nursing/Designee will review the most recent reports from the facility's contract dental provider to ensure that 1) recommendations for referral for additional services have been discussed with the resident and/or the resident's legal representative 2) follow up appointments have been made as appropriate and 3) oral hygiene recommendations outside of the routine oral cares addressed in the facility's related policies/procedures have been addressed in the care plan and certified nursing assistant care guides. Review of the dental reports will be completed by April 11, 2017. The interdisciplinary team will continue to review care plans for completeness, accuracy, and relevancy during the residents' quarterly care conferences, with a significant changes in condition, and more often if necessary. To ensure ongoing compliance, oral care/dental needs have been added as a specific discussion topic during the residents' care conferences. Compliance will be reviewed at the April quarterly Quality Council meeting.	

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F 280	Continued From page 8 limited to dental and nutritional status, special treatment and procedures. The facility should use the results of the assessments to develop, review and revise the resident's comprehensive care plan.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to follow the plan of care for oral care for 1 of 3 residents (R75) reviewed for dental status and services. Findings: R75's Minimum Data Set (MDS) dated 2/16/17 reads obvious/likely cavity or broken natural teeth. Functional status is extensive assist of one person for personal hygiene. R75's oral cavity assessment dated 2/16/17 reads obvious or likely cavity or broken natural teeth and inflamed or bleeding gums or loose natural teeth with an intervention of oral hygiene assistance and staff assist resident with oral cares. Summary of finding and plan of care describe last dental appointment on 6/6/16 showed multiple root tips, obvious decayed teeth	F 282	Madonna Towers of Rochester, Inc. provides services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicates the plan to the direct	4/11/17

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F 282	Continued From page 9 and heavy plague. R75 needs assistant with oral cares twice a day. Dentist recommended dental evaluation of root tips for removal. Social services notified regarding these concerns. R75's care plan reads that R75 has a self-deficit related to decreased mobility as an intervention assist of one person for oral care. During an observation on 3/2/17 at 7:04 a.m. Nursing assistant (NA)-E did not offer oral care to R75 before breakfast. At 8:30 a.m., R75 in room with NA-H assist to bed no oral care offered after breakfast by NA-H. Interview with NA-E on 3/2/17 at 8:47 a.m. verified that R75's oral care not offered before breakfast attempts made to brush after breakfast. NA-E asked if that was completed, stated that she is laying down now and probably was not completed. Observation and assessment with registered nurse (RN)-B on 3/2/17 at 12:07 p.m. of R75's mouth found with broken and missing teeth with decay and caps on teeth. Interview with RN-B at 12:13 p.m. asked about oral care for R75 and how staff updated of what cares the resident should receive. RN-B stated it is in the care plan and in general, staff are to complete oral care. RN-B reviewed the NA's care guide and found that nothing listed for R75 to have staff give oral care twice daily as the dentist recommended on last exam. RN-B stated that it is a standard of care to brush teeth and give oral care daily. Interview with Director of nursing (DON) on 3/2/17 at 2:59 p.m. stated oral care is a standard of care, during orientation the staff are explained	F 282	care givers by use of the nursing assistant care guides. The care plan policies and procedures were reviewed and revised to more clearly address activities of daily living. During the April 4 and 6, 2017, mandatory meetings, the nursing staff will be reminded/instructed 1) that the residents' plans of care must be followed 2) that providing oral hygiene cares twice daily is the facility's standard of practice and 3) that job performance expectations include being aware of and following the resident's plan of care including oral care. The orientation for new employees will continue to address the importance of following the resident's plan of care for activities of daily living including twice daily oral care. To monitor compliance, by April 11, 2017, the most recent reports from the contracted dental service will be reviewed to ensure that all recommended oral hygiene cares outside of the twice daily (morning and evening) oral cares defined as a standard of practice by facility policy/procedures are addressed in the care plan and the certified nursing assistant resident care guides. Care plans will be updated as needed to reflect ongoing monitoring of dental concerns and oral hygiene needs not addressed as a routine standard of practice. To ensure ongoing compliance, oral care/dental needs have been added as a specific discussion topic and will be reviewed during the residents' care conferences. If	

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F 282	Continued From page 10 that oral cares are to be given twice daily at least once in the morning and once at bedtime Facility policy review titled Oral Hygiene dated 10/16 reads standard is residents unable to carry out activities of daily living receive the necessary services to maintain good oral hygiene. Nursing staff will provide assistants with oral hygiene to each resident every morning, night and as needed.	F 282	noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the April quarterly Quality Council meeting.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to shave 1 of 3 residents (R50) who is unable to carry out activities of daily living necessary to maintain good grooming. Finding included: During observation on 3/1/17, at 8:29 a.m. resident was sitting in her wheelchair at table for breakfast. Resident was fully dressed and up for the day. R50 noted to have white-gray whiskers on chin. On 3/2/17 at 7:10 a.m. R50 was sitting in small lounge across from nursing station fully dressed and continues to have white-gray whiskers on chin. At 11:38 a.m. R50 was being assisted with lunch and noted to continue to have white-gray whiskers on her chin. On 3/3/17 at 8:15 a.m. resident was up fully	F 312	Madonna Towers of Rochester, Inc. provides the necessary services to maintain good nutrition, grooming, personal care and oral hygiene. Based on the comprehensive resident assessment, the staff provides cares which assist the resident to maintain and enhance his/her self-esteem and self-worth including assistance with removal of facial hair according to resident preferences and as outlined in the plan of care. The residents' need for assistance with personal hygiene/grooming is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary. The procedure for removing facial hair was reviewed and revised. During the mandatory meetings April 4 and 6, 2017,	4/11/17

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F 312	Continued From page 11 dressed, sitting in her wheelchair, looking out her window, noted that facial hair had been removed. During interview on 3/2/17, at 9:39 a.m. nursing assistant (NA)-C stated that resident requires assistance with all her grooming and hygiene care. Shaving should be completed on bath day for women at least and then spot checked on a daily basis. During interview on 3/2/17, at 11:40 a.m. NA-A said, "I shave them every bath day and with some shave them more often if needed." During interview on 03/02/2017, at 11:47 a.m. NA-D stated "Her bath is once a week, fingernails and shaving is done with the bath." When asked what she would do for resident if needed to be shaved other than on bath day. Stated she would check with the nurse to see what I could do for them. I don't think the care sheet states specific regarding shaving. During interview on 3/2/17 at 12:48 p.m. with registered nurse (RN)-A, What is your expectations as to when grooming hygiene be completed, if someone needs shaving including women, RN-A said, "My expectation is they would do it with morning care." RN-A also stated, "I just checked with a couple of aides, they state that they will do it if they notice it with morning care. And if the resident will let them and if there is a razor available. Unless the resident is on Coumadin [blood thinning medication], then they let the nurse know." During interview on 3/2/17, at 2:00 p.m. NA-B stated R50's bath is Monday. NA-B then said she had trimmed nails, shaved hair during bath.	F 312	the nursing staff will be 1) reinstructed on the facility's policies for providing personal hygiene/grooming to the residents 2) reminded that their job description requires knowledge of and responsibility for following the residents' plans of care and 3) instructed on the facility policy for removing facial hair and the importance of shaving female residents with excessive facial hair unless the resident/legal representative prefers otherwise. The need to provide cares as necessary to improve/enhance the residents' appearance, comfort, and dignity as well as respect for their preferences will be emphasized. The grooming plan of care for resident number 50 was reviewed and found appropriate in addressing the resident's personal care needs. The direct care staff are aware of the need to shave the resident's chin hairs as part of the routine grooming/bathing procedures. The Activity Director/designee will be responsible for monitoring compliance by randomly checking female residents for excessive chin hair during large group activities for two weeks. If noncompliance is noted, the clinical manager will be notified and additional monitoring and staff training will be done. Ongoing monitoring for excessive facial hairs will be done weekly as part of the bathing process. Compliance will be reviewed at the April Quality Council Meeting.	

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F 312	Continued From page 12 However, had not worked this past Monday so another NA completed her bath. During phone interview on 3/3/17 at 8:05 a.m. with R50's family member/power of attorney, regarding if it would bother her to have facial hair on her chin. She said, "Absolutely, it would have bothered her, she was a very pristine person and always wanted to look nice." During interview on 3/3/17 at 9:20 a.m. with DON and Administration, DON stated, My expectations would be that staff would shave facial hairs daily and as needed especially for females. Nursing Care bath list indicated that R50's scheduled bath day is on Monday a.m. R50's care plan last reviewed/revised on 1/20/17, indicated that R50 had self care deficit related to dementia and overall debility. She is dependent on staff assistance with all activities of daily living, which includes: hygiene and grooming (shaving, oral care, combing hair). MaDonna Towers of Rochester Activities of Daily Living (Daily Life Functions) Reviewed dated 10/16. Purpose of activities of daily living is to provide assistance to residents for daily life functions. MaDonna Towers of Rochester Shaving the Resident reviewed 12/20/16. Purpose of the procedure is to promote cleanliness and to provide skin care.	F 312		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General.	F 329		4/11/17

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 _____	C 03/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 329	Madonna Towers of Rochester staff	

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F 329	Continued From page 14 facility failed to follow physician orders for blood glucose checks for 1 of 5 residents (R52) reviewed for unnecessary medications. Findings include: R52's Resident Face Sheet dated 3/3/17, identified diagnosis of diabetes mellitus. R52's current physician orders included check blood glucose twice daily- staggered so one day before breakfast and supper, next day before lunch and at HS. Notify CNP (certified nurse practitioner) if BG (blood glucose) > (greater than) 300 or BG < (less than) 100 every shift. R52's current electronic care plan included problem: has diabetes mellitus requiring insulin therapy and approaches included monitor blood glucose/accuchecks as ordered and as needed for signs and symptoms of hypoglycemia/hyperglycemia. R52's medication/treatment administration records (MAR/TAR's) dated 1/1/17 through 3/2/17 identified notify CNP if BG >300 or BG <100 every shift and BG readings for the following dates: 1/4/17, at 6:00 a.m. 97, No CNP notified 1/11/17, at 8:00 p.m. 312, No CNP notified 1/14/17, at 4:00 p.m. 345, No CNP notified 1/17/17, at 8:00 p.m. 309, No CNP notified 1/19/17, at 8:00 p.m. 367, No CNP notified 1/26/17, at 6:00 a.m. 96, No CNP notified 1/27/17, at 8:00 a.m. 350, No CNP notified 1/31/17, at 8:00 p.m. 312, No CNP notified 2/1/17, at 8:00 p.m. 313, No CNP notified 2/3/17, at 8:00 p.m. 375, No CNP notified 2/6/17, at 6:00 a.m. 92, No CNP notified	F 329	ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is routinely reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. Each resident's medication regimen will continue to be reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during routine 30/60 day visits and more often as indicated. The staff notify the physician or designated clinician of circumstances which may impact the administration/dose of prescribed medications. For non emergency communication with the prescribing clinician, the Situation, Background, Assessment, Recommendation (SBAR) form is used. To verify communication with the clinician, the SBAR form will now be uploaded to the electronic medical record. During the mandatory meetings April 4 and 6, 2017, the licensed nursing staff will be instructed on the new filing/retention procedures for SBAR forms. During the consultant pharmacist's monthly medication audits and the quarterly care conferences, the resident's medications will continue to be reviewed to assure that	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 15 2/11/17, at 8:00 p.m. 337, No CNP notified 2/14/17, at 4:00 p.m. 453, No CNP notified 2/17/17, at 8:00 p.m. 348, No CNP notified 2/19/17, at 8:00 p.m. 348, No CNP notified 2/21/17, at 8:00 p.m. 409, No CNP notified 2/27/17, at 8:00 p.m. 360, No CNP notified On 3/2/17, at 1:40 p.m., health information manager (HIM)-D and registered nurse (RN)-C stated when the doctor is notified the nurses would document the information in the resident progress notes and the SBAR (facility form) would be documented in the resident progress notes. RN-C confirmed R52's current physician order's included an order for notify CNP BG over 300 and below 100 and the order was on R52's medication/treatment administration record. RN-C confirmed staff were initialing on the MAR/TAR for the order. RN-C reviewed R52's record and confirmed R52 had BG's over 300 and under 100 and R52's record lacked documentation of notifying the CNP of BG's over 300 and under 100. RN-C stated an SBAR (facility form) is filled out and placed on the CNP's desk for the next day in regards to notifying the CNP of BG's over 300 and under 100. RN-C stated the CNP-E is here Monday through Friday. RN-C stated we do not keep record of the SBAR's given to the CNP. RN-C confirmed R52's record lacked documentation the CNP was notified of BG's over 300 and under 100 at the time the BG's were obtained. On 3/03/17, at 9:00 a.m., the director of nursing (DON) stated (when queried notifying the CNP of BG's over 300 and under 100) usually anytime the nurses complete and SBAR the nurses will document (regarding the SBAR completed) in the nurses notes. The DON confirmed R52's current	F 329	medication use is being adequately monitored and documented. For resident number 52, the physician/nurse practitioner was routinely notified of blood sugar readings outside of the acceptable parameters. On days a clinician was at the facility, the SBAR form was used to notify him/her of high/low blood sugar readings. On days a clinician was not in the building, the outcall physician was notified of blood sugar readings outside of acceptable parameters. The staff is aware of the facility policy requiring that clinician notification of high/low blood sugar readings must be verified in the resident's medical record. The nurse practitioner reviewed and revised the order for blood sugar reading notification for resident number 52; the acceptable blood sugar range was expanded. Compliance with documentation procedures will be monitored by the Health Information Manager through review of the residents' records with blood sugar level parameters three times a week for two weeks. If the blood sugar reading is outside of the prescribed parameters, the Health Information Manager will verify that 1) a related SBAR form was completed and a copy uploaded to the electronic record or 2) a progress note was documented regarding notification of the outcall clinician of low/high blood sugar. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed	

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	245153	A. BUILDING _____ B. WING _____	C 03/03/2017

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

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F 329	Continued From page 16 physician order's included an order for notify CNP BG over 300 and below 100. The DON reviewed R52's record and confirmed R52's record lacked documentation of notifying the CNP of BG's over 300 and under 100. At the time, the administrator asked the DON if the SBAR is shredded and the DON replied I do not know what CNP-E does with them. The DON stated CNP-E is here Monday through Friday and reviews the SBAR's when here. A policy for notifying the physician as ordered was requested but not provided.	F 329	at the April quarterly Quality Council meeting.	

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	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/02/2017**

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 000	INITIAL COMMENTS	K 000		

A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Madonna Towers) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Madonna Towers of Rochester is a 1-story building with no basement.
The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (111) construction. In 1979, addition was constructed and was determined to be of Type V(111) construction. In 1998, an addition was added and was determined to be Type II (111). In 2002, an addition was added and was determined to be Type V (111). Because the original building are a Type II(111) and the 2 additions are of the type V (111) of construction and meet the construction type allowed for existing buildings, the facility was surveyed as a V (111) building. This will be surveyed as one building under LSC 2012.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification.

The facility has a capacity of 62 certified beds.

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

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

Electronically submitted

March 21, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5153026

Dear Ms. Redalen:

The above facility was surveyed on February 28, 2017 through March 3, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00419	A. BUILDING: _____ B. WING _____	C 03/03/2017

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On Febuary 28, March 1, 2 and 3, 2017 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed to follow the plan of care for oral care for 1 of 3 residents (R75) reviewed for dental status and services. Findings: R75's Minimum Data Set (MDS) dated 2/16/17 reads obvious/likely cavity or broken natural teeth. Functional status is extensive assist of one person for personal hygiene. R75's oral cavity assessment dated 2/16/17 reads obvious or likely cavity or broken natural teeth and inflamed or bleeding gums or loose natural teeth with an intervention of oral hygiene assistance and staff assist resident with oral cares. Summary of finding and plan of care describe last dental appointment on 6/6/16 showed multiple root tips, obvious decayed teeth and heavy plague. R75 needs assistant with oral cares twice a day. Dentist recommended dental	2 565	Corrected	4/11/17

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2 565	Continued From page 3	2 565		

evaluation of root tips for removal. Social services notified regarding these concerns.

R75's care plan reads that R75 has a self-deficit related to decreased mobility as an intervention assist of one person for oral care.

During an observation on 3/2/17 at 7:04 a.m. Nursing assistant (NA)-E did not offer oral care to R75 before breakfast. At 8:30 a.m., R75 in room with NA-H assist to bed no oral care offered after breakfast by NA-H.

Interview with NA-E on 3/2/17 at 8:47 a.m. verified that R75's oral care not offered before breakfast attempts made to brush after breakfast. NA-E asked if that was completed, stated that she is laying down now and probably was not completed.

Observation and assessment with registered nurse (RN)-B on 3/2/17 at 12:07 p.m. of R75's mouth found with broken and missing teeth with decay and caps on teeth. Interview with RN-B at 12:13 p.m. asked about oral care for R75 and how staff updated of what cares the resident should receive. RN-B stated it is in the care plan and in general, staff are to complete oral care. RN-B reviewed the NA's care guide and found that nothing listed for R75 to have staff give oral care twice daily as the dentist recommended on last exam. RN-B stated that it is a standard of care to brush teeth and give oral care daily.

Interview with Director of nursing (DON) on 3/2/17 at 2:59 p.m. stated oral care is a standard of care, during orientation the staff are explained that oral cares are to be given twice daily at least once in the morning and once at bedtime

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2 565	Continued From page 4 Facility policy review titled Oral Hygiene dated 10/16 reads standard is residents unable to carry out activities of daily living receive the necessary services to maintain good oral hygiene. Nursing staff will provide assistants with oral hygiene to each resident every morning, night and as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include frequency of brushing teeth for 2 of 3	2 570	Corrected	4/11/17

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2 570	Continued From page 5 residents (R33 and R75) reviewed for dental status. Findings Include: R33's Chart Progress Note from R33's dental provider dated 1/23/17, identified diagnoses/assessment: generalized recession related to early chronic periodontal disease. Treatment: encourage R33 to focus along gum line during twice daily brushing. R33's current electronic care plan identified: Problem: Dental needs related to dental assessment notation of xerostomia, gum line recession, extensive restoration and exposed bone (#21) with oral surgery consult opting to observe and treat if develops pain/symptoms. Approaches included: Dental consults as ordered. Has own teeth which are heavily restored and at risk for cavities. Oral care; A x 1 (assist of one). Report signs/symptoms of mouth pain, missing or chipped teeth for follow up with provider as needed. Problem: Self-care deficit related to right above knee amputation stump revision with prior left below knee amputation requires assistance with activities of daily living. Approaches included: Oral care assist of one (set up). However, it lacked dentist recommendation to brush teeth twice each day. R33's care guide sheets dated 2/27/17 lacked to include frequency of brushing teeth. On 3/2/17, at 8:58 a.m. R33 was observed to be sitting up in her wheelchair in her room. At the time nursing assistant (NA)-G stated she had assisted R33 with getting up this a.m. NA-G stated when queried if had assisted R33 with oral cares, NA-G stated usually R33 completes oral	2 570		

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2 570	Continued From page 6	2 570		

cares herself after we set up, when R33 asks for help. At the time, R33 stated she had not brushed her teeth.

On 3/3/17, at 8:54 a.m., the director of nursing (DON) stated our care plans are not that specific in regards to including frequency of brushing teeth. Our expectation is nursing assistants are to do oral cares with a.m. and p.m. cares. When queried regarding treatment order from R33's dental provider to encourage R33 to focus along gum line during twice daily brushing to be included on the care plan, the DON stated I think that is how you should brush everybody's teeth. The DON confirmed frequency of brushing teeth was not included on R33's care plan.

R75's significant Minimum Data Set (MDS) dated 9/15/16 reads obvious/likely cavity or broken natural teeth.
R75's oral cavity assessment dated 2/16/17 reads obvious or likely cavity or broken natural teeth and inflamed or bleeding gums or loose natural teeth with an intervention of oral hygiene assistance and staff assist resident with oral cares. Summary of finding and plan of care describe last dental appointment on 6/6/16 showed multiple root tips, obvious decayed teeth and heavy plague. R75 needs assistant with oral cares twice a day. Dentist recommended dental evaluation of root tips for removal. Social services notified regarding these concerns.

R75's review of dentist oral dental form dated 6/6/16, please see that R75's teeth get brushed twice daily and needs a dental visit to evaluate root tips for removal and follow up dental visit to evaluate root tips.

R75's care plan had been reviewed and had not

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2 570	Continued From page 7 included the dentist recommendation to brush teeth twice daily. Interview with social worker (SW) on 3/2/17 at 1:33 p.m. the facility has a contracted dentist who comes to the facility to perform dental services for the residents. Families updated with dental recommendation if any during the care conferences. Review of the last dental appointment dated 6/6/16 assessment with SW and verified that there was to be a follow up recommendations from the dentist. At 2:16 p.m. social worker updated the last care conference was 2/22/17 and verified that there was no mention of follow up dental services for R75's to resident or family. The facility failed to update care plan with recommendations from dentist including not following through with a follow up appointment. Facility policy review titled Dental Services dated 6/2016 reads; routine and emergency services are available to meet the resident's oral health services in accordance with the residents assessment and plan of care. Policy review titled Assessment, Comprehensive dated 12/2016 reads the purpose; is to develop consistent quality care that will attain or maintain, the facility will complete a comprehensive assessment of the resident's needs. The assessment must include the following but not limited to dental and nutritional status, special treatment and procedures. The facility should use the results of the assessments to develop, review and revise the resident's comprehensive care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could	2 570		

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2 570	Continued From page 8 develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interviews and record review, the facility failed to shave 1 of 3 residents (R50) who is unable to carry out activities of daily living necessary to maintain good grooming. Finding included: During observation on 3/1/17, at 8:29 a.m. resident was sitting in her wheelchair at table for breakfast. Resident was fully dressed and up for the day. R50 noted to have white-gray whiskers on chin. On 3/2/17 at 7:10 a.m. R50 was sitting in small lounge across from nursing station fully dressed and continues to have white-gray whiskers on	2 920	Corrected	4/11/17

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2 920	Continued From page 9 chin. At 11:38 a.m. R50 was being assisted with lunch and noted to continue to have white-gray whiskers on her chin. On 3/3/17 at 8:15 a.m. resident was up fully dressed, sitting in her wheelchair, looking out her window, noted that facial hair had been removed. During interview on 3/2/17, at 9:39 a.m. nursing assistant (NA)-C stated that resident requires assistance with all her grooming and hygiene care. Shaving should be completed on bath day for women at least and then spot checked on a daily basis. During interview on 3/2/17, at 11:40 a.m. NA-A said, "I shave them every bath day and with some shave them more often if needed." During interview on 03/02/2017, at 11:47 a.m. NA-D stated "Her bath is once a week, fingernails and shaving is done with the bath." When asked what she would do for resident if needed to be shaved other than on bath day. Stated she would check with the nurse to see what I could do for them. I don't think the care sheet states specific regarding shaving. During interview on 3/2/17 at 12:48 p.m. with registered nurse (RN)-A, What is your expectations as to when grooming hygiene be completed, if someone needs shaving including women, RN-A said, "My expectation is they would do it with morning care." RN-A also stated, "I just checked with a couple of aides, they state that they will do it if they notice it with morning care. And if the resident will let them and if there is a razor available. Unless the resident is on Coumadin [blood thinning medication], then they let the nurse know."	2 920		

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2 920	Continued From page 10 During interview on 3/2/17, at 2:00 p.m. NA-B stated R50's bath is Monday. NA-B then said she had trimmed nails, shaved hair during bath. However, had not worked this past Monday so another NA completed her bath. During phone interview on 3/3/17 at 8:05 a.m. with R50's family member/power of attorney, regarding if it would bother her to have facial hair on her chin. She said, "Absolutely, it would have bothered her, she was a very pristine person and always wanted to look nice." During interview on 3/3/17 at 9:20 a.m. with DON and Administration, DON stated, My expectations would be that staff would shave facial hairs daily and as needed especially for females. Nursing Care bath list indicated that R50's scheduled bath day is on Monday a.m. R50's care plan last reviewed/revised on 1/20/17, indicated that R50 had self care deficit related to dementia and overall debility. She is dependent on staff assistance with all activities of daily living, which includes: hygiene and grooming (shaving, oral care, combing hair). MaDonna Towers of Rochester Activities of Daily Living (Daily Life Functions) Reviewed dated 10/16. Purpose of activities of daily living is to provide assistance to residents for daily life functions. MaDonna Towers of Rochester Shaving the Resident reviewed 12/20/16. Purpose of the procedure is to promote cleanliness and to provide skin care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could	2 920		

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2 920	Continued From page 11 provide training for all nursing staff related to providing activities of daily living (ADL's). The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure interpretation of tuberculin	21426	Corrected	4/11/17

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21426	Continued From page 12 skin tests (TST) included negative or positive readings for 4 of 5 residents (R38, R147, R150, R157) in the sample. Findings include: R38 received first step TST on 8/24/16, at 1:00 p.m., with results read on 8/26/16, at 1:45 p.m., as 0 millimeters (mm). R38 received second step TST on 9/7/16, at 2:22 p.m., with results read on 9/9/16, at 2:00 p.m., as 0 mm. The first and second step TST failed to include the reading of negative or positive as required. R147 received first step TST on 1/25/17, at 1:00 p.m., with results read on 1/27/17, at 1:26 p.m., as 0 mm. R147 received second step TST on 2/8/17, at 10:28 a.m., with results read on 2/10/17, at 11:27 a.m., as 0 mm. The first and second step TST failed to include the reading of negative or positive as required. R150 received first step TST on 2/2/17, at 1:30 p.m., with results read on 2/4/17, at 1:37 p.m., as 0 mm. R150 received second step TST on 2/16/17, at 4:00 p.m., with results read on 2/18/17, at 3:10 p.m., as 0 mm. The first and second step TST failed to include the reading of negative or positive as required. R157 received first step TST on 2/16/17, at 11:30 a.m., with results read on 2/18/17, at 11:45 a.m., as 0 mm. The first step TST failed to include the reading of negative or positive as required. Document review of facility TB (tuberculosis) Control Program Overview policy dated 8/2016, did not contain the requirement to include the negative or positive interpretation along with induration.	21426		

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21426	Continued From page 13 Document review of Minnesota Department of Health Tuberculosis Prevention and Control Program dated 7/2013, page 23, directed the following: TST documentation for residents should include the date (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative). If this information is not available, documentation of a history of infection with TB (e.g.,a previous positive skin test or history of active TB disease) by a physician in the resident ' s medical record is acceptable. During interview on 3/2/17, at 845 a.m., director of nursing verified the lack of interpretation of TST as negative or positive. SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures and update to include all required information. The director of nursing could educate nursing staff to record interpretation. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration;	21535		4/11/17

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21535	Continued From page 14 C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow physician orders for blood glucose checks for 1 of 5 residents (R52) reviewed for unnecessary medications. Findings include: R52's Resident Face Sheet dated 3/3/17, identified diagnosis of diabetes mellitus. R52's current physician orders included check blood glucose twice daily- staggered so one day before breakfast and supper, next day before lunch and at HS. Notify CNP (certified nurse practitioner) if BG (blood glucose) > (greater than) 300 or BG < (less than) 100 every shift. R52's current electronic care plan included problem: has diabetes mellitus requiring insulin	21535	Corrected	

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21535	Continued From page 15 therapy and approaches included monitor blood glucose/Accucheck as ordered and as needed for signs and symptoms of hypoglycemia/hyperglycemia. R52's medication/treatment administration records (MAR/TAR's) dated 1/1/17 through 3/2/17 identified notify CNP if BG >300 or BG <100 every shift and BG readings for the following dates: 1/4/17, at 6:00 a.m. 97, No CNP notified 1/11/17, at 8:00 p.m. 312, No CNP notified 1/14/17, at 4:00 p.m. 345, No CNP notified 1/17/17, at 8:00 p.m. 309, No CNP notified 1/19/17, at 8:00 p.m. 367, No CNP notified 1/26/17, at 6:00 a.m. 96, No CNP notified 1/27/17, at 8:00 a.m. 350, No CNP notified 1/31/17, at 8:00 p.m. 312, No CNP notified 2/1/17, at 8:00 p.m. 313, No CNP notified 2/3/17, at 8:00 p.m. 375, No CNP notified 2/6/17, at 6:00 a.m. 92, No CNP notified 2/11/17, at 8:00 p.m. 337, No CNP notified 2/14/17, at 4:00 p.m. 453, No CNP notified 2/17/17, at 8:00 p.m. 348, No CNP notified 2/19/17, at 8:00 p.m. 348, No CNP notified 2/21/17, at 8:00 p.m. 409, No CNP notified 2/27/17, at 8:00 p.m. 360, No CNP notified On 3/2/17, at 1:40 p.m., health information manager (HIM)-D and registered nurse (RN)-C stated when the doctor is notified the nurses would document the information in the resident progress notes and the SBAR (facility form) would be documented in the resident progress notes. RN-C confirmed R52's current physician order's included an order for notify CNP BG over 300 and below 100 and the order was on R52's medication/treatment administration record. RN-C confirmed staff were initialing on the MAR/TAR for the order. RN-C reviewed R52's record and	21535		

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21535	Continued From page 16	21535		

confirmed R52 had BG's over 300 and under 100 and R52's record lacked documentation of notifying the CNP of BG's over 300 and under 100. RN-C stated an SBAR (facility form) is filled out and placed on the CNP's desk for the next day in regards to notifying the CNP of BG's over 300 and under 100. RN-C stated the CNP-E is here Monday through Friday. RN-C stated we do not keep record of the SBAR's given to the CNP. RN-C confirmed R52's record lacked documentation the CNP was notified of BG's over 300 and under 100 at the time the BG's were obtained.

On 3/03/17, at 9:00 a.m., the director of nursing (DON) stated (when queried notifying the CNP of BG's over 300 and under 100) usually anytime the nurses complete and SBAR the nurses will document (regarding the SBAR completed) in the nurses notes. The DON confirmed R52's current physician order's included an order for notify CNP BG over 300 and below 100. The DON reviewed R52's record and confirmed R52's record lacked documentation of notifying the CNP of BG's over 300 and under 100. At the time, the administrator asked the DON if the SBAR is shredded and the DON replied I do not know what CNP-E does with them. The DON stated CNP-E is here Monday through Friday and reviews the SBAR's when here.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review/revise policy and provide education for staff regarding unnecessary medications. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21535	Continued From page 17 (21) days.	21535		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity for each resident according to needs for 1 of 1 resident (R75), who were dependent upon staff for toileting. Findings: R75's quarter Minimum Date Set (MDS) dated 2/16/17 identifies R75 functional status for toilet use is extensive assist of one person. R75 is moderately impaired with a score or 9 out of 15 on the Brief Interview for Mental Status (cognitive assessment), bowel and bladder assessment is frequently incontinent of bowel meaning at least once per week. R75's care plan reads alteration in elimination, is incontinent of bowel and bladder, R75 requires assistance to the toilet with one person and the stand aide (a device/machine that assist the resident to stand and transfer while on a platform). R75 also has an alteration in mobility, decreased strength and endurance with an intervention for prompt to toilet after meals and	21805	Corrected	4/11/17

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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) COMPLETE DATE
21805	Continued From page 18	21805		

bedtime and on first night rounds.

Nursing assistants care guide reads assist of one person with toileting, do not leave sitting in her room in her wheel chair and is incontinent of bowel and bladder.

Observation on 3/2/17 at 8:03 a.m. noted R75 wheeling self from dining room out in the hall, activity aide (AA)-A came up behind R75 and offered to assist her to her room, once in room R75 said to (AA)-A she had to use the bathroom. (AA)-A said in response to request to use bathroom, "I have to get help." R75 repeated, "I have to go to the bathroom, I have to go bad!" (AA)-A said, "I'll go find someone.

Twenty four minutes later at 8:27 a.m. R75 was observed in room crying and on entering her room there was a strong smell of stool. When R75 saw surveyor she lifted hand and asked for help. Surveyor immediately notified NA-H who had been standing by the nursing station. It was also noted that R75's call light was activated and staff had not responded to the light. At 8:30 a.m. NA-H and surveyors entered R75's room and R75 continued to cry. NA-H was observed to help remove R75's pants while seated on toilet. NA-H said R75 had soiled her pants with stool. R75 continued to cry from the time NA-H entered room to assist with toileting until NA-H had completed cleaning the incontinent episode. After helping R75 to bed, NA-H ask if "ok", R75 said "No"

An interview with social worker (SW) on 3/2/17 at 1:44 p.m. included the sharing of R75's incontinent of stool and having to wait for assistance even though R75 had informed staff of urgent need to use toilet. SW would expect staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00419	A. BUILDING: _____ B. WING _____	C 03/03/2017

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21805	Continued From page 19 to assist right away. SW stated it would not be good if resident had an accident while waiting for help. Interview on 3/2/17 at 3:06 p.m. with director of nursing (DON) and administrator concerning incontinent episode for R75 yesterday and lack of timely assistance. The DON and administrator both said their goal for answering lights timely is 10 minutes if resident calls for help by activation call light. On asking how long residents should expect to wait when they verbally say to staff they need to use bathroom immediately. Again both DON and administrator agreed that the goal would still be 10 minutes maximum to respond to request. Policy review titled Quality of Life-Dignity dated 12/16 reads under the policies interpretation and implementation; Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: Promptly responding to the residents request for toileting assistance. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		