DEPARTMENT OF HEALTI	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: J7YX
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00419
1. MEDICARE/MEDICAID PROVIDE NO.(L1) 245153	ER	3. NAME AND AL (L3) MADONNA			TER INC	4. TYPE OF ACTION: <u>7(</u> L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID (L2) 931216100	NO.	(L4) 4001 19TH A (L5) ROCHESTE		RTHWEST	(L6) 55901	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF 0 (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>03</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 DATE OF SURVEY 04/2 ACCREDITATION STATUS: 	20/2017 ^(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	V	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re			2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	62 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
13.Total Certified Beds	62 (L17)	B. Not in Comp	liance with Progr		5. Life Safety Code	9. Beds/Room
13. Total Certified Beds	02 (217)	-	and/or Applied		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	WN	-			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
2 60					(-)(-)(-)(-).	
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	AKKS (IF APPLICA	ABLE SHOW LIC CA	INCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Sarah Strenke, HFE II		0	6/29/2017	(L19)	Kamala Fiske-Downing.	Enforcement Specialist 06/29/2017 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBIL	ITY		IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572)
1. Facility is Eligible to P	articipate	RIGE	ITS ACT:		2. Ownership/Contro 3. Both of the Above	bl Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible						
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNINC	6 DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
03/14/1968					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL
	· · =/			()	PETERMINALION ALL	



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,

ate Comston

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



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 cc: Licensing and Certification File



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	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAL	D SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID:	J7YX
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Faci	lity ID: 00419
1. MEDICARE/MEDICAID PROVIDE (L1) 245153 2.STATE VENDOR OR MEDICAID N		 NAME AND AI (L3) MADONNA (L4) 4001 19TH A 	TOWERS OF	FROCHES		3. Termination	<u>2 (</u> L8) 2. Recertification 4. CHOW
(L2) 931216100		(L5) ROCHESTE	ER, MN		(L6) 55901		6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF O (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>03</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Co	
6. DATE OF SURVEY 03/03/	- ()	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X Daw	10 NF	14 CORF	FISCAL YEAR ENDING	DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:	:
To (b):		0	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Servic	
		1. A	cceptable POC		4. 7-Day RN (Rural SN		
12.Total Facility Beds	62 (L18)				5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	62 (L17)	X B. Not in Con Requirements	npliance with Pro and/or Applied	-	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
2 60							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Danette Bakken, HFE I	I	0	3/31/2017	(L19)	Kamala Fiske-Downing.	Enforcement Specialis	st 05/09/2017 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	
 DETERMINATION OF ELIGIBILI 1. Facility is Eligible to Pa 	TY	20. COM	IPLIANCE WIT ATS ACT:		21. 1. Statement of Fina	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HC	2FA-1513)
2. Facility is not Eligible	(L21)				5. Boul of the Above		
	(121)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30))
OF PARTICIPATION 03/14/1968	BEGINNINC	J DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	<u>INVOLUNTA</u> 05-Fail to Mee	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Mee	t Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider St	atus Change
(L27)	B. Rescind St	spension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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:

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

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

<u>Remedies</u> - 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

<u>Informal Dispute Resolution</u> - 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 <u>Email: gary.nederhoff@state.mn.us</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumalu 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
				·		С
		245153	B. WING			03/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
MADONN	A TOWERS OF ROO	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 000			
	as your allegation of Department's acce enrolled in ePOC, at the bottom of the form. Your electron	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 241 SS=D	on-site revisit of yo validate that substa regulations has be your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with ITY AND RESPECT OF	F 241			4/11/17
	resident in a mann promotes mainten her quality of life re- individuality. The fa promote the rights This REQUIREME by: Based on observa- review, the facility	st treat and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident. NT is not met as evidenced tion, interview, and document failed to promote dignity for ording to needs for 1 of 1		Madonna Towers of Roch and care for residents in a environment that maintain	manner and an	
	resident (R75), wh for toileting. Findings:	o were dependent upon staff		each resident's dignity and recognition of his or her in- facility policies and proced protect and promote the rig residents.	dividuality. The ures address,	
	2/16/17 identifies F use is extensive as moderately impaire	mum Date Set (MDS) dated R75 functional status for toilet ssist of one person. R75 is ed with a score or 9 out of 15 ew for Mental Status (cognitive		The staff routinely interact and provide care and serv support and enhance their and self-worth including ne	ices that self-esteem	

Electronically Signed

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.

		AND HUMAN SERVICES				APPROVE 0938-039
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY PLETED
		245153	B. WING _		() () () () () () () () () () () () () (C 0 3/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/0	55/2017
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 241	Continued From pa	-	F 24			
	frequently incontine once per week.	el and bladder assessment is ent of bowel meaning at least		assistance with activities of daily (grooming, dressing, bathing, eat toileting) as identified in the comprehensive assessment and	ing, and	
	incontinent of bowe assistance to the to	ads alteration in elimination, is el and bladder, R75 requires bilet with one person and the e/machine that assist the		in the plan of care. The facility policy addressing diging quality of life was reviewed and for		
1	resident to stand ar platform). R75 also	has an alteration in mobility, and endurance with an		appropriate. The activity staff was immediately educated about individualized toi	/	
		mpt to toilet after meals and		plans and the need for prompt no of the appropriate staff to respon residents' care requests.	ed for prompt notification e staff to respond to	
	person with toileting	care guide reads assist of one g, do not leave sitting in her chair and is incontinent of		During the April 4 and 6, 2017 ma educational meetings, all staff will reminded of the resident's right to dignified and respectful treatmen	l be 1)	
	wheeling self from activity aide (AA)-A	/17 at 8:03 a.m. noted R75 dining room out in the hall, .came up behind R75 and		reinstructed on the need for time response to care requests, espec urgent requests for toileting and 3	y cially 3)	
	R75 said to (AA)-A (AA)-A said in resp	r to her room, once in room she had to use the bathroom. onse to request to use o get help." R75 repeated, "I		informed that the facility policy is respond to requests as soon as p with a prompt response time defi ten minutes or less. The Staff	ossible	
	have to go to the ba (AA)-A said, "I'll go	athroom, I have to go bad!" find someone.		Development Coordinator will con instruct new employees on reside rights as part of the orientation pr	ents' ocess.	
	observed in room c room there was a s	s later at 8:27 a.m. R75 was crying and on entering her trong smell of stool. When she lifted hand and asked for		The residents' right to respect an is also addressed as part of the a employee education/training.		
	had been standing also noted that R75	ediately notified NA-H who by the nursing station. It was 5's call light was activated and nded to the light. At 8:30 a.m.		The care plan for resident number reviewed. The plan appropriately staff to transport the resident to h after meals when there is staff av	instructs er room	
	NA-H and surveyor	rs entered R75's room and ry. NA-H was observed to help		immediately assist her with toileti resident's plan of care will continu	ng. The	

Facility ID: 00419

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
				_		С
		245153	B. WING _			/03/2017
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	
MADONI	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 241	Continued From pa	age 2	F 24	11		
	said R75 had soiled	s while seated on toilet. NA-H d her pants with stool. R75 om the time NA-H entered			reviewed and revised at least quarterly and with changes in condition.	
	completed cleaning	vith toileting until NA-H had ning the incontinent episode. 75 to bed, NA-H ask if "ok", R75			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	
	1:44 p.m. included incontinent of stool assistance even the urgent need to use to assist right away good if resident had	ocial worker (SW) on 3/2/17 at the sharing of R75's and having to wait for ough R75 had informed staff of toilet. SW would expect staff v. SW stated it would not be d an accident while waiting for			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	
	nursing (DON) and incontinent episode timely assistance. both said their goal 10 minutes if reside call light. On askin expect to wait when need to use bathro DON and administr	at 3:06 p.m. with director of administrator concerning of or R75 yesterday and lack of The DON and administrator for answering lights timely is ent calls for help by activation g how long residents should n they verbally say to staff they om immediately. Again both rator agreed that the goal inutes maximum to respond to			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	12/16 reads under implementation; De standards of care t prohibited. Staff sh residents as neede the residents reque	Quality of Life-Dignity dated the policies interpretation and emeaning practices and hat compromise dignity are nall promote dignity and assist of by: Promptly responding to est for toileting assistance. y(3),483.21(b)(2) RIGHT TO	F 28			4/11/17

Facility ID: 00419

If continuation sheet Page 3 of 17

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY
			A. BUILD	ING	à		C
		245153	B. WING			03/	03/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 SS=D	PARTICIPATE PLA 483.10 (c)(2) The right to p	NNING CARE-REVISE CP	F 2	280			
	and implementation	n of his or her person-centered ing but not limited to:					
	including the right to be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to and the right to request son-centered plan of care.					
	expected goals and amount, frequency,	icipate in establishing the d outcomes of care, the type, , and duration of care, and any d to the effectiveness of the					
	(iv) The right to rece included in the plan	eive the services and/or items of care.					
		the care plan, including the gnificant changes to the plan					
	right to participate in	nall inform the resident of the n his or her treatment and sident in this right. The nust					
	(i) Facilitate the incl resident representa	lusion of the resident and/or ttive.					
	(ii) Include an asses strengths and need	ssment of the resident's ls.					
	(iii) Incorporate the	resident's personal and					

Facility ID: 00419

If continuation sheet Page 4 of 17

		AND HUMAN SERVICES				FORM	APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				· · /	PLETED
							C
		245153	B. WING			03/0	03/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	NA TOWERS OF ROC	HESTER INC			ROCHESTER, MN 55901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
- 000							
F 280		-	F 2	280			
	cultural preterences	s in developing goals of care.					
	483.21						
	(b) Comprehensive	Care Plans					
	(2) A comprehensiv	ve care plan must be-					
	(i) Developed within the comprehensive	n 7 days after completion of assessment.					
	(ii) Prepared by an i includes but is not I	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	rse with responsibility for the					
	(C) A nurse aide wit resident.	th responsibility for the					
	(D) A member of fo	od and nutrition services staff.					
	the resident and the An explanation mus medical record if the and their resident re	racticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the n.					
		te staff or professionals in mined by the resident's needs the resident.					
		revised by the interdisciplinary sessment, including both the d quarterly review					

If continuation sheet Page 5 of 17

		AND HUMAN SERVICES	-		FORM	04/05/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING _			03/2017
NAME OF I	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STAT		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTH ROCHESTER, MN 55901	WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From pa	-	F 28	80		
	by: Based on observat review, the facility f include frequency of residents (R33 and status. Findings Include: R33's Chart Progree provider dated 1/23 diagnoses/assessm related to early chro Treatment: encoura line during twice da R33's current elector Problem: Dental ne assessment notatio recession, extensiv bone (#21) with ora observe and treat if Approaches include Has own teeth whic risk for cavities. Ora Report signs/sympt chipped teeth for for needed. Problem: S above knee amputa left below knee amp with activities of da Oral care assist of lacked dentist reco twice each day.	nent: generalized recession onic periodontal disease. age R33 to focus along gum ily brushing. ronic care plan identified: reds related to dental on of xerostomia, gum line re restoration and exposed al surgery consult opting to develops pain/symptoms. ed: Dental consults as ordered. ch are heavily restored and at al care; $A \ge 1$ (assist of one). toms of mouth pain, missing or allow up with provider as Self-care deficit related to right ation stump revision with prior putation requires assistance ily living. Approaches included: one (set up). However, it mmendation to brush teeth		Madonna Towers of develop comprehensis seven days after the of comprehensive asses are prepared by an in which includes the attr registered nurse with resident, and other ap Professional discipling plan and provide nece enhance the residents and quality of life. The families/legal represe encouraged to particip planning process and conferences to the gr possible. Care plans a reviewed and revised qualified persons after assessment and more necessary. The care plan and de and procedures were appropriate. Accordin a standard of care, re assisted with oral care evening. During the n April 4 and 6, 2017, th be 1) informed of the requirement that the re be current at all times the facility policies for and updates and 3) re importance of includir interventions that add	ive care plans within completion of the ssment. Care plans terdisciplinary team, tending physician, a responsibility for the opropriate staff. es work together to essary services to s' functional abilities e residents and their ntatives are pate in the care the quarterly care eatest extent are routinely by a team of er each quarterly e often as ntal services policies reviewed and found g to facility policy as esidents are routinely e in the morning and nandatory meetings ne nursing staff will regulatory residents' care plans s' 2) reinstructed on care plan reviews eminded of the ng care plan	

Facility ID: 00419

If continuation sheet Page 6 of 17

		& MEDICAID SERVICES				MB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY PLETED
		245153	B. WING				C 03/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MADONI	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 280	Continued From pa	ige 6	F 2	80			
	On 3/2/17, at 8:58 a sitting up in her who time nursing assista assisted R33 with g stated when querie cares, NA-G stated cares herself after help. At the time, R her teeth. On 3/3/17, at 8:54 a (DON) stated our c in regards to includ teeth. Our expectat do oral cares with a queried regarding t dental provider to e gum line during twid included on the car that is how you sho The DON confirme was not included on R75's significant M 9/15/16 reads obvio natural teeth. R75's oral cavity as reads obvious or lik teeth and inflamed natural teeth with a assistance and stat cares. Summary of describe last denta showed multiple roo	a.m. R33 was observed to be eelchair in her room. At the ant (NA)-G stated she had getting up this a.m. NA-G d if had assisted R33 with oral usually R33 completes oral we set up, when R33 asks for 33 stated she had not brushed a.m., the director of nursing are plans are not that specific ing frequency of brushing ion is nursing assistants are to a.m. and p.m. cares. When reatment order from R33's uncourage R33 to focus along ce daily brushing to be e plan, the DON stated I think uld brush everybody's teeth. d frequency of brushing teeth			in addition to the routine cares add in the facility's oral care policies an procedures (twice daily oral care is standard of care). The facility's contract dental service a report of their findings/recommendations to the re- and/or the resident's legal represe A licensed nurse routinely reviews report. During the April meetings, t nurses will be instructed to ensure oral hygiene recommendations are to the care plan and the certified no assistant care guides if they are in addition to the routine standard of addressed in the facility policy and recommendations for additional de care are discussed with the reside legal representative and follow up appointments are arranged as nec Resident number 33 – The reside care plan and the certified nursing assistant care guide were updated reflect twice daily brushing with att given to brushing along the gum lir resident's oral hygiene/dental need be addressed during the quarterly conferences and more often if nee The care plan will be updated with changes in the resident's oral hygin needs. Resident number 75 – The June 6	e sends esident ntative. the he that 1) e added ursing care 2) that ental nt's essary. nt's to ention ne. The ds will care eded. ene	
	cares twice a day.	Dentist recommended dental ps for removal. Social services			dental report for follow up care incl twice daily brushing and evaluation tips for removal. The social worker discussed the dentist's recommend	udes of root	

Facility ID: 00419

If continuation sheet Page 7 of 17

		& MEDICAID SERVICES			<u>DMB NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245153	B. WING		()	C)3/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/0	J3/2017
	NA TOWERS OF ROC	CHESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 280	6/6/16, please see twice daily and new root tips for remova evaluate root tips. R75's care plan ha included the dentis teeth twice daily. Interview with socia 1:33 p.m. the facilit comes to the facilit the residents. Fan recommendation if conferences. Revie appointment dated and verified that th recommendations social worker upda was 2/22/17 and ve mention of follow u resident or family. The facility failed to recommendations following through w Facility policy revie 6/2016 reads; routi are available to me services in accorda assessment and p Policy review titled dated 12/2016 reads	ntist oral dental form dated that R75's teeth get brushed eds a dental visit to evaluate al and follow up dental visit to d been reviewed and had not t recommendation to brush al worker (SW) on 3/2/17 at ty has a contracted dentist who y to perform dental services for nilies updated with dental any during the care ew of the last dental 6/6/16 assessment with SW ere was to be a follow up from the dentist. At 2:16 p.m. ted the last care conference erified that there was no p dental services for R75's to o update care plan with from dentist including not vith a follow up appointment. w titled Dental Services dated ne and emergency services bet the resident's oral health ance with the residents	F 280		r reports r dental g mouth are ore ral will ncing ant review acility's that 1) cussed ent's soutine y's oeen ertified view of ed by ry team for vancy e anges in ssary. To ed as a e	

Facility ID: 00419

If continuation sheet Page 8 of 17

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE			0938-039 SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:					PLETED
							C
		245153	B. WING			03/0	03/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MADON	A TOWERS OF ROC	HESTER INC			01 19TH AVENUE NORTHWEST DCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 280	treatment and procuse the results of the	ge 8 d nutritional status, special edures. The facility should ne assessments to develop, he resident's comprehensive	F 2	280			
F 282 SS=D	•	RVICES BY QUALIFIED ARE PLAN	F 2	282			4/11/17
		ive Care Plans led or arranged by the facility, comprehensive care plan,					
	accordance with ea care.	qualified persons in tch resident's written plan of NT is not met as evidenced					
	by: Based on interview review, the facility fa	v, observation and document ailed to follow the plan of care f 3 residents (R75) reviewed			Madonna Towers of Rochester, Inc. provides services that meet profession standards of quality and are delivered appropriately qualified persons (e.g., licensed, certified) in accordance with	d by	
	Findings: R75's Minimum Da	ta Set (MDS) dated 2/16/17			each resident's written plan of care. T interdisciplinary care planning team 1 uses an assessment process to deve	Гhe)	
	reads obvious/likely cavity or broken natural teeth. Functional status is extensive assist of one person for personal hygiene.				an individualized care plan for each resident that supports the highest practicable level of function and well- 2) implements procedures and practic		
	reads obvious or lik teeth and inflamed natural teeth with a	sessment dated 2/16/17 ely cavity or broken natural or bleeding gums or loose n intervention of oral hygiene if assist resident with oral			as outlined in the plan 3) reviews the at least quarterly and with significant changes in condition and 4) makes modifications as necessary.	plan	
	cares. Summary of describe last dental	f finding and plan of care l appointment on 6/6/16 ot tips, obvious decayed teeth			The facility has policies and procedur for developing individualized plans of and communicates the plan to the dir	care	

Facility ID: 00419

If continuation sheet Page 9 of 17

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	_ COM	PLETED
		245153	B. WING			C 03/2017
NAME OF	PROVIDER OR SUPPLIER	240100		STREET ADDRESS, CITY, STA		J3/2017
	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTH ROCHESTER, MN 5590	IWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 282	Continued From pa	age 9	F 28	32		
	cares twice a day. evaluation of root ti notified regarding th R75's care plan rea related to decrease assist of one perso During an observat Nursing assistant (I R75 before breakfa with NA-H assist to breakfast by NA-H. Interview with NA-E verified that R75's of breakfast attempts NA-E asked if that	ads that R75 has a self-deficit ed mobility as an intervention in for oral care. tion on 3/2/17 at 7:04 a.m. NA)-E did not offer oral care to ast. At 8:30 a.m., R75 in room b bed no oral care offered after		care guides. The car procedures were rev more clearly address living. During the April 4 an meetings, the nursin reminded/instructed plans of care must b providing oral hygier the facility's standard that job performance being aware of and f	viewed and revised to s activities of daily d 6, 2017, mandatory g staff will be 1) that the residents' the followed 2) that he cares twice daily is d of practice and 3) e expectations include following the re including oral care. ew employees will the importance of it's plan of care for	
	nurse (RN)-B on 3/ mouth found with b decay and caps on 12:13 p.m. asked a how staff updated o should receive. RN and in general, staf RN-B reviewed the that nothing listed f care twice daily as last exam. RN-B st care to brush teeth Interview with Direo 3/2/17 at 2:59 p.m.	essessment with registered 2/17 at 12:07 p.m. of R75's proken and missing teeth with teeth. Interview with RN-B at about oral care for R75 and of what cares the resident I-B stated it is in the care plan ff are to complete oral care. NA's care guide and found for R75 to have staff give oral the dentist recommended on ated that it is a standard of and give oral care daily.		the most recent report contracted dental set to ensure that all reconnected hygiene cares outsid (morning and evening as a standard of pra- policy/procedures ar care plan and the ce assistant resident car will be updated as ne ongoing monitoring of and oral hygiene need a routine standard of ongoing compliance needs have been and discussion topic and	rvice will be reviewed commended oral le of the twice daily ng) oral cares defined ctice by facility e addressed in the ortified nursing are guides. Care plans eeded to reflect of dental concerns eds not addressed as f practice. To ensure , oral care/dental ided as a specific	

Facility ID: 00419

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING			C 03/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		03/2017
MADONI	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	RY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD Y OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) DEFICIENCY)		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 282	that oral cares are fonce in the morning Facility policy review 10/16 reads standa out activities of dail services to maintain staff will provide as	ge 10 to be given twice daily at least g and once at bedtime w titled Oral Hygiene dated rd is residents unable to carry y living receive the necessary n good oral hygiene. Nursing sistants with oral hygiene to y morning, night and as	F 28	32 noncompliance is noted, a auditing and staff training Compliance will be review quarterly Quality Council r	will be done. ed at the April	
F 312 SS=D	DEPENDENT RES (a)(2) A resident wh activities of daily liv services to maintain personal and oral h This REQUIREMEN by:	no is unable to carry out ing receives the necessary n good nutrition, grooming, and ygiene. NT is not met as evidenced	F 31			4/11/17
	review, the facility (R50) who is unable living necessary to Finding included: During observation resident was sitting breakfast. Resider the day. R50 noted on chin. On 3/2/17 at 7:10 a lounge across from and continues to ha chin. At 11:38 a.m. lunch and noted to whiskers on her chi	tion, interviews and record failed to shave 1 of 3 residents to carry out activities of daily maintain good grooming. on 3/1/17, at 8:29 a.m. in her wheelchair at table for at was fully dressed and up for to have white-gray whiskers .m. R50 was sitting in small nursing station fully dressed ave white-gray whiskers on R50 was being assisted with continue to have white-gray in. .m. resident was up fully		Madonna Towers of Roch provides the necessary se maintain good nutrition, gr personal care and oral hyg the comprehensive reside the staff provides cares will resident to maintain and e self-esteem and self-worth assistance with removal o according to resident prefe outlined in the plan of care need for assistance with p hygiene/grooming is reas and with significant chang The plan of care is revised The procedure for removin was reviewed and revised mandatory meetings April	ervices to rooming, giene. Based on nt assessment, hich assist the nhance his/her n including f facial hair erences and as b. The residents' rersonal sessed quarterly es in condition. d as necessary. ng facial hair . During the	

Facility ID: 00419

If continuation sheet Page 11 of 17

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	SURVEY
		A. BUILDI	NG _			
	245153	B. WING			03/0	3/2017
PROVIDER OR SUPPLIER						
IA TOWERS OF ROC	HESTER INC					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	¢	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
Continued From pa	age 11	F 3	12			
dressed, sitting in h window, noted that During interview or assistant (NA)-C st assistance with all care. Shaving shou for women at least daily basis. During interview or said, "I shave them During interview or NA-D stated "Her b and shaving is don what she would do shaved other than check with the nurs them. I don't think the regarding shaving. During interview or registered nurse (F expectations as to completed, if some women, RN-A said would do it with mo "I just checked with that they will do it if care. And if the resi is a razor available Coumadin [blood the	her wheelchair, looking out her facial hair had been removed. A 3/2/17, at 9:39 a.m. nursing ated that resident requires her grooming and hygiene and then spot checked on a A 3/2/17, at 11:40 a.m. NA-A in every bath day and with more often if needed." A 03/02/2017, at 11:47 a.m. bath is once a week, fingernails e with the bath." When asked for resident if needed to be on bath day. Stated she would be to see what I could do for the care sheet states specific A 3/2/17 at 12:48 p.m. with RN)-A, What is your when grooming hygiene be one needs shaving including d, "My expectation is they orning care." RN-A also stated, a couple of aides, they state they notice it with morning ident will let them and if there . Unless the resident is on hinning medication], then they			the facility's policies for providing per hygiene/grooming to the residents a reminded that their job description requires knowledge of and respons for following the residents' plans of and 3) instructed on the facility policy removing facial hair and the importa- shaving female residents with exce facial hair unless the resident/legal representative prefers otherwise. The need to provide cares as necessary improve/enhance the residents' appearance, comfort, and dignity as as respect for their preferences will emphasized. The grooming plan of care for reside number 50 was reviewed and found appropriate in addressing the reside personal care needs. The direct can are aware of the need to shave the resident's chin hairs as part of the r grooming/bathing procedures. The Activity Director/designee will be responsible for monitoring compliar randomly checking female resident excessive chin hair during large gro activities for two weeks. If noncomp is noted, the clinical manager will be notified and additional monitoring a staff training will be done. Ongoing monitoring for excessive facial hairs be done weekly as part of the bathi	ersonal 2) ibility care cy for ance of ssive he y to s well be lent d ent's re staff routine be nce by s for outine ence by s for outine ence staff routine be s for outine ence staff routine be s for outine ence staff routine be s for outine ence staff routine be s for outine ence staff routine be s for outine ence staff routine s for outine ence staff routine s for outine ence staff routine s for outine ence staff routine s for outine ence staff routine ence staff routine ence staff s for outine ence staff routine ence staff routine enc	
	Continued From pa dressed, sitting in h window, noted that During interview or said, "I shave them some shave them During interview or said, the would do shaved other than check with the nurs them. I don't think the regarding shaving. During interview or NA-D stated "Her ba and shaving is don what she would do shaved other than check with the nurse them. I don't think the regarding shaving. During interview or registered nurse (F expectations as to completed, if some women, RN-A said would do it with mo "I just checked with that they will do it if care. And if the res is a razor available Coumadin [blood the let the nurse know. During interview or	DF CORRECTION IDENTIFICATION NUMBER: 245153 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	OF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTA A. BUILDI 245153 B. WING PROVIDER OR SUPPLIER 245153 VA TOWERS OF ROCHESTER INC ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFID REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 dressed, sitting in her wheelchair, looking out her window, noted that facial hair had been removed. F 3 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. F 3 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	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: 245153 B. WING PROVIDER OR SUPPLIER 245153 B. WING VA TOWERS OF ROCHESTER INC ID SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 312 Continued From page 11 F 312 dressed, sitting in her wheelchair, looking out her window, noted that facial hair had been removed. F 312 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. F 312 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." F 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 stat	OP DEFICIENCIES (X1) PROVIDERSUPPLIENCUA (X2) MULTIPLE CONSTRUCTION PROVIDER OR SUPPLIER 245153 B. WING AT OWERS OF ROCHESTER INC STREET ADDRESS, CITY, STATE, ZIP CODE MATOWERS OF ROCHESTER INC STREET ADDRESS, CITY, STATE, ZIP CORE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY ON LSC IDENTIFYING INFORMATION) IP Continued From page 11 dressed, sitting in her wheelchair, looking out her window, noted that facial hair had been removed. F 312 Continued From page 11 dressed, sitting in her wheelchair, looking out her window, noted that facial hair had been removed. F 312 During interview on 3/2/17, at 13:40 a.m. NA-A said, "I shave them grooming and hygiene care. Shaving should be completed on bath day for women at least and the spot checked on a daily basis. F 312 During interview on 3/2/17, 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." The grooming plan of care for residents' appearance, comfort, and dignity av ergonoming 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 the resident is on coumadin [blood thinning medication], then they is a razor available. Unless the resident is on coumadin [blood thinning medication], then they is noted, the chincal manager will be avaiting recess. Compliance will be call hair that they will do it if t	OP DEFICIENCIES F CORRECTION (X1) PROVIDERSUPPLIER(ULA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) MUDING 245153 B. WING 0300000000000000000000000000000000000

Facility ID: 00419

If continuation sheet Page 12 of 17

		AND HUMAN SERVICES			FORM	04/05/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	СОМ	E SURVEY PLETED C
		245153	B. WING) 03/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	However, had not v another NA comple During phone interview with R50's family m regarding if it would on her chin. She sa bothered her, she v always wanted to lo During interview on and Administration, would be that staff and as needed esp Nursing Care bath scheduled bath day R50's care plan las indicated that R50 I dementia and overa on staff assistance which includes: hyg oral care, combing MaDonna Towers of Living (Daily Life Fu 10/16. Purpose of a provide assistance functions.	vorked this past Monday so ted her bath. view on 3/3/17 at 8:05 a.m. nember/power of attorney, d bother her to have facial hair id, "Absolutely, it would have vas a very pristine person and bok nice." 3/3/17 at 9:20 a.m. with DON DON stated, My expectations would shave facial hairs daily ecially for females. list indicated that R50's v is on Monday a.m. t reviewed/revised on 1/20/17, had self care deficit related to all debility. She is dependent with all activities of daily living, jiene and grooming (shaving, hair). of Rochester Activities of Daily unctions) Reviewed dated activities of daily living is to to residents for daily life	F 312			
F 329 SS=D	Resident reviewed procedure is to proprovide skin care. 483.45(d)(e)(1)-(2) FROM UNNECESS		F 329			4/11/17
	483.45(d) Unneces	sary Drugs-General.				

If continuation sheet Page 13 of 17

		AND HUMAN SERVICES				FORM	04/05/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 03/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MADONN	A TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	unnecessary drugs drug when used (1) In excessive do therapy); or (2) For excessive do (3) Without adequa (4) Without adequa (5) In the presence which indicate the o discontinued; or (6) Any combination paragraphs (d)(1) t 483.45(e) Psychotr Based on a compre- resident, the facility (1) Residents who drugs are not given medication is neces condition as diagno clinical record; (2) Residents who gradual dose reduc interventions, unles an effort to disconti This REQUIREMEN	ag regimen must be free from . An unnecessary drug is any se (including duplicate drug luration; or the monitoring; or the indications for its use; or of adverse consequences dose should be reduced or ns of the reasons stated in hrough (5) of this section. opic Drugs. ehensive assessment of a r must ensure that have not used psychotropic these drugs unless the ssary to treat a specific osed and documented in the use psychotropic drugs receive stions, and behavioral as clinically contraindicated, in		329			
	by: Based on interview	v and document review, the			Madonna Towers of Rochester sta	ff	

Facility ID: 00419

If continuation sheet Page 14 of 17

STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	i		C
		245153	B. WING			- 03/2017
NAME OF I	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROO	CHESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 329	Continued From pa	age 14	F 329			
	facility failed to foll glucose checks for	ow physician orders for blood r 1 of 5 residents (R52) cessary medications.		ensure that each resident's drug free from unnecessary drugs. T resident's drug regime is routing	he	
Findings R52's Re identified R52's cu blood glu before br lunch and	Findings include:			reviewed by the interdisciplinary team, physician and consultant	care	
		ce Sheet dated 3/3/17, s of diabetes mellitus.		pharmacist to assure that media not used in excessive doses, fo excessive duration, without ade monitoring, without adequate in	r quate	
	blood glucose twic before breakfast a lunch and at HS. N	sician orders included check e daily- staggered so one day nd supper, next day before lotify CNP (certified nurse (blood glucose) > (greater		or in the presence of adverse consequences which indicate th should be reduced or the drug discontinued.		
	than) 300 or BG <	(less than) 100 every shift.		Each resident's medication regi continue to be reviewed by the pharmacist monthly and by the	consultant	
	problem: has diabe therapy and appro-	etes mellitus requiring insulin aches included monitor blood ks as ordered and as needed		physician/nurse practitioner dur 30/60 day visits and more often indicated. The staff notify the ph designated clinician of circumst	as as nysician or	
	hypoglycemia/hype			which may impact the administr of prescribed medications. For emergency communication with	ation/dose non	
	records (MAR/TAF identified notify CN	R's) dated 1/1/17 through 3/2/17 IP if BG >300 or BG <100 readings for the following		prescribing clinician, the Situation Background, Assessment, Recommendation (SBAR) form To verify communication with th	on, is used.	
	1/4/17, at 6:00 a.m 1/11/17, at 8:00 p.r 1/14/17, at 4:00 p.r	n. 97, No CNP notified m. 312, No CNP notified m. 345, No CNP notified		the SBÁR form will now be uplo the electronic medical record.	aded to	
	1/19/17, at 8:00 p. 1/26/17, at 6:00 a. 1/27/17, at 8:00 a.	m. 309, No CNP notified m. 367, No CNP notified m. 96, No CNP notified m. 350, No CNP notified m. 312, No CNP notified		During the mandatory meetings and 6, 2017, the licensed nursir be instructed on the new filing/r procedures for SBAR forms. Du	ng staff will etention uring the	
	2/1/17, at 8:00 p.m 2/3/17, at 8:00 p.m	m. 312, No CNP notified n. 313, No CNP notified n. 375, No CNP notified n. 92, No CNP notified		consultant pharmacist's monthly medication audits and the quart conferences, the resident's med will continue to be reviewed to a	erly care dications	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/05/201 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245153	B. WING			03/0	C)3/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	A TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 329	2/14/17, at 4:00 p.m 2/17/17, at 8:00 p.m 2/19/17, at 8:00 p.m 2/21/17, at 8:00 p.m 2/21/17, at 8:00 p.m 2/27/17, at 8:00 p.m On 3/2/17, at 1:40 p manager (HIM)-D a stated when the dow would document the progress notes and would be document notes. RN-C confirr order's included an 300 and below 100 medication/treatme confirmed staff wer for the order. RN-C confirmed R52 had and R52's record la notifying the CNP o 100. RN-C stated a out and placed on t day in regards to no 300 and under 100. here Monday throug	 a. 337, No CNP notified b. 453, No CNP notified b. 348, No CNP notified b. 348, No CNP notified b. 348, No CNP notified b. 409, No CNP notified b. 409, No CNP notified c.m., health information nd registered nurse (RN)-C ctor is notified the nurses e information in the resident the SBAR (facility form) red in the resident progress ned R52's current physician order for notify CNP BG over and the order was on R52's nt administration record. RN-C e initialing on the MAR/TAR reviewed R52's record and BG's over 300 and under 100 cked documentation of f BG's over 300 and under n SBAR (facility form) is filled he CNP's desk for the next tifying the CNP of BG's over RN-C stated the CNP-E is gh Friday. RN-C stated we do he SBAR's given to the CNP. 	F 3	29	medication use is being adequated monitored and documented. For resident number 52, the physician/nurse practitioner was ro notified of blood sugar readings ou the acceptable parameters. On da clinician was at the facility, the SB/ was used to notify him/her of high/ blood sugar readings. On days a c was not in the building, the outcall physician was notified of blood sug readings outside of acceptable parameters. The staff is aware of t facility policy requiring that cliniciar notification of high/low blood sugar readings must be verified in the re- medical record. The nurse practitic reviewed and revised the order for sugar reading notification for resid- number 52; the acceptable blood s range was expanded. Compliance with documentation procedures will be monitored by th Health Information Manager throug review of the residents' records wi sugar level parameters three times week for two weeks. If the blood su	e gh butinely utside of ys a AR form low linician gar he sident's blood ent sugar	
	300 and under 100 obtained. On 3/03/17, at 9:00 (DON) stated (when BG's over 300 and the nurses completed document (regarding	CNP was notified of BG's over at the time the BG's were a.m., the director of nursing n queried notifying the CNP of under 100) usually anytime e and SBAR the nurses will g the SBAR completed) in the DON confirmed R52's current			reading is outside of the prescribed parameters, the Health Information Manager will verify that 1) a related form was completed and a copy up to the electronic record or 2) a pro- note was documented regarding notification of the outcall clinician of low/high blood sugar. If noncompli noted, additional auditing and staff will be done. Compliance will be re-	n d SBAR bloaded gress of ance is training	

Facility ID: 00419

If continuation sheet Page 16 of 17

		AND HUMAN SERVICES			FORM	04/05/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATI COM	E SURVEY PLETED
		245153	B. WING			C 03/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	BG over 300 and be R52's record and co documentation of n 300 and under 100, asked the DON if th DON replied I do no them. The DON sta through Friday and here.	cluded an order for notify CNP elow 100. The DON reviewed onfirmed R52's record lacked otifying the CNP of BG's over . At the time, the administrator he SBAR is shredded and the ot know what CNP-E does with tted CNP-E is here Monday reviews the SBAR's when	F 329		il	

Facility ID: 00419

If continuation sheet Page 17 of 17

NUMERATOR DEFICIENCIES NO PLAN OF CORRECTION IDENTIFICATION NUMBER: NO PLAN OF CONSTRUCTION A BUICING of - MAIN BUILDING of BUING NOI OATE SUPPLY CONFLICTION BUING NOI OATE SUPPLY CONFLICTION CONFLICTIO		MENT OF HEALTH			F515	3025	FORM	03/03/2017 APPROVED 0.0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 4001 19TH AVENUE NORTHWEST RCOLESTER, MN 55001 700, 10 ELECATO EPIDERCY MUNRAPY STATEMENT OF OFFICIENCIES OR LISC IDENTERYNG INFORMATION 700, 10 ELECATO EPIDERCY MUNRAPY STATEMENT OF OFFICIENCIES OR LISC IDENTERYNG INFORMATION 700, 10 ELECATO EPIDERCY MUNRAPY STATEMENT OF OFFICIENCIES OR LISC IDENTERYNG INFORMATION 701 ELECATO EPIDERCY MUNRAPY STATEMENT OF OFFICIENCIES OR LISC IDENTERYNG INFORMATION 703 ELECATO EPIDERCY MUNRAPY STATEMENT OF OFFICIENCIES OR LISC IDENTERYNG INFORMATION 704 ELECATO EPIDERCY MUNRAPY STATEMENT OF OFFICIENCIES OR LISC IDENTERYNG INFORMATION 705 ELECATO EPIDERCY MUNRAPY STATEMENT OF OFFICIENCIES OR LISC IDENTERYNG INFORMATION 706 IESC IDENTERYNG INFORMATION 707 STATE FIN MARSHALL DENTERYNG INFORMATION 708 REFERENCED TO THE APPROPRIATE DEFICIENCY 709 DIDIAG WITH the requirements for participation IN Medicare/Medicaid at 42 CFR, Subpat 403, City, LIE Statefy from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard T01, LIE Statefy Code (LISC), Chapter 19 Existing Health Care. 716 Madonna Towers) of Rochester is a 1-story building with no basement. 716 The building was constructed in 1967 and was determined to be of Type II (111) 717 Construction, In 1978, and the 2012 entition of National meet the construction on type allowed for existing building are a Type II (111) buil								
MADONNA TOWERS OF ROCHESTER INC Data 13FH AVENUE NORTHWEST ROCHESTER, MN 55901 V(4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTION OR LSD CENTERY MONTON) ID RECENT CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO IN SHOULD BE SURVEY, (MadONA TOWER'S BE SHOULD BE SURVEY AND TOWER'S BE SHOULD BE TO PE CROSS-REFERENCE TO INFORMATION DUIDING WAS CROSTRUCED IN ASSOCIATION TO CROSTRUCTON IN THE PERICE TO INFORMATION DUIDING WAS CROSTRUCED IN SHOULD BE SURVEY AS AND THE SHOULD BE STRUCE TO INFORMATION TO CROSTRUCTON AND ACCENTRICE TO INFORMATION TO BE AN ADDING WAS CROSTRUCED AND SHOULD BE SURVEY AS AND THE SHOULD BE SHOULD BE SURVEY AND SHOULD BE SURVEY AS AND THE SHOULD BE SURVEY AND SHOULD BE SURVEY AS AND THE SHOULD AND SHOULD BE SURVEY AS SURVEY AS AND AND THE SHOU			245153		B. WING		03/0	2/2017
ROCHESTER, MN 55901 CM) ID TRG SUMMARY STATEMENT OF DEFICIENCIES OR LSC DENTFYING INFORMATION ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MARKING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) COMMETTION (EACH DEFICIENCY) K 000 INITIAL COMMENTS K 000 A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Free Marshal Division, At the time of this survey, (Madona Towers) was found in compliance with the requirements for participation in Medicare/Medical at 42 CFR, Subpart 483,70(a), Life Safety Code (LSC), Chapter 19 Existing Health Care. K 000 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 at 1957 and was determined to be of Type II (111) construction. In 1979, addition was added and was determined to be of Type V (1111). construction and meet the constructed and was determined to be of Type II (111). construction in the 2 additions are of the type V (111) focustuction and meet the constructed and was determined to be of Type II (111). toristuction and meet the construction type a allowed for existing building are a Type V (1111). Because the original building are a Type II (111) and the 2 addition was eddet in the survey of as one building under LSC 2012. The building is protected by a full fire sprinkler system. The facility has a capacity of 62 certified beds. The facility has a capacity of 62 certified beds.								
Date of the second se	MADON	NA TOWERS OF RO	DCHESTER INC					
PHETRA CEACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATIONY PRETA CEACH OBJECT CONSERVENT CONSTRUCTION OF TAG CEACH OBJECT CONSTRUCTION CONSTRUCTION CEACH OBJECT CONSTRUCTION CONSTRUCTION CEACH OBJECT CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONSTRUCTION TO THE ADDITION CONSTRUCTION TO THE ADDITION CEACH OBJECT CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONSTRUCTION TO THE ADDITION TO THE ADDITION CAN AD		OUR MADY OT						(X5)
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 in 1967 and was determined to be of Type V(111) construction. In 1979, addition was added and was determined to be of Type V(111) construction. In 1979, addition was added and was determined to be of Type V(111) construction. In 1998, an addition was added and was determined to be of Type V(111) or Struction. In 1998, an addition was added and was determined to be of type IV(111) or Struction. In 1998, an addition was added and sadditon 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. 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.	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
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 Medicaer/Medicaid at 22 CFR, Subpart 493.70(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 addetrmined to be of Type V(111) construction. In 1978, addition was added and was adetermined to be of Type V(111) construction. In 1988, an addition save of the type V (111) of construction and meet the construction type Jallowed for existing buildings, the facility was surveyed as one building. This will be surveyed as one building. This will be surveyed as one 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.	K 000	INITIAL COMMENT	ſS		K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		by the Minnesota D State Fire Marshal survey, (Madonna T compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing Madonna Towers o building with no bas The building was co The original building was determined to construction. In 197 and was determine construction. In 198 was determined to addition was added Type V (111). Beca Type II(111) and the (111) of constructio type allowed for exis surveyed as a V (11 surveyed as one bu The building is prot system. The facility full corridor smoke spaces open to the for automatic fire de The facility has a ca	Pepartment of Public Division. At the time Towers) was found in a requirements for pa- aid at 42 CFR, Subpa- ety from Fire, and the Fire Protection Associ- 01, Life Safety Code g Health Care. f Rochester is a 1-st sement. Onstructed at 4 differ g was constructed in be of Type II (111) 79, addition was con- d to be of Type V(11 28, an addition was a be Type II (111). In 2 and was determine use the original build e 2 additions are of t n and meet the con- sisting buildings, the f 11) building. This will uilding under LSC 20 ected by a full fire sp has a fire alarm sys detection, resident r corridors that are m epartment notificatio	Safety - of this articipation art 2012 ciation (LSC), ory ent times. 1967 and structed 1) added and 002, an d to be ling are a he type V struction acility was be 12. orinkler tem with coms and onitored n. d beds.				

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.



Protecting, Maintaining and Improving the Health of Minnesotans

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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

PRINTED: 03/31/2017 FORM APPROVED

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
		00419	B. WING		03/0	C 3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
MADON	NA TOWERS OF ROC	HESTER INC	AVENUE N TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 03/30/17

Electronically Signed

If continuation sheet 1 of 20

PRINTED: 03/31/2017 FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00419	B. WING		C 03/03/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ADONN	NA TOWERS OF ROC	HESTER INC	H AVENUE NO			
0(0)15			STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading the date your orders will be electronically submitting to the nent of Health.				
	On Febuary 28, March 1, 2 and 3, 2017 sur of this Department's staff, visited the above provider and the following correction orders issued. Please indicate in your electronic p correction that you have reviewed these ord and identify the date when they will be comp	s staff, visited the above llowing correction orders are icate in your electronic plan of have reviewed these orders,				
	the State Licensing federal software.	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "II statute/rule out of of "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.				

J7YX11

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (/	X3) DATE SURVEY COMPLETED
		00419	B. WING		C 03/03/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
MADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE N TER, MN 55	IORTHWEST 901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		4/11/17
	Subp. 3. Use. A co must be used by all care of the resident	omprehensive plan of care personnel involved in the			
	by: Based on interview review, the facility fa	ent is not met as evidenced , observation and document ailed to follow the plan of care f 3 residents (R75) reviewed d services.		Corrected	
	Findings:				
	reads obvious/likely	ta Set (MDS) dated 2/16/17 / cavity or broken natural tatus is extensive assist of one I hygiene.			
	reads obvious or lik teeth and inflamed natural teeth with a assistance and staf cares. Summary of describe last dental showed multiple roo and heavy plague.	sessment dated 2/16/17 tely cavity or broken natural or bleeding gums or loose n intervention of oral hygiene f assist resident with oral f finding and plan of care l appointment on 6/6/16 ot tips, obvious decayed teeth R75 needs assistant with oral Dentist recommended dental			

J7YX11

PRINTED: 03/31/2017 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING			C 03/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	AVENUE NO			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	ge 3	2 565			
	evaluation of root ti notified regarding th	ps for removal. Social services nese concerns.				
		ids that R75 has a self-deficit d mobility as an intervention n for oral care.				
Nursing assistant (NA) R75 before breakfast.	ion on 3/2/17 at 7:04 a.m. NA)-E did not offer oral care to ist. At 8:30 a.m., R75 in room bed no oral care offered after					
	verified that R75's o breakfast attempts NA-E asked if that	on 3/2/17 at 8:47 a.m. bral care not offered before made to brush after breakfast. was completed, stated that now and probably was not				
	nurse (RN)-B on 3/2 mouth found with b decay and caps on 12:13 p.m. asked a how staff updated of should receive. RN- and in general, staff RN-B reviewed the that nothing listed for care twice daily as t last exam. RN-B sta	essessment with registered 2/17 at 12:07 p.m. of R75's proken and missing teeth with teeth. Interview with RN-B at bout oral care for R75 and of what cares the resident -B stated it is in the care plan f are to complete oral care. NA's care guide and found or R75 to have staff give oral the dentist recommended on ated that it is a standard of and give oral care daily.				
	3/2/17 at 2:59 p.m. of care, during orie that oral cares are t	etor of nursing (DON) on stated oral care is a standard entation the staff are explained to be given twice daily at least g and once at bedtime				

J7YX11

PRINTED: 03/31/2017 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 03/03/2017	
		00419				
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ADONN	A TOWERS OF ROC	HESTER INC	FH AVENUE NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page 4		2 565			
	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.					
	The director of nurs a system to educate monitoring system	HOD OF CORRECTION: sing or designee could develop e staff and develop a to ensure staff are providing the written plan of care.)			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		9			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision		2 570			4/11/17
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to revise the care plan to f brushing teeth for 2 of 3		Corrected		

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00419	B. WING		C 03/03/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MADON	NA TOWERS OF ROO	CHESTER INC	TH AVENUE NO STER, MN 559			
(X4) ID PREFIX TAG	D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 5	2 570			
	residents (R33 and status.	I R75) reviewed for dental				
	Findings Include:					
	provider dated 1/2: diagnoses/assessive related to early chr Treatment: encour line during twice date R33's current elect Problem: Dental net assessment notative recession, extensive bone (#21) with ora- observe and treat in Approaches includ Has own teeth white risk for cavities. Or Report signs/symp chipped teeth for for needed. Problem: above knee amput left below knee arm with activities of date Oral care assist of	nent: generalized recession onic periodontal disease. age R33 to focus along gum	r			
	include frequency	-				
	sitting up in her wh time nursing assist assisted R33 with stated when querie	a.m. R33 was observed to be eelchair in her room. At the cant (NA)-G stated she had getting up this a.m. NA-G ed if had assisted R33 with oral d usually R33 completes oral				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. DUILDING.			с	
		00419	B. WING		03/	03/2017	
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
IADONN	IA TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC ⁻ CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	ge 6	2 570				
		we set up, when R33 asks for 33 stated she had not brushed	I				
	(DON) stated our c in regards to includ teeth. Our expectat do oral cares with a queried regarding t dental provider to e gum line during twi included on the car that is how you sho	a.m., the director of nursing are plans are not that specific ing frequency of brushing ion is nursing assistants are to a.m. and p.m. cares. When reatment order from R33's incourage R33 to focus along ce daily brushing to be e plan, the DON stated I think uld brush everybody's teeth. d frequency of brushing teeth in R33's care plan.					
	9/15/16 reads obvio natural teeth. R75's oral cavity as reads obvious or lik teeth and inflamed natural teeth with a assistance and stat cares. Summary of describe last denta showed multiple roo and heavy plague. cares twice a day.	inimum Data Set (MDS) dated bus/likely cavity or broken assessment dated 2/16/17 tely cavity or broken natural or bleeding gums or loose in intervention of oral hygiene if assist resident with oral finding and plan of care l appointment on 6/6/16 ot tips, obvious decayed teeth R75 needs assistant with oral Dentist recommended dental ps for removal. Social services nese concerns.					
	6/6/16, please see twice daily and nee	ntist oral dental form dated that R75's teeth get brushed ds a dental visit to evaluate al and follow up dental visit to					
	R75's care plan had	d been reviewed and had not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S COMPL		
				A. BUILDING:		C	
		00419	B. WING			3/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IADONN	A TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
0.570			0.570	DEFICIEN	JY)		
2 570	Continued From pa	-	2 570				
	included the dentis teeth twice daily.	t recommendation to brush					
	1:33 p.m. the facilit comes to the facilit the residents. Fam recommendation if conferences. Revie appointment dated and verified that the recommendations social worker upda was 2/22/17 and ver	al worker (SW) on 3/2/17 at ty has a contracted dentist who y to perform dental services fon illies updated with dental any during the care ew of the last dental 6/6/16 assessment with SW ere was to be a follow up from the dentist. At 2:16 p.m. ted the last care conference erified that there was no p dental services for R75's to					
	recommendations	o update care plan with from dentist including not <i>v</i> ith a follow up appointment.					
	6/2016 reads; routi are available to me services in accorda assessment and pl Policy review titled dated 12/2016 read consistent quality of the facility will com assessment of the assessment must i limited to dental an treatment and proc use the results of the	w titled Dental Services dated ne and emergency services set the resident's oral health ance with the residents an of care. Assessment, Comprehensive ds the purpose; is to develop care that will attain or maintain, plete a comprehensive resident's needs. The include the following but not id nutritional status, special cedures. The facility should he assessments to develop, he resident's comprehensive					
		THOD OF CORRECTION: sing (DON) or designee, could					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		.E CONSTRUCTION ()	(3) DATE SURVEY COMPLETED C	
		00419	B. WING		03/03/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE N TER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	
2 570	Continued From pa	ge 8	2 570			
	related to care plan designee, could pro staff related to the t revisions. The qual committee could pe ensure compliance	nent policies and procedures revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		4/11/17	
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility (R50) who is unable	ent is not met as evidenced ion, interviews and record failed to shave 1 of 3 residents e to carry out activities of daily maintain good grooming.		Corrected		
	Finding included:					
	resident was sitting breakfast. Residen the day. R50 noted on chin. On 3/2/17 at 7:10 a lounge across from	on 3/1/17, at 8:29 a.m. in her wheelchair at table for it was fully dressed and up for I to have white-gray whiskers m. R50 was sitting in small nursing station fully dressed ave white-gray whiskers on				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		C 03/03/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
IADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	lunch and noted to whiskers on her chi On 3/3/17 at 8:15 a dressed, sitting in h window, noted that During interview on assistant (NA)-C sta assistance with all f care. Shaving shou for women at least daily basis. During interview on said, "I shave them some shave them r During interview on NA-D stated "Her b and shaving is done what she would do shaved other than of check with the nurs them. I don't think the regarding shaving. During interview on registered nurse (R expectations as to completed, if some women, RN-A said would do it with mo "I just checked with that they will do it if	R50 was being assisted with continue to have white-gray	2 920	DEFICIENC	т,	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
				A. BUILDING:		
		00419	B. WING			C 03/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	A TOWERS OF ROC	HESTER INC	TH AVENUE NO			
			STER, MN 559			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 10	2 920			
	stated R50's bath is had trimmed nails,	n 3/2/17, at 2:00 p.m. NA-B s Monday. NA-B then said she shaved hair during bath. worked this past Monday so eted her bath.				
	with R50's family m regarding if it would on her chin. She sa	view on 3/3/17 at 8:05 a.m. nember/power of attorney, d bother her to have facial hair aid, "Absolutely, it would have was a very pristine person and pok nice."				
	and Administration, would be that staff	n 3/3/17 at 9:20 a.m. with DON , DON stated, My expectations would shave facial hairs daily pecially for females.				
	scheduled bath day R50's care plan las indicated that R50 dementia and over on staff assistance	list indicated that R50's y is on Monday a.m. st reviewed/revised on 1/20/17, had self care deficit related to all debility. She is dependent with all activities of daily living giene and grooming (shaving, hair).				
	Living (Daily Life Fi 10/16. Purpose of a	of Rochester Activities of Daily unctions) Reviewed dated activities of daily living is to to residents for daily life				
	Resident reviewed	of Rochester Shaving the 12/20/16. Purpose of the mote cleanliness and to				
		THOD OF CORRECTION: sing (DON) or designee, could				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00419	B. WING	B. WING		03/03/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IADONI	NA TOWERS OF ROC	HESTER INC	FH AVENUE NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
2 920	Continued From pa	age 11	2 920				
	providing activities quality assessment could perform rand compliance. TIME PERIOD FOI	all nursing staff related to of daily living (ADL's). The t and assurance committee om audits to ensure R CORRECTION: Twenty-one					
21426		A.04 Subd. 3 Tuberculosis	21426			4/11/17	
	 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. 		t				
	by:	ent is not met as evidenced and document review, the		Corrected			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00419	B. WING		C 03/03/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	FH AVENUE NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 12	21426			
		cluded negative or positive residents (R38, R147, R150, e.				
	Findings include:					
	p.m., with results re as 0 millimeters (m TST on 9/7/16, at 2 9/9/16, at 2:00 p.m	step TST on 8/24/16, at 1:00 ead on 8/26/16, at 1:45 p.m., m). R38 received second step 2:22 p.m., with results read on ., as 0 mm. The first and ailed to include the reading of e as required.	0			
	p.m., with results re as 0 mm. R147 re 2/8/17, at 10:28 a.r 2/10/17, at 11:27 a	step TST on 1/25/17, at 1:00 ead on 1/27/17, at 1:26 p.m., ceived second step TST on n., with results read on .m., as 0 mm. The first and ailed to include the reading of e as required.				
	p.m., with results re 0 mm. R150 receiv 2/16/17, at 4:00 p.r 2/18/17, at 3:10 p.r	step TST on 2/2/17, at 1:30 ead on 2/4/17, at 1:37 p.m., as ved second step TST on n., with results read on n., as 0 mm. The first and ailed to include the reading of e as required.	5			
	a.m., with results re as 0 mm. The first	step TST on 2/16/17, at 11:30 ead on 2/18/17, at 11:45 a.m., step TST failed to include the e or positive as required.				
	Control Program O did not contain the	of facility TB (tuberculosis) verview policy dated 8/2016, requirement to include the e interpretation along with				

J7YX11

If continuation sheet 13 of 20

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
				A. BUILDING:		
		00419	B. WING		C 03/03/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE NC TER, MN 5590			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETI DATE
21426	Continued From pa	age 13	21426			
	Health Tuberculosi Program dated 7/2 following: TST documentation the date (i.e., mont millimeters of indur document "0" mm) positive or negative available, documer with TB (e.g., a prev history of active TB	of Minnesota Department of s Prevention and Control 013, page 23, directed the n for residents should include h, day, year), the number of ration (if no induration, , and interpretation (i.e., e). If this information is not natation of a history of infection vious positive skin test or disease) by a physician in the I record is acceptable.				
		a 3/2/17, at 845 a.m., director the lack of interpretation of positive.				
	The director of nurs policies and procec required informatio could educate nurs	director of nursing could				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535			4/11/17
	must be free from unnecessary drug	al. A resident's drug regimen unnecessary drugs. An is any drug when used: e dose, including duplicate drug re duration:				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00419	B. WING		C 03/03/2017	
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ADONN	A TOWERS OF ROC	HESTER INC		ORTHWEST		
			TER, MN 55			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 14	21535			
	D. in the prese which indicate the of discontinued. In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finance This standard is inter available through th	quate indications for its use; or ence of adverse consequences dose should be reduced or lrug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on interview facility failed to follo glucose checks for	ent is not met as evidenced and document review, the bw physician orders for blood 1 of 5 residents (R52) essary medications.		Corrected		
	Findings include:					
		ce Sheet dated 3/3/17, s of diabetes mellitus.				
	blood glucose twice before breakfast ar lunch and at HS. N practitioner) if BG (ician orders included check e daily- staggered so one day nd supper, next day before otify CNP (certified nurse blood glucose) > (greater (less than) 100 every shift.				
	problem: has diabe	ronic care plan included etes mellitus requiring insulin				
nesota De	epartment of Health		6899	J7YX11	If continucti	on sheet 15

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING			C 03/2017
NAME OF	AME OF PROVIDER OR SUPPLIER STREET A			TATE, ZIP CODE		
		4001 19T	H AVENUE NO	ORTHWEST		
MADON	NA TOWERS OF ROC	ROCHES	TER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 15	21535			
	records (MAR/TAR identified notify CN every shift and BG dates: 1/4/17, at 6:00 a.m 1/11/17, at 8:00 p.m 1/14/17, at 4:00 p.m 1/17/17, at 8:00 p.m 1/26/17, at 6:00 a.m 1/27/17, at 8:00 p.m 2/3/17, at 8:00 p.m 2/6/17, at 6:00 a.m 2/11/17, at 8:00 p.m 2/11/17, at 8:00 p.m	reatment administration 's) dated 1/1/17 through 3/2/17 P if BG >300 or BG <100 readings for the following . 97, No CNP notified n. 312, No CNP notified n. 345, No CNP notified n. 309, No CNP notified n. 367, No CNP notified n. 367, No CNP notified n. 350, No CNP notified n. 312, No CNP notified . 313, No CNP notified . 313, No CNP notified . 375, No CNP notified . 337, No CNP notified n. 337, No CNP notified n. 348, No CNP notified n. 348, No CNP notified n. 348, No CNP notified n. 348, No CNP notified n. 409, No CNP notified n. 360, No CNP notified				
	On 3/2/17, at 1:40 pmanager (HIM)-D a stated when the do would document th progress notes and would be documen notes. RN-C confirmorder's included an 300 and below 100 medication/treatmet confirmed staff wer	p.m., health information and registered nurse (RN)-C ctor is notified the nurses e information in the resident the SBAR (facility form) ted in the resident progress med R52's current physician order for notify CNP BG over and the order was on R52's ent administration record. RN-C re initialing on the MAR/TAR				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING		C 03/03/2017	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		00/00/201	
		4001 191	TH AVENUE NO			
MADONI	NA TOWERS OF ROC	CHESTER INC ROCHES	STER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DA	
21535	Continued From pa	age 16	21535			
	and R52's record la notifying the CNP of 100. RN-C stated a out and placed on day in regards to n 300 and under 100 here Monday throu not keep record of RN-C confirmed R documentation the 300 and under 100 obtained.	CNP was notified of BG's over at the time the BG's were				
	(DON) stated (whe BG's over 300 and the nurses complet document (regardin nurses notes. The physician order's in BG over 300 and b R52's record and c documentation of r 300 and under 100 asked the DON if t DON replied I do n them. The DON sta	a.m., the director of nursing in queried notifying the CNP of under 100) usually anytime te and SBAR the nurses will ing the SBAR completed) in the DON confirmed R52's current included an order for notify CNF below 100. The DON reviewed confirmed R52's record lacked notifying the CNP of BG's over 0. At the time, the administrator he SBAR is shredded and the ot know what CNP-E does with ated CNP-E is here Monday I reviews the SBAR's when				
	The director of nur- could review/revise for staff regarding Quality Assessmen	THOD FOR CORRECTION: sing (DON) and/or designee e policy and provide education unnecessary medications. The nt and Assurance (QAA) o random audits to ensure				

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C 03/03/2017	
		00419	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MADONN	NA TOWERS OF ROC	HESTER INC	TH AVENUE N STER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET E DATE	
21535	Continued From pa	ge 17	21535			
	(21) days.					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		4/11/17	
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	This MN Requiremo	ent is not met as evidenced				
	Based on observati review, the facility	ion, interview, and document ailed to promote dignity for rding to needs for 1 of 1 o were dependent upon staff		Corrected		
	Findings:					
	2/16/17 identifies R use is extensive as moderately impaire on the Brief Intervie assessment), bowe	num Date Set (MDS) dated 75 functional status for toilet sist of one person. R75 is d with a score or 9 out of 15 ew for Mental Status (cognitive el and bladder assessment is ent of bowel meaning at least				
	incontinent of bowe assistance to the to stand aide (a device resident to stand ar platform). R75 also decreased strength	ads alteration in elimination, is and bladder, R75 requires bilet with one person and the e/machine that assist the nd transfer while on a has an alteration in mobility, and endurance with an mpt to toilet after meals and				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00419		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING: B. WING		C	
		00419				03/03/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ADONN	NA TOWERS OF ROO	HESTER INC	TH AVENUE NO STER, MN 559			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET 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.					
	observed in room of room there was a s R75 saw surveyor help. Surveyor imm had been standing also noted that R75 staff had not respo NA-H and surveyor R75 continued to c remove R75's pant said R75 had soile continued to cry fro room to assist with completed cleaning	es later at 8:27 a.m. R75 was crying and on entering her strong smell of stool. When she lifted hand and asked for nediately notified NA-H who by the nursing station. It was 5's call light was activated and nded to the light. At 8:30 a.m. rs entered R75's room and ry. NA-H was observed to help is while seated on toilet. NA-H d her pants with stool. R75 om the time NA-H entered toileting until NA-H had g the incontinent episode. o bed, NA-H ask if "ok", R75				
	1:44 p.m. included incontinent of stool assistance even th	ocial worker (SW) on 3/2/17 at the sharing of R75's and having to wait for ough R75 had informed staff o toilet. SW would expect staff				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00419		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER.	A. BUILDING: B. WING			
		00419			C 03/03/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ADONN	A TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 559			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF			
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21805	Continued From page 19		21805			
	to assist right away. SW stated it would not be good if resident had an accident while waiting for help.					
	nursing (DON) and incontinent episode timely assistance. both said their goal 10 minutes if reside call light. On askin expect to wait when need to use bathro DON and administr	at 3:06 p.m. with director of administrator concerning for R75 yesterday and lack of The DON and administrator for answering lights timely is ent calls for help by activation g how long residents should n they verbally say to staff they om immediately. Again both rator agreed that the goal inutes maximum to respond to	,			
	12/16 reads under implementation; De standards of care t prohibited. Staff sh residents as neede	Quality of Life-Dignity dated the policies interpretation and emeaning practices and hat compromise dignity are nall promote dignity and assist ed by: Promptly responding to est for toileting assistance.				
	The director of nurs develop, review, an procedures to ensu The director of nurs educate all appropri procedures. The director of nurs	THOD OF CORRECTION: sing (DON) or designee could ad/or revise policies and ure compliance. sing (DON) or designee could riate staff on the policies and sing (DON) or designee could systems to ensure ongoing				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				