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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JZ4H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00419

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245153**
2.STATE VENDOR OR MEDICAID NO.
(L2) **931216100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADONNA TOWERS OF ROCHESTER INC**
(L4) **4001 19TH AVENUE NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/22/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245153

October 29, 2014

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

Dear Ms. Redalen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 21, 2014 the above facility is certified for:

2	Skilled Nursing Facility Beds
60	Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fitz-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 29, 2014

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

RE: Project Number S5153023

Dear Ms. Redalen:

On September 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 11, 2014. 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 October 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 11, 2014, effective October 21, 2014 and therefore remedies outlined in our letter to you dated September 22, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245153	A. Building B. Wing	10/27/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **10/21/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/21/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/21/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/21/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GKN/KFD	10/28/2014	10160	10/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/11/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JZ4H

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(L4) **4001 19TH AVENUE NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

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3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2014** (L34)

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2 AOA 3 Other

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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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Compliance Based On:
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___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	62			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Josephine Hassinger, HFE NE II 10/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/20/2014 (L20)

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

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____ 2. Facility is not Eligible
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03/14/1968
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23. LTC AGREEMENT BEGINNING DATE
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24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
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02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
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07-Provider Status Change
00-Active

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(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 22, 2014

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

RE: Project Number S5153023

Dear Ms. Redalen:

On September 11, 2014, 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;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 21, 2014, 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 December 11, 2014 (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 March 11, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	09/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		10/21/14

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

Electronically Signed | 10/02/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	09/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident's designated family member with abnormal lab test results that resulted in a medication change from an oral diabetic agent to the use of insulin for 1 of 1 resident (R63) reviewed for notification of change. Findings include: R63's family (F)-A member was interviewed on 8/6/14, at 6:00 p.m. F-A stated that he had not been informed timely when R63's oral diabetic agent was changed to insulin. F-A added that he was informed by staff, but after the fact and it was only mentioned to him by facility staff when he was visiting R63. In addition, F-A, who had requested to be identified as an active Medical Doctor, stated that he was upset that he was not even included in the discussion related to the change from an oral diabetic medication to insulin and was not made aware of laboratory results that led up to the change from an oral diabetic agent to insulin. Review of the progress notes dated 4/22/14, at 3:58 p.m. read: New order put in for patient for	F 157	Regulation 483.10(b)(11) Tag F157 Notification of Changes Madonna Towers of Rochester routinely informs the resident, consults with the resident□s physician, and notifies the resident□s legal representative or an interested family member when there is 1) an accident involving the resident which results in injury and has the potential for requiring physician intervention 2) a significant change in the resident□s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psycho-social status in either life-threatening conditions or clinical complications) and/or 3) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The facility□s policies and procedures related to communicating/tracking changes in condition and notifying the physician and family of changes in	

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	245153	A. BUILDING _____ B. WING _____	09/11/2014

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F 157	Continued From page 2 Humulin (insulin). Progress notes dated 4/23/14, at 10:16 a.m. included blood test for A1C (Hemoglobin A1c test is used as a standard tool to determine blood sugar control for patients with diabetes) was 9.4%, this is an improvement from prior A1c which was greater than 12% (The American Diabetes Association currently recommends an A1c goal of less than 7.0%, while other groups such as the American Association of Clinical Endocrinologists recommend a goal of less than 6.5%.) However, will transition R63 from oral Glimepiride an oral blood sugar lowering medication to NPH insulin 24 units every morning. Progress notes dated 4/24/14, at 11:40 a.m. noted that F-A here in facility visiting R63 and F-A was updated regarding the initiation of the insulin in place of Glimepiride and A1C level. Progress notes dated 5/30/14, at 12:11 p.m. indicated; R63 with hyperglycemia (high blood sugar readings) for the blood glucose will increase Humulin N to 34 units subcutaneous in the a.m. and add Humulin N 10 units subcutaneous in the evening. The progress notes on 5/30/14 lacked documentation that F-A had been informed of the increase in the insulin medication. Progress notes dated 6/4/14, at 12:43 p.m. indicated R63 seen by medical doctor (MD)-A for recertification today. MD-A wrote orders at 3:32 p.m. for an increase in Humulin N to 38 units in a.m. and 12 units in evening and to reduce by half if not eating. The progress notes on 6/4/14 lacked documentation that F-A had been informed that R63's insulin doses had been increased.	F 157	condition/treatment were reviewed and found appropriate. During the October 7, 2014 mandatory meeting, the nursing staff will be reeducated on 1) the regulatory notification requirements and 2) the facility□s policies and procedures for family notification of changes in the residents□ condition/treatments including abnormal laboratory test findings and medication changes. The circumstances surrounding the lack of notification of the family regarding the laboratory test results and the subsequent change in medication for resident number 63 were thoroughly investigated by the resident□s interdisciplinary care team. The family was notified within a timely manner of the abnormal laboratory test and the physician□s order to discontinue the oral blood sugar lowering medication and start insulin injections. The family was not immediately updated about subsequent laboratory findings and medication adjustments. The resident□s care plan has been revised to clarify that the family wishes to and will be promptly notified of changes in condition including abnormal laboratory tests and medication changes. To assure the highest quality resident care and services and to assure continuous quality improvement, the circumstances and the time line of family notification of the change in treatment for resident number 63 will be reviewed with the licensed nursing staff during the October 7, 2014 meeting.	

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F 157	Continued From page 3 Progress notes dated 7/1/14, at 4:16 p.m. identified that R63's care conference was held and F-A, attended and was made aware that R63's current medical status, however not mention diabetes regimen did was changed and now included insulin for control. Progress notes dated 7/9/14, at 11:23 a.m. identified that R63's most current A1c 9.0 reading had been an improved compared to July 2013 reading of 12.2 and April 2014 reading of 9.4. This progress note lacked documentation that FM-A had been informed of these lab values. The above progress notes and lack of F-A having been informed were verified by the charge licensed practical nurse (LPN)-A on 9/11/14, at 11:35 a.m. LPN-A stated that she regularly works as the charge nurse on the wing where R63 currently resides. LPN-A further added that F-A should have been notified per facility policy when R63's medication was changed from an oral diabetic agent to insulin and per our policy, F-A should have been informed each time R63's insulin was changed. A review of the document titled Activities-Preferences for Customary Routine and Activities dated 3/24/14, identified that is was very important to R63 to have his family involved in discussions relating to his care. Review of the policy titled CHANGES IN CONDITION STATUS-NOTIFICATION REQUIREMENTS with a revision date of 9/2013, specified: A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal	F 157	Changes in a residents condition are routinely discussed during the Monday through Friday morning interdisciplinary meetings, the daily shift-to-shift charge nurses reports, and the interdisciplinary care conferences. The Director of Nurses/designee will monitor compliance of timely and appropriate family notification of changes in the residents condition through random record reviews for 30 days. If noncompliance with timely notification is noted, additional auditing and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting. Completion date: October 21, 1014	

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F 157	Continued From page 4 representative or an interested family member when there is a need to alter treatment significantly.	F 157		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently document effectiveness of the medication and/or non-pharmacological interventions were	F 329	483.25(l) Tag F329 Unnecessary Drugs Madonna Towers of Rochester staff	10/21/14

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F 329	Continued From page 5 attempted first and if they were effective for as needed (PRN) pain, antianxiety and anti-psychotic medications being administered for 2 of 5 residents (R22, R29); and failed to adequately and clearly identify indications (resident specific symptoms) for use of an anti-anxiety medication and document severity of pain prior to as needed pain medication use for 1 of 5 residents (R29) reviewed for unnecessary medications. Findings include: R22's resident admission record dated 9/11/14, identified diagnoses of but not limited to chronic pain, disorder persistent mental and palliative care. R22's significant change Minimum Data Set (MDS) dated 8/17/14, identified pain, validated with verbal and facial expressions of pain and no behaviors. R22's current(located in computer) physician order report dated 9/10/14, identified an order for haloperidol lactate concentrate (an anti-psychotic medication) 2 mg (milligrams)/(per) ml (milliliter) administer one ml every four hours as needed and oxycodone concentrate (pain medication) 20 mg/ml one ml every hour as needed. Document review of R22's behavior tracking tool dated 9/14, identified target behaviors of anxiety displayed by restlessness related to shortness of breath and restlessness displayed by attempts to wander and behavior that is not redirectable and receives Haldol (antipsychotic medication.) During review of R22's care plan problem start date 9/3/13, identified problem takes antipsychotic medication for anxiety or	F 329	ensure that each resident□s drug regime is free from unnecessary drugs. The resident□s drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible. The policy and procedure for administration of psychotropic medications was reviewed and found appropriate. During the consultant pharmacist□s monthly medication audits and the quarterly care planning process, the resident□s medications will continue to be reviewed to assure that the resident is receiving the lowest effective medication dose with appropriate indications and monitoring. During the mandatory meetings on October 7, 2014 and October 16, 2014, the licensed nurses and trained medication assistants will be re-educated on the facility policies and procedures for administering as needed medications including 1) The guidelines/parameters for the administration of as needed psychotropic medications 2) the facility policies for documenting severity of pain	

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F 329	Continued From page 6 restlessness with approach of but not limited to monitor for drug use effectiveness and adverse consequences if this medication is used, is on scheduled and prn medication, attempt other interventions prior to prn use as able, utilize if other interventions are not successful and problem alteration in comfort related to lumbago, chronic back pain with approach of but not limited to not able to rate pain, ask if in pain, ask to describe as best as can in own words, monitor for non-verbal indicators of pain. During review of R22's resident progress notes dated 8/01/14 through 9/10/14; the non-narcotics controlled notes and the narcotic flow sheet dated 9/1/14 through 9/30/14; narcotic flow sheet dated from 8/01/14 through 8/31/14, the following had been noted: R22 had received two doses of prn Haldol and 60 doses of prn oxycodone and documentation of non-pharmacological interventions tried before administration of the medications and effectiveness of the medications after administration had not been consistently documented. During interview on 9/11/14, at 9:36 a.m., registered nurse (RN)-A verified non-pharmacological interventions and effectiveness of the pain medication had not been consistently documented for both the Haldol and oxycodone. RN-A then stated nurses should try non-pharmacological intervention before administering a prn medication. During interview on 9/11/14, at 9:45 a.m., director of nursing had stated they are supposed to be trying non-pharmacological interventions before giving a prn medication and documenting the effectiveness when any as needed pain or	F 329	and 3) documenting nonpharmacological interventions and the effectiveness of as needed analgesics and psychotropic medications. During the mandatory meeting October 16, 2014, the nursing assistants will be reminded to 1) be observant for and report symptoms of pain 2) report significant resident behaviors to the charge nurse and 3) document the residents mood and target behaviors according to facility policy. Resident number 22-The 93-year-old resident was readmitted to the facility August 7, 2014. Due to the declining condition of the resident, the family chose to begin hospice care on August 8, 2014. The resident experienced periods of extreme agitation, confusion, and restlessness during which unsafe self-transfers were frequently attempted placing the resident at increased risk of falls and injury. To reduce the residents anxiety and promote comfort, multiple pharmacological and nonpharmacological interventions, including one-to-one supervision, were attempted under the direction of the attending physician and the hospice medical/nursing staff. The September 10, 2014 note by the attending physician states, started on Haldol on September 2, 2014. Ativan was tried first for restlessness, agitation and delirium, but was found not to be effective. Haldol was then started. Per MD, "We find this to be more effective in the elderly to aid in patients comfort." The resident died at	

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F 329	Continued From page 7 psychotropic medication is given. R29 was admitted 8/22/2014 with diagnoses which included debility, chronic pain, rehab procedures, depressive disorder, and insomnia, history of falls, diabetes, and history of fracture according to the admission face sheet. Physician orders dated 8/22/2014 were reviewed. The following was written for pain medication: Ben gay gel (to treat pain) for neck pain twice a day, oxycodone (narcotic) 5 mg every 6 hours prn for chronic pain; Tylenol ES (pain medication) 500 mg 2 tabs three times a day.; Voltaren (nonsteroidal anti-inflammatory drug) gel topical three times a day for chronic pain-neck; and lorazepam 0.25 milligrams every 8 hours prn for anxiety. The computerized physician orders also included: pain management: monitor pain by using 1-10 pain rating scale to assess if current pain medications and interventions are effective every shift. A pain assessment was completed on 8/22/2014 and reviewed. R29 ' s pain was described as daily, aching pain that comes and goes. Anxiety brings on the pain. Resident frequently whimpers, but rates pain low. History of depression and is often sad. Measures taken to alleviate pain were analgesics, cold, heat, massage, rest. Non-pharmacological interventions for pain included: active listening, patient education, cold, encourage verbalization, heat, repositioning. Had history of recent falls, and has chronic neck pain. R29's Admission Minimum Data Set dated 8/28/2014 identified the resident was not able to be assessed or no information provided for the	F 329	the facility September 10, 2014. As part of the facility□s continuing quality improvement process, the documentation related to the administration of the resident□s psychotropic, analgesic, and other comfort medications was reviewed by the nursing supervisor and administrative staff. For training and instructional purposes the findings will be addressed during the October 7 nursing staff meeting. Resident number 29-After an unsuccessful attempt to transition to an assisted living facility, the 96-year-old resident was readmitted to the facility August 22, 2014 with the diagnoses of chronic neck and back pain as well as depression and anxiety. The nurses document frequent complaints of pain and symptoms of depression and anxiety with crying, sometimes inconsolable, despite the best effort of the staff and family to comfort her. The resident meets weekly with a licensed psychotherapist who notes the diagnosis of histrionic personality traits. The psychotherapist noted that during the September 19, 2014 visit, the resident was frustrated, upset, and sobbed throughout the session stating that nobody cares about her anymore. The resident□s medication regimen was reviewed by the pharmacist September 30, 2014 and is routinely reviewed by the psychotherapist, the attending physician/nurse practitioner, the interdisciplinary care team during care	

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F 329	Continued From page 8 cognitive status. The pain was assessed as frequently. R29's care plan, no date: Problem start date: 7/27/2014: Alteration in comfort related to chronic neck and back pain, recent gallbladder surgery. Approach start date: 7/27/2014-Medications as ordered. Monitor for effectiveness. Use pain scale of 0-10, or to describe in own words. Notify Dr. /CNP of changes. Problem start date: 7/27/2014: Potential for adverse side effects: Uses psychotropic medications related to depression & anxiety. Approach start date: 7/27/2014: Monitor and report signs of sedation, hypotension, dizziness, increased weakness, and/or changes in behavior. Monitor resident's mood and response to medication. Pharmacy consults as needed. The resident's care plan did not address any non-pharmacological interventions to use prior to the use of the as needed medication for pain. However, several non-pharmacological interventions were noted on the admission pain assessment. Medication/treatment sheets dated 8/22/2014 through 9/9/2014 were reviewed for as needed use of pain and antianxiety medication. For 8/2014: the as needed pain medication oxycodone was given 34 times with 15 times effectiveness was not documented after the medication had been given and twice documented the medication was not effective when given. The as needed anti-anxiety medication was given 8 times for symptoms of being teary eyed, anxious or crying. Effectiveness of the medication was not documented twice and one time documented as ineffective. For 9/2014, as needed oxycodone pain medication was given 18 times and 5 times	F 329	conferences, and PRN with the goal of improving the resident□s mood, decreasing episodes of crying/anxiousness, and effectively managing the resident□s pain. Guidelines/parameters for administering the as needed antianxiety and antipsychotic medications have been reviewed. The nurses will be re-educated to 1) follow the resident□s guidelines/parameters for administering the as needed psychotropic medications 2) routinely offer nonpharmacological interventions prior to administering as needed medications to treat anxiety/pain 3) document the effectiveness of the as needed medications and 4) respect the resident□s right to refuse the nonpharmacological interventions and receive the requested medication. The care plan has been reviewed and appropriately reflects the medication administration guidelines. The resident□s mood, anxiety, and pain symptoms will continue to be monitored and the attending physician will be notified of any increase in symptoms. To monitor compliance, the Director of Nursing/designee will review the documentation for nonpharmacological interventions and effectiveness of interventions for as needed antipsychotic, antianxiety and analgesic medications for selected resident for thirty days. If noncompliance is noted, additional staff training and monitoring will be done.	

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F 329	Continued From page 9 the effectiveness was not documented. The as needed anti-anxiety medication was given 7 times for symptoms of anxious, anxiety, or tearful. Non-pharmacological interventions used prior to the as needed pain medication and anti-anxiety medication were not documented as being attempted prior to the use of the as needed medication. The pain scale 0-10 was documented as plus and minus on both 8/2014 and 9/2014 medication/treatment sheets. No numbers for rating the pain were used although it was a physician order to do so. The staff did not consistently document use of non-pharmacological interventions prior to use of the as needed pain medication and did not consistently document effectiveness of the as needed pain medication once it was given. No criteria were evident for the specific symptoms in using the anti-anxiety medication. Nursing progress notes dated 8/22/2014 through 9/9/2014 were reviewed. Documentation of use of non-pharmacological interventions attempted prior to use of as needed pain and anti-anxiety medications was not evident. On 9/9/2014 at 1:15 p.m., registered nurse (RN)-A was interviewed regarding documentation of use of as needed pain medication. The effectiveness was documented on pain sheet and flow sheet on back of the medication/treatment sheets. The staff should be documenting effectiveness every time they give a prn (as needed) medication. When asked about non-pharmacological interventions RN-A indicated that other options are available and would probably be documented in the progress	F 329	Compliance will be reviewed during the next Quality Council meeting. Completion Date: October 21, 2014	

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F 329	Continued From page 10 notes if they were used. On 9/10/2014 at 1:10 p.m., RN-A was interviewed regarding documentation of the pain scale being used for R29. If the resident cannot give us a number we document plus if having pain and minus if not. The staff asks the resident if having pain, and if the resident says yes, can verbalize having pain but may not be able to put a number on it. On 9/11/2014 at 8:15 a.m., RN-E was interviewed regarding R29's pain management. RN-E stated the resident was alert often in tears and weepy and would give a number rating to the pain when asked. The resident was clear about wanting the pills. RN-E indicated she did not know what the plus and minus documentation indicated for pain management. The staff was to use the rating scale numbers from 0-10. The staff always tries repositioning and the prn (as needed) analgesics do help. The non-pharmacological interventions attempted are not always documented but they are offered. Sometimes in progress note. RN-E indicated effectiveness should be documented in the medication/treatment sheets. RN-E also verified other interventions were not on the care guide that the nurse aides use. On 9/11/2014 at 10:35 a.m., RN-E was interviewed about giving Ativan prn (as needed) for anxiety. She indicated the resident could usually tell which pill was needed and the family was there to let nurses know. The staff does try other non- pharmacological interventions but it may not be documented. RN-E verified there were no specific criteria for use of the as needed anti-anxiety medication. Effectiveness was to be documented on the medication and treatment	F 329		

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F 329	Continued From page 11 sheets the same way other prn's were. On 9/12/2014 at 11:30 a.m., the director of nurses was interviewed regarding the resident's care plan problem dates and approaches. R29 had been in the facility off and on many times. The staff just continues working and updating that care plan. The care plan provided by the facility to the surveyor was the most current care plan regardless of the dates. R29's final care plan would be completed today and the information would still be the current, most up to date information. Document review of the facility MEDICATION MONITORING AND MANAGEMENT policy dated 2006, read, "Procedures A. 6) b. The resident is monitored for the effectiveness of the medication or possible adverse consequences. Results are documented in the resident's record." Document review of the facility Medication Administration by Licensed and Non-Licensed Personnel dated last revised 8/11, read, "Procedure U. When giving PRN medications, follow-up documentation as to the effectiveness of the medication needs to be documented on the back of the MAR [medication administration record]."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		10/21/14

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 12 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pharmacy consultant identified lack of documentation of non-pharmacological interventions and effectiveness for as needed pain medication being administered and reported this irregularity to the doctor and director of nursing for 1 of 5 residents (R22) reviewed for unnecessary medications. Findings include: R22's resident admission record dated 9/11/14, identified diagnoses of but not limited to chronic pain, disorder persistent mental and palliative care. R22's significant change Minimum Data Set (MDS) dated 8/17/14, identified pain, validated with verbal and facial expressions of pain and no behaviors. R22's current(located in computer) physician order report dated 9/10/14, identified an order for haloperidol lactate concentrate (an anti-psychotic medication) 2 mg (milligrams)/(per) ml (milliliter) administer one ml every four hours as needed and oxycodone concentrate (pain medication) 20 mg/ml one ml every hour as needed. Document review of R22's behavior tracking tool dated 9/14, identified target behaviors of anxiety	F 428	Regulation 483.60(c) Tag F428 Drug Regimen Review The goal of Madonna Towers of Rochester is to prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least monthly by a licensed pharmacist. The pharmacist routinely reports irregularities to the attending physician, and the director of nursing, and these reports are routinely acted upon. The Administrator, Director of Nursing and Consultant Pharmacist discussed the 1) need for tracking/documenting nonpharmacological interventions and the effectiveness of as needed pain medications and 2) reporting of this irregularity to the doctor and director of nursing. The policies entitled, Medication management and Medication Regime Review were reviewed and found appropriate. Discussion included the planned transition to electronic medication administration records in March 2015. The new system will prompt the nurse to document nonpharmacological interventions and the effectiveness of as needed medications.	

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F 428	Continued From page 13 displayed by restlessness related to shortness of breath and restlessness displayed by attempts to wander and behavior that is not redirectable and receives Haldol (antipsychotic medication.) During review of R22's care plan problem start date 9/3/13, identified problem takes antipsychotic medication for anxiety or restlessness with approach of but not limited to monitor for drug use effectiveness and adverse consequences if this medication is used, is on scheduled and prn medication, attempt other interventions prior to prn use as able, utilize if other interventions are not successful and problem alteration in comfort related to lumbago, chronic back pain with approach of but not limited to not able to rate pain, ask if in pain, ask to describe as best as can in own words, monitor for non-verbal indicators of pain. During review of R22's resident progress notes dated 8/01/14 through 9/10/14; the non-narcotics controlled notes and the narcotic flow sheet dated 9/1/14 through 9/30/14; narcotic flow sheet dated from 8/01/14 through 8/31/14, the following had been noted: R22 had received two doses of prn Haldol and 60 doses of prn oxycodone and documentation of non-pharmacological interventions tried before administration of the medications and effectiveness of the medications after administration had not been consistently documented. During interview on 9/11/14, at 9:36 a.m., registered nurse (RN)-A verified non-pharmacological interventions and effectiveness of the pain medication had not been consistently documented for both the Haldol and oxycodone. RN-A then stated nurses should try	F 428	Resident number 22, a 93-year-old female, was readmitted to the facility August 7, 2014. Due to the declining condition of the resident, the family chose to begin hospice care August 8, 2014. The resident experienced periods of extreme agitation, confusion, and restlessness during which unsafe self-transfers were frequently attempted placing the resident at increased risk of falls and injury. To reduce the resident□s anxiety and promote comfort, multiple pharmacological and non-pharmacological interventions, including one-to-one supervision, were attempted under the direction of the attending physician and the hospice medical/nursing staff. The September 10, 2014 note by the attending physician states, started on Haldol on September 2, 2014. Ativan was tried first for restlessness, agitation and delirium, but was found not to be effective. Haldol was then started. Per MD, "We find this to be more effective in the elderly to aid in patients□ comfort." The resident died at the facility September 10, 2014. As part of the facility□s continuing quality improvement process, the documentation related to the administration of the resident□s psychotropic, analgesic and other comfort medications was reviewed by the nursing supervisory and administrative staff. For training and instructional purposes the findings will be addressed during the October 7, 2014 nursing staff meeting.	

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F 428	Continued From page 14 non-pharmacological intervention before administering a prn medication. During interview on 9/11/14, at 9:45 a.m., director of nursing had stated they are supposed to be trying non-pharmacological interventions before giving a prn medication and documenting the effectiveness when any as needed pain or psychotropic medication is given. During interview on 9/11/14, at 9:45 a.m., director of nursing had stated they are supposed to be trying non-pharmacological interventions before giving a prn medication and documenting the effectiveness when given. During interview on 9/11/14, at 10:02 a.m., consultant pharmacist (CP)-B had stated expectations are before giving a prn medication should document non-pharmacological interventions that have been tried and should be documenting effectiveness of the medication. Document review of the facility policy CONSULTANT PHARMACIST REPORTS dated 2006, read, "Procedures E. The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MARs); prescribers' orders; progress notes of prescriber, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The consultant pharmacist's evaluation includes, but is not limited to reviewing and/to evaluating the following: 19) Medical condition and response to drug therapy are evaluated to	F 428	To monitor compliance, the Director of Nursing/designee will randomly review the documentation for non-pharmacological interventions and effectiveness of interventions for as needed antipsychotic, antianxiety and analgesic medications for selected resident for thirty days. The consultant pharmacist will randomly audit records for documentation of the effectiveness of as needed medications and non-pharmacological interventions for the next three monthly visits. The pharmacist□s audit results will be reported to the Director of Nursing. Compliance will be reviewed during the next Quality Council meeting and ongoing. Completion Date: October 21, 2014	

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F 428	Continued From page 15 assure the appropriateness of the medication regimen."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		10/21/14

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F 441	Continued From page 16 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures for proper disinfecting of a shared blood glucose monitoring device which was used for 1 of 1 resident (R101) and had the potential to affect all residents who required blood glucose monitoring while residing on the B hall of the home. Findings include: R101 had blood glucose reading done and the licensed nurse did not sanitize the glucometer before storage. During observation on 9/10/14, at 11:30 a.m. registered nurse (RN)-C removed blood glucose monitor from the treatment cart used on the B hallway. RN-C said that this glucometer is used for more than one resident. RN-C donned gloves and checked R101's blood glucose. RN-C then removed her gloves, removed a Sani-wipe from a purple top container and quickly wiped the glucometer, discarded the wipe and placed the glucometer on top of the treatment cart. RN-C documented the results of the blood glucose reading and after initialing the box that the blood glucose check was completed, RN-C verified that she was finished with this task. Observation of the glucometer at the same date and time, noted that the Sani-wipe used for disinfection of the glucometer was dry and no wet liquid was identified on the machine.	F 441	Regulation 483.65 Tag F441 Infection Control Madonna Towers of Rochester has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has policies and procedures reflecting an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. Resident-specific glucose monitoring machines will now be assigned to residents who require blood glucose monitoring weekly or more often. To avoid cross contamination, the resident□s glucometer will be stored in his/her room. Policies and procedures will be revised to reflect the change from multi-resident use to single-resident use glucometers. Glucometer machines will be sanitized according to facility policy and manufacturer□s instruction before being returned to the central storage area.	

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F 441	Continued From page 17 An interview was conducted with RN-C on 9/11/14, at 8:31 a.m. verified that she did not allow the disinfecting Sani-wipe to remain in contact with the glucometer and to allow it to be wet for 2 minutes, after using it on 9/10/14 according to the Sani Wipe directions for thoroughly sanitizing glucometer. RN-C further added that she had never been made aware of that information. A review of the identified instructions for disinfecting the glucometer listed on the outside of the purple top Sani-wipes identified that the Sani-wipe should remain wet and in contact with the glucometer for a period of 2 minutes. Review of the policy titled GLUCOMETER USE, CALIBRATION AND CLEANING-For multi-use and Single Resident use, last revised 7/2014, identified that the glucometer device in use at Madonna Towers Nursing Care will be properly maintained and cleaned/disinfected between resident use by a professional licensed nurse....Current CDC (centers for disease control) guidelines recommend cleaning/disinfecting the meter between each resident test. The following procedure is based on manufacturer's glucometer device guidelines. a. Put on non-sterile gloves. b. Clean the outside case of the glucometer device with facility approved Germicidal Disposable Wipes. If visible blood is present on the glucometer 2 wipes must be used:use one wipe to clean and a second wipe to disinfect. c. Take extreme care not to get liquid in the test strip and key code ports. d. Once the meter has been disinfected it should	F 441	During the mandatory meetings on October 7 and on October 16, 2014, the nursing staff will be instructed on the new glucometer policy and procedures and reinstructed on the procedures for sanitizing the machines. Compliance will be monitored by the infection control nurse through direct observation and return demonstrations of the glucometer sanitizing process. If noncompliance is noted, additional monitoring and staff instruction will be done. The findings will be reviewed during the next Quality Council quarterly meeting. Completion date: October 21, 2014	

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F 441	Continued From page 18 be left to air dry for 2 minutes prior to the next resident's use. e. Remove gloves and sanitize hands. The facility's infection control nurse (RN)-A was interviewed on 9/10/14, at 3:35 p.m. RN-A verified that the glucometer was supposed to be disinfected using the purple top sanitizing wipes and allowed to remain wet on the contact surface for two minutes. RN-A further added that in order for the Sani-wipes to properly disinfect shared equipment surfaces, the lids must be kept closed or the wipe will become dry. RN-C removed a Sani-wipe from a purple top container, which she had with her, and noted that the wipe was dry to the touch.	F 441		

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	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Madonna Towers of Rochester was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility will be surveyed as two separate buildings. Madonna Towers of Rochester is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (111) construction. In 1979, addition was constructed and was determined to be of Type V(111) construction. In 1998, an addition was added and was determined to be Type II (111). In 2002, an addition was added and was determined to be Type V (111). Because the original building are a Type II(111) and the 2 additions are of the type V (111) of construction and meet the construction type allowed for existing buildings, the facility was surveyed as a V (111) building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 52 at the time of the survey.	K 000		

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

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

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		

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	245153	A. BUILDING **02** B. WING _____	**09/09/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Madonna Towers of Rochester Inc. was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. This facility will be surveyed as two separate buildings. Madonna Towers of Rochester Inc. new additions were constructed at 2 different times. A 1-story addition was constructed in 2008 and was determined to be of Type V (111) construction. In 2011, a 1-story addition was constructed and was determined to be of Type V (111) construction. Because the 2 additions are of the same type of construction and meet the construction type allowed for new buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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K 000	Continued From page 1 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		