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CENTERS FOR MEDICARE & MEDICAID SERVICES

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MEDICARE/MEDICAID CERTIFICATI	ON AN	D TRANS	MITTAL
PART I - TO BE COMPLETED BY THE S	STATE	SURVEY	AGENCY

ID: NH0D

		PART I	- TO BE COMP	LETED BY T	HE STAT	TE SURVEY	AGENCY	Facility ID: 00419
I. MEDICARE/MEDICA (L1) 245153 2.STATE VENDOR OR M (L2) 931216100		0.	 NAME AND AI (L3) MADONNA (L4) 4001 19TH A (L5) ROCHESTH 	TOWERS OF I	ROCHEST		5) 55901	 TYPE OF ACTION: <u>2</u> (L8) Initial Recertification Termination CHOW Validation Complaint On-Site Visit Other
5. EFFECTIVE DATE CI (L9)	HANGE OF OWN	ERSHIP	 PROVIDER/SU 01 Hospital 	JPPLIER CATEGO 05 HHA	RY 09 ESRD	<u>03</u> (L 13 PTIP	.7) 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 DATE OF SURVEY ACCREDITATION ST 0 Unaccredited 2 AOA 	02/23/20 TATUS: 1 TJC 3 Other	22 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CER From (a) : To (b) : 12.Total Facility Beds 13.Total Certified Beds	RTIFICATION	62 (L18)62 (L17)	Complian 1. B. Not in Co		ram	2. T 3. 2 4. 7	roved Waivers Of Th Cechnical Personnel 4 Hour RN Day RN (Rural SNF Life Safety Code A*	e Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BE	D BREAKDOWN		requirements	and of Approv		15. FACILIT		(2.2)
18 SNF 2	18/19 SNF 60	19 SNF	ICF	IID		-	or 1861 (j) (1):	(L15)
(L37)	(L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AC	TURE	· · · · · · · · · · · · · · · · · · ·	Date :	02/25/2022	(L19)		SURVEY AGENCY A	PPROVAL Date: prcement Specialist 02/25/2022 (L20)
	PA	RT II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	OFFICE O	OR SINGLE STA	ATE AGENCY
 DETERMINATION (X_1. Facility 2. Facility 		cipate (L21)		MPLIANCE WITH GHTS ACT:	CIVIL	2		cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE		23. LTC AGREEM	ENT 2	4. LTC AGREEN	1ENT	26. TERMIN	NATION ACTION:	(L30)
OF PARTICIPATIO 03/14/1968		BEGINNING		ENDING DAT	Έ	<u>VOLUNTARY</u> 01-Merger, Cle	<u>7</u> <u>00</u> osure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)			tion W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION I	DATE: 2 (L27)	 ALTERNATI^A A. Suspension B. Rescind Sus 	n of Admissions:	(L44)			oluntary Termination on for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
				(L45)				
28. TERMINATION DA	TE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARK	S	
			03001					
		(L28)			(L31)			
31. RO RECEIPT OF CM	IS-1539		. DETERMINATION 02/24/2022	OF APPROVAL D				
		(L32)			(L33)	DETERMI	NATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 25, 2022

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

RE: CCN: 245153 Cycle Start Date: January 7, 2022

Dear Administrator:

On January 19, 2022, we notified you a remedy was imposed. On February 23, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 2, 2022.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective February 3, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 19, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 3, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 2, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 25, 2022

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

Re: Reinspection Results Event ID: NH0D12

Dear Administrator:

On February 23, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Mi Ping

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Electronically delivered February 25, 2022 CMS Certification Number (CCN): 245153

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

Dear Administrator:

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 February 2, 2022 the above facility is certified for:

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

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

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

Please contact me if you have any questions.

Sincerely,

· Juig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

CENTERS FOR MEDICARE & MEDICAID SERVICES

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ID: NH0D

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	AGENCY		Facility ID: 00419
1. MEDICARE/MEDICAID PROVII (L1) 245153 2.STATE VENDOR OR MEDICAID (L2) 931216100		3. NAME AND AI (L3) MADONNA (L4) 4001 19TH A (L5) ROCHESTE	TOWERS OF	FROCHES		55901	 TYPE OF ACT Initial Termination Validation 	 Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>03</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey Af	9. Other ter Complaint
 6. DATE OF SURVEY 01/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 	07/2022 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENI 12/31	DING DATE: (L35)
2 AOA 3 Other								
11LTC PERIOD OF CERTIFICATIO From (a): To (b):	DN	Compliance		AS:	2. Tech 3. 24 H	nical Personnel	The Following Require 6. Scope of 7. Medical I F) 8. Patient Ro	Services Limit Director
12. Total Facility Beds	62 (L18)	1. A				Safety Code	9. Beds/Roo	
13.Total Certified Beds	62 (L17)	X B. Not in Con Requirements	npliance with Prog and/or Applied V			B*	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY	MEETS		
18 SNF 18/19 SNF 2 60	19 SNF	ICF	IID		1861 (e) (1) or	· 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA		ANCELLATION 1	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
Ruth Furan, HFE NE I	l	0	2/01/2022	(L19)	Melissa Poe	pping, Enforc	ement Specialist	02/23/2022 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OF	R SINGLE ST	FATE AGENCY	
19. DETERMINATION OF ELIGIBIT 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	2. 0		acial Solvency (HCFA-2 I Interest Disclosure Str : 	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 03/14/1968	BEGINNING	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> 01-Merger, Clos			UNTARY o Meet Health/Safety
(L24)	(7.41)		(L25)		02-Dissatisfactio	on W/ Reimburse	ement 06-Fail t	o Meet Agreement
	(L41)							
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS n of Admissions:	(1.44)		03-Risk of Involu 04-Other Reason		07-Provi	ider Status Change
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspensio		(L44) (L45)				OTHER	ider Status Change
	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions:	(L45)				07-Provi	ider Status Change
(L27)	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions: uspension Date:	(L45)	(L31)	04-Other Reason		07-Provi	ider Status Change
(L27)	27. ALTERNATI A. Suspensio B. Rescind S 29 (L28)	n of Admissions: uspension Date: 9. INTERMEDIARY/	(L45) CARRIER NO.		04-Other Reason		07-Provi	ider Status Change



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 19, 2022

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

RE: CCN: 245153 Cycle Start Date: January 7, 2022

Dear Administrator:

On January 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 3, 2022.

• Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 3, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

Madonna Towers Of Rochester Inc January 19, 2022 Page 2 only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 3, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Madonna Towers Of Rochester Inc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 3, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

Madonna Towers Of Rochester Inc January 19, 2022 Page 3 (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

> Karen Aldinger, Unit Supervisor St. Cloud A District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: karen.aldinger@state.mn.us Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 July 7, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at

Madonna Towers Of Rochester Inc January 19, 2022 Page 4

https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov.</u>

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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>https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

Madonna Towers Of Rochester Inc January 19, 2022 Page 5 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:

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145 Cell: (507) 361-6204 Email: william.abderhalden@state.mn.us Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Mi Ping

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245153	B. WING	i		01/	07/2022
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			1001 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
	compliance with Ap Preparedness Required conducted during a	1/7/22, a survey for pendix Z, Emergency uirements, §483.73(b)(6) was standard recertification was IN compliance.					
F 000	signature is not req page of the CMS-2 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility pt of the electronic documents TS	F(000			
	recertification surve facility by the Minne determine if your fa requirements of 42	1/7/22 , a standard ey was completed at your esota Department of Health to acility was in compliance with CFR Part 483, Subpart B, ong Term Care Facilities. Your compliance.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 554 SS=D	onsite revisit of you validate substantial regulations has bee Resident Self-Adm	in Meds-Clinically Approp	F٤	554			2/2/22
	§483.10(c)(7) The i	right to self-administer					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						01/26/2022

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.

PRINTED: 01/26/2022

		(Y2) MU					
	IDENTIFICATION NUMBER:					PLETED	
	245153	B. WING			01/0	07/2022	
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
NA TOWERS OF ROC	HESTER INC						
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	¢	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE	
Continued From pa	ge 1	F 5	54				
defined by §483.21 this practice is clinic This REQUIREMEN by: Based on observat review, the facility fa assessment and eco of medications for for self-administrati sample of 16 reside for medication error self-administration Findings include: R3's quarterly Minir 12/15/21, identified supervisor for most diagnoses included arthritis, depression During a room obse 1/4/22, at 10:30 a.n medications in her medications were co gave them to herse eye drops, inhalers cream. R3 stated s sugar checks durin to six times a day, a observed in a plasti stated she informed completed the bloo administered her in	 (b)(2)(ii), has determined that cally appropriate. NT is not met as evidenced tion, interview, and document ailed to complete an ducation for self-administration I of 1 resident (R3) reviewed on of medications from a total ents, resulting in the potential rs related to the inappropriate of medications. num Data Set (MDS) dated cognitively intact and required activities of daily living. R3's, diabetes, rheumatoid n and chronic pain syndrome. ervation and interview on n. R3 had multiple prescription room. R3 verbalized the surrent medications that she off. The medications included, and a topical antifungal he performed her own blood g the day, approximately four and the supplies were ic container on her dresser. R3 d the nurse when she d sugar check, and the nurse sulin based on that. R3 further 			updated. Orders were reviewed with provider and updated as applicable include ability to self-check blood gl levels. Items that were in room were removed or secured if approved for self-administration. Education on u medications was provided to R3. Residents who are approved for self-administration of medications h the potential to be affected by the a practice. Like residents were re-eva and orders verified and MAR update indicating medications that are appr for self-administration. MARS were updated as needed to indicate whice medications can be self-administered The Director of Nursing or designed provided education to licensed nurse trained medication aides, and certifinursing assistants beginning the we January 24, 2022 on self-administration medication, securing medications in resident room or medication cart, an identifying on MAR which medication be self-administered. The Director of Nursing or designed complete direct observation audits of self-administration three times week	h to lucose e se of nave lleged aluated ed roved h ed. ess, ied esk of ation of n nd ons can e will of kly for		
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER NA TOWERS OF ROC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa medications if the in defined by §483.21 this practice is clinic This REQUIREMEN by: Based on observat review, the facility fa assessment and ec of medications for f for self-administrati sample of 16 reside for medication error self-administration Findings include: R3's quarterly Minin 12/15/21, identified supervisor for most diagnoses included arthritis, depression During a room obse 1/4/22, at 10:30 a.n medications were of gave them to herse eye drops, inhalers cream. R3 stated s sugar checks durin to six times a day, a observed in a plast stated she informed completed the bloo administered her in stated, and showed mist treatment (NM	DF CORRECTION IDENTIFICATION NUMBER: 1DENTIFICATION NUMBER: 245153 PROVIDER OR SUPPLIER NA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete an assessment and education for self-administration of medications for 1 of 1 resident (R3) reviewed for self-administration of medications from a total sample of 16 residents, resulting in the potential for medication errors related to the inappropriate self-administration of medications.	RS FOR MEDICARE & MEDICAID SERVICES FOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153 B. WING PROVIDER OR SUPPLIER NA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFINE Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete an assessment and education for self-administration of medications for 1 of 1 resident (R3) reviewed for self-administration of medications from a total sample of 16 residents, resulting in the potential for medication errors related to the inappropriate self-administration of medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/15/21, identified cognitively intact and required supervisor for most activities of daily living. R3's diagnoses included, diabetes, rheumatoid arthritis, depression and chronic pain syndrome. During a room observation and interview on 1/4/22, at 10:30 a.m. R3 had multiple prescription medications in her room. R3 verbalized the medications were current medications that she gave them to herself. The medications included eye drops, inhalers, and a topical antifungal cream. R3 stated she performed her own blood sugar checks during the day, approximately four to six times a day, and the supplies were observed in a plastic container on her dresser. R3 stated she i	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING. 245153 B. WING PROVIDER OR SUPPLIER 245153 NA TOWERS OF ROCHESTER INC IM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 1 medications if the interdisciplinary team, as defined by \$483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: F 554 Based on observation, interview, and document review, the facility failed to complete an assessment and education for self-administration of medications for 1 of 1 resident (R3) reviewed for self-administration of medications. Findings include: F 3's diagnoses included, diabetes, rheumatoid arthritis, depression and chronic pain syndrome. During a room observation and interview on 1/4/22, at 10:30 a.m. R3 had multiple prescription medications were current medications included eye drops, inhalers, and a topical antifungal cream. R3 stated she performed her own blood sugar checks during the day, approximately four to six times a day, and the supplies were observed in a plastic container on her dresser. R3 stated she informed the nurse when she completed the blood sugar check, and the nurse administered her insulin based on that. R3 further stated, and showed this surveyor, her nebulized mist treatment (NMT) set up in the bottom drawer	RS FOR MEDICARE & MEDICAID SERVICES Of OF DEFICIENCIES (X) PROVIDERSUPPLER/CLM (X2) MULTIPLE CONSTRUCTION PEORDER 245153 B. WING PROVIDER OR SUPPLIER 245153 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, NN 65901 MING SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 1 PROVIDERS FLAN OF CORRECTIVA SHOLDL (EACH DEFICIENCY) Continued From page 1 F 554 medications if the interdisciplinary team, as defined by \$483.21(b)(2)(ii), has determined that this practice is clinically appropriate. F 554 Findings include: F 554 Findings include: F 35 quarterly Minimum Data Set (MDS) dated 12/15/21, identified cognitively intact and required supervisor for most activities of daily living. R3's diagnoses included, diabetes, rheumatoid arthritis, depression and chronic pain syndrome. F 554 During a room observation and therview on 1/4/22, at 10:30 a.m. R3 had multiple prescription medications in her room. R3 verbalized the medications in her room or medications included eye drops, inhalers, and a topical antifungal cream. R3 stated she pe	RS FOR MEDICARE & MEDICAID SERVICES OMB NO. OF DEFICENCIES (X1) PROVIDERSUPPLERICLA LIDENTIFICATION NUMBER: (R2) MULTIPLE CONSTRUCTION A BUILDING (R3) DATE COM PROVIDER OR SUPPLER 245153 B. WING (C1) PROVIDERSUPPLERINC 01/0 NA TOWERS OF ROCHESTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 4001 9TH AVENUE NORTHWEST ROCHESTER, MN 5501 01/0 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTIONS PLAUE OR SUPPLICE REGULATORY OR LSC IDENTIFYING INFORMATION) IPPERING PREVIDENCY MUST REPRECEDED OF THE APPROPRIATE DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) IPPERING PREVIDENCY MUST REPRECEDED OF THE APPROPRIATE DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) F 554 Continued From page 1 medications if the interdisciplinary team, as defined by \$483.21(b)(2)(ii), has determined that this practice is clinically appropriate self-administration of medications from a total samele of 16 residents, resulting in the potential for medications for 1 of 1 resident (R3) reviewed for self-administration. area paproved for self-administration. Tormedications from a total sample of 16 residents, resulting in the potential for medications and chronic pain syndrome. F 554 Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/15/21, identified cognitively intact and required supervision rom stactives of daily ling. R3's diagnoses included, diabetes, rheumatoid arthritis, depression and chronic pain syndrome. F 554 During a room observation and interview on 11/4/22, at 10:30 a.m. R3 had multiple prescription med	

Facility ID: 00419

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		& MEDICAID SERVICES			OMB NO. 0938-03 (X3) DATE SURVEY			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED		
		245153	B. WING		01	/07/2022		
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE				
MADONI	NA TOWERS OF ROC	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE		
F 554	"Whenever I feel th	e need to do them," and that edication cup and mouthpiece	F 554	I Improvement for review and recommendations.				
	review of the medic present, 16 medica 1. Antihistamine ey twice a day. R3 sta 2. Nasal spray one R3 stated, "I do my 3. Flonase nasal sp daily. R3 stated, "I 4. Ciprodex ear dro seven days for righ 6/7/21. R3 stated "I I just haven't given 5. Two Ventolin (res (INH) two puffs twic one that shoots out unable to state wha 6. Diclofenac (mild mild arthritic pain, u 7. Lidocaine gel thr moderate/severe a gel for pain if the D 8. Two tubes of Tria (antifungal cream) had a while ago," m 11/5/21 and resider 9. Artificial Tears or as needed prescrib "I no longer use." 10. Glucose tabs e total, resident state used any as I have	spray each nostril twice a day. self." oray two sprays each nostril do myself." ops two drops right ear for t ear infection prescribed am not using that any longer. it back to the nurse." spiratory medication) inhalers ce a day. R3 stated "I use the t better." However she was at INH was the preferred one. analgesic) topical cream for						

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/	07/2022
NAME OF	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 DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 554	unlabeled in bottom "it's been a while sin breathing machine, what medication the know what it is." R3 she used it when, "t nightstand." R3 furt provided any educa utilize the DuoNeb's observe her when o checks. R3's EMR for the Ja under the, Orders ta 11/5/21, which inclu- self-administer Albu- respiratory medicat spray) after set-up.' noted for R3 to corr eye and ear drops o R3's EMR under the a Self-Administratio completed on 11/4/2 after a hospitalizatio 11/4/21, covered he medications only, a drops, creams, or c sugar checks. During an interview Registered Nurse (I determine if a resid medication pass the complete a Self-Add form. RN-B stated s creams, eye drops, had not personally g	and dresser drawer. R3 stated, nce I've had to use my " and when asked if R3 knew ey were, she stated, "no I don't also stated the nurse knew they see the machine on my ther stated the facility had not ation to her regarding how to s, give her eye drops or doing her own blood sugar anuary 2022 physician orders, ab revealed orders dated uded, "resident is ok to uterol, Advair, DuoNebs (all ions) and Flonase (nasal " No other specific orders were nplete her blood sugar checks,	F	554			

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/	07/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 554	and/or expired. RN- R3 if she had comp documentation purp unaware how often reviewed/looked at and stated she did resident perform he complete her eye d During an interview stated that she com of Medications asse on the history of R3 re-admission proce speak to the respira and not the creams RN-A did state that the respiratory and up by the nurse or to [TMA]." RN-A also s the nurse or TMA b medication and the on her own, but not in her room. During an interview the director of nursi practical nurse (LPI was able to self-adm nasal medications a TMA, but not to hav room. The DON als until, 1/6/22, that R3 her room. The DON did not have a syste appropriateness for	-B stated, she typically asked oleted the medications for poses. RN-B stated she was the medications were for current doses/not expired not routinely observe the er blood sugar checks, lrops, or inhaler. on 1/6/22, at 11:30 a.m. RN-A hpleted the Self-Administration essment, dated 11/4/21, based B and as part of the ess. RN-A was only able to atory and nasal medications s, eye drops, or ear drops. R3 was able to self-administer nasal medications, "after set trained medication aide stated, "after set up" meant brought the resident her in resident was allowed to do t for the medications to be left of the medications left in the so stated he was not aware 3 had sixteen medications in N stated the facility currently em in place for review of r a resident to continue with of medications or checking the	F 5	554			

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		E & MEDICAID SERVICES). 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245153	B. WING		01	/07/2022
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MADONN	IA 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 554	Continued From pa	age 5	F 55	4		
	R3's medical docto aware, and agreed her respiratory and also stated she wo her if there was an condition that woul continue to self-ad further stated, rega expect the facility y medications in R3' medications are cu duplicates. The MI may complete her R3 had conducted December 2021, in determine her com stated she was aw completing her ow not aware in the fac originally dated 6/3 when the resident 2021. The MD state order showed as a oversight of the fac	-				
	"Self-Administratio February 2019 rev approach nurse at the nurse will trans to the resident to s	n of Medications," initiated on ealed, "Residents will the time they are required, and sfer the unopened medication elf-administer" and " the ability to self-administer will				
		to the interdicciplinery teem				

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING _			01/	07/2022
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			01 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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
TAG F 565	Continued From par CFR(s): 483.10(f)(5) §483.10(f)(5) The re- and participate in re- (i) The facility must group, if one exists, reasonable steps, v to make residents a upcoming meetings (ii) Staff, visitors, or resident group or fa- the respective grou (iii) The facility mus- person who is appro- group and the facility providing assistance requests that result (iv) The facility mus- resident or family g the grievances and groups concerning in the facility. (A) The facility mus- response and ration (B) This should not facility must implem- request of the resid §483.10(f)(6) The re- family member(s) or representative(s) m families or resident residents in the faci- This REQUIREMEN	age 6 b)(i)-(iv)(6)(7) esident has a right to organize esident groups in the facility. provide a resident or family , with private space; and take with the approval of the group, and family members aware of s in a timely manner. other guests may attend amily group meetings only at p's invitation. to provide a designated staff oved by the resident or family ty and who is responsible for e and responding to written from group meetings. to consider the views of a roup and act promptly upon recommendations of such issues of resident care and life to be able to demonstrate their hale for such response. be construed to mean that the nent as recommended every lent or family group. esident has a right to r groups. esident has a right to have or other resident neet in the facility with the representative(s) of other ility. NT is not met as evidenced	F 56	65	DEFICIENCY)	RATE	DATE
		t Council interview, policy			F 565		

IENCIES CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI			DATE SURVEY COMPLETED	
			_			
	245153	B. WING			01/07/2022	
OR SUPPLIER						
ERS OF ROO	CHESTER INC					
CH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE	
and review g minutes, i o follow up o sident Coun 17, and R30 meetings o created the re care need en the facil rsing staffin s include: of the facil revealed, "the concerns demonstrate ts/concerns l." an interview at 1:11 p.m ince (R3, R ey regularly lity and had s," about del k of staffing facility relia agencies; l o know the	 of the Resident Council t was determined the facility on concerns brought forth by icil, for five residents (R 3, R11, 0) who regularly attended but of a total census of 54. The potential that residents would ds met or experience weight ity did not respond to concerns ig levels and meal service. ity's undated Resident Council he facility listens to and acts c of the residents The es follow-through on written voiced by the Resident w with the Resident Council on L, all five residents in 11, R15, R17, and R30) stated attended Resident Council in I been complaining, "for layed call light response times g. The residents complained ed heavily on staff from nursing but the agency staff did not resident's specific care needs. 	F 50	65	R 3, 11, 15, 17, and 30 were visited with and formal concern/grievance process completed for the concerns they have identified with follow up by assigned department for concerns. Residents who have concerns or grievances have the potential to be impacted by the alleged practice. The Social worker was educated on using th concerns and grievance process follow Resident Council meetings to ensure follow up is completed. The Regional Nurse Specialist provided education to the Social Worker, Directo of Nursing, and Executive Director on using the grievance/concern process to record concerns or grievances and trac and document follow up on resident council concerns. The Executive Director or designee will complete follow up audits with identified residents weekly on response to conce and their satisfaction with- progress towards resolution of concerns. Audits continue until concerns are resolved to the resident s satisfaction. Results of audits will be forwarded to the facility Quality Council for Performance Improvement for review and recommendations.	he ing d or o k d rns	
	ERS OF ROO SUMMARY ST. CH DEFICIENC SULATORY OR I UNIT OF THE SULATORY OR I SUMMARY ST. COLORING OF THE SULATORY OR I UNIT OF THE SULATORY OR I SUMMARY ST. COLORING OF THE SULATORY OR I SUMMARY ST. SUMMARY ST.	v of the facility's undated Resident Council revealed, "the facility listens to and acts ne concerns of the residents The demonstrates follow-through on written ts/concerns voiced by the Resident	ERS OF ROCHESTER INC ID SUMMARY STATEMENT OF DEFICIENCIES ID SULATORY OR LSC IDENTIFYING INFORMATION) PREFID Used From page 7 F 5 and review of the Resident Council g minutes, it was determined the facility o follow up on concerns brought forth by sident Council, for five residents (R 3, R11, 17, and R30) who regularly attended Immeetings out of a total census of 54. The created the potential that residents would /// cere needs met or experience weight rent the facility did not respond to concerns rsign staffing levels and meal service. gs include: and acts v of the facility's undated Resident Council revealed, "the facility listens to and acts ne concerns of the residents The demonstrates follow-through on written ts/concerns voiced by the Resident for at 1:11 p.m., all five residents in ance (R3, R11, R15, R17, and R30) stated ey regularly attended Resident Council in lity and had been complaining, "for s," about delayed call light response times sk of staffing. The residents complained e facility relied heavily on staff from nursing g agencies; but the agency staff did not o know the resident's specific care needs.	ERS OF ROCHESTER INC ID SUMMARY STATEMENT OF DEFICIENCIES (CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ued From page 7 , and review of the Resident Council g minutes, it was determined the facility o follow up on concerns brought forth by sident Council, for five residents (R 3, R11, 17, and R30) who regularly attended I meetings out of a total census of 54. The created the potential that residents would <i>ve</i> care needs met or experience weight nen the facility did not respond to concerns irrsing staffing levels and meal service. gs include: v of the facility's undated Resident Council revealed, "the facility listens to and acts ne concerns of the residents The demonstrates follow-through on written ts/concerns voiced by the Resident iI." an interview with the Resident Council on at 1:11 p.m., all five residents in ance (R3, R11, R15, R17, and R30) stated ay regularly attended Resident Council in ility and had been complaining, "for s," about delayed call light response times ck of staffing. The residents complained e facility relied heavily on staff from nursing g agencies; but the agency staff did not o know the resident's specific care needs. residents further complained that the	IOR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ERS OF ROCHESTER INC 4001 19TH AVENUE NORTHWEST SUMMARY STATEMENT OF DEFICIENCIES ID SULATORY OR LSC IDENTIFYING INFORMATION) PREVIX ued From page 7 PREVIX , and review of the Resident Council PREVIX g minutes, it was determined the facility F 565 II.7, and R30) who regularly attended F 365 II.8 eacting sout of a total census of 54. The created the potential that residents would ec are needs met or experience weight string staffing levels and meal service. F 565 gs include: Yo f the facility's undated Resident Council evealed, "the facility listens to and acts to concerns of the residents The demonstrates follow-through on written ts/concerns voiced by the Resident Council on at 1:11 p.m., all five residents in ance (R3, R11, R15, R17, and R30) stated ay regularly attended Resident Council in lility and had been complaining, "for s," about delayed call light response times ik of staffing. The residents soution on the ageincy staff did not o know the resident's specific care needs. The Executive Director or designee will continue until concerns. Audits will be forwarded to the facility autil of the resident's specific care needs.	

		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		E SURVEY PLETED
		245153	B. WING			01/0	07/2022
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565	Continued From pa	ige 8	F٤	65			
	for 7/6/21, 8/3/21, 9 12/7/21, and 1/4/22 revealed the Reside with food service at meeting on 10/5/21 levels all months ex the Resident Count no feedback to the planned to resolve satisfaction with the When interviewed of administrator stated when the Resident concern, the Social the attention of the leadership team wo plan to address the keep the residents towards resolution. was aware of the re- the SW would have feedback to the residents towards resolution pro- we need to do a be When interviewed of SW stated, she aw the Resident Count plans to resolve the them with the resid residents in attendar resolving their condi- that's a lie, but what	on 1/7/22, at 10:31 a.m. the d, it was his expectation that Council brought forth a I Worker (SW) would bring it to facility leadership team, the buld come up with an action e concerns, and the SW would informed of the progress The administrator stated, he esidents' concerns, and that e documentation of the facility's sidents. "I know we have a bblem with the residents, and tter job with that."					0/0/00
F 657 SS=D	Care Plan Timing a	ind Revision	F€	657			2/2/22

		H AND HUMAN SERVICES E & MEDICAID SERVICES				APPROVE 0938-039	
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>`</i>	PLE CONSTRUCTION	(X3) DA	TE SURVEY	
		245153	B. WING		01	/07/2022	
NAME OF I	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP (CODE		
	NA TOWERS OF RO			4001 19TH AVENUE NORTHWEST			
				ROCHESTER, MN 55901			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	O THE APPROPRIATE DATE		
F 657	Continued From p	age 9	F 65	7			
	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-						
(t (ii ((r ((i) Developed with the comprehensiv	in 7 days after completion of e assessment. n interdisciplinary team, that					
	includes but is not (A) The attending	limited to physician.					
	resident.	vith responsibility for the					
		ood and nutrition services staff. practicable, the participation of					
	the resident and the An explanation mu	he resident's representative(s). List be included in a resident's he participation of the resident					
	and their resident not practicable for	representative is determined the development of the					
		in. ate staff or professionals in ermined by the resident's needs					
		y the resident. revised by the interdisciplinary ssessment, including both the					
	comprehensive ar assessments.	nd quarterly review					
	by:	ENT is not met as evidenced w and document review, the		F 657			
	facility failed to up	date the care plan for 1 of 3 reflect resident care needs.		R30 care plan was updated 01-06-2022 and 01-07-202	2. Full care		
	Findings include:			plan review for R30 was co week of January 24,2022. Residents who have chang	•		
	11/17/21 indicated	nimum Data Set (MDS) dated I he was cognitively intact, but sistance of one person with his		and resultant changes in ca interventions have the pote impacted by the alleged pra	are plan ntial to be		

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` '	G		PLETED
		245153	B. WING		01/0	07/2022
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD DR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY) DEFICIENCY)		D BE	(X5) COMPLETIO DATE	
F 657	Continued From pa	age 10	F 65	7		
	urinary catheter an function. His diagned degenerative neuro R30's Oral Health S provider indicated to by them on 9/8/21, partial dentures wit natural tooth. R30 of His oral/dental stat inflamed [underline gums. The listed da as, "resident needs recommendations" were, "toothbrushin brush teeth and gu minutes, as tolerate fluoride toothpaste brushing teeth. One denture brush and and partialssoakin harmful plaque. At dentures, then soa overnight. Dry mout counter] dry mouth document indicated follow up/care conf adjusted. Remind H brush and soak it a Recommend clean When interviewed of family member (FM of periodontal disea an, "expensive gun due to poor oral co	Screening Form from a dental that R30 had been examined and was noted to have upper th heavy debris, and only one did not have lower dentures. us was marked as having ed] or bleeding [underlined] aily oral care plan was marked a staff supervision." The by the dental care provider ng each morning and evening, ms for approximately 2 ed, using a soft toothbrush and . Remove partials before ce daily use a toothbrush or mild soap to brush dentures ng alone will not remove bedtime, remove and brush k them in a denture cup th care, use an OTC [over the product as needed." The d the notes to nursing staff for erence: resident needs partial nim to take out partial nightly, and brush teeth twice daily. ing and exam."		plan reviews were initiated by the interdisciplinary team the week of 10, 2022. The use of the printed of guide has been eliminated as the information in the document is ave the electronic health record and accessible by facility and agency are reviewing the care plan document Instructions for viewing care plans added to the agency orientation g Unit managers will review new ord changes in condition and update of plans on an ongoing basis. The Director of Nursing or design provided education the week of Ja 24, 2022 to nursing team member including licensed nurses, trained medication assistants, and certifien nursing assistants on care plan up and accessing care plan and task in the electronic health record. The Director of Nursing or design audit care plans for updates three weekly for four weeks, twice week four weeks and then weekly for for weeks. The Director of Nursing or designee will ensure audit include validating staff understand process review care plan in the electronic record. Results of audits will be su to the Quality Council for Perform Improvement for review and recommendations.	are ailable in staff by s was uide. ders and care ee anuary rs ed odates updates updates ee will times cly for ur s s to health ubmitted	

If continuation sheet Page 11 of 48

		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING	i		01/(07/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	and ensure he had On 1/6/22, an EHR R30 had a colostom plan since his admi related to R30's new was also added on self-care deficits ind added to the care p intervention to remi dentures nightly, bri teeth twice daily wa other intervention w These items were a staff were questioned direction in these an When interviewed of nursing assistant (N knew to take care of tell her. She stated with brushing, but s not brushed for long aware of R30's den of oral care. On 1/07/22, 8:46 a. care plan and the 1 R30 and confirmed interventions related LPN-C stated interv added to the care p dental care and it w mouth, and inflame paper care guide fo information when it of bladder and toile	adequate oral care. care plan problem indicating ny was first added to his care ission in 2020. A problem area ed to have a urinary catheter 1/6/22. A problem related to cluding in oral cares, was olan on 10/22/20, but an ind him to take out his partial ush and soak it, and brush as added on 1/7/22, and no vas noted prior to that date. added to the care plan after ed about the lack of staff reas. on 1/06/22, at 9:03 a.m. NA)-A stated, the way she of R30 was because he could he would refuse assistance she would remind him if he had g enough. NA-A was not tal concerns and importance m. LPN-C reviewed the EHR /6/22 paper care guide for there were no listed d to his dental problems. ventions should have been olan after he was seen for vas noted he had debris in his ed tissue. LPN-C confirmed the or R30 gave conflicting indicated he was incontinent ting should be offered every 3 cated he had a colostomy bag	F	657			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/0	07/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 12	F 6	57			
	director of nursing (managers or floor n	on 1/7/22, at 9:42 a.m. the DON) stated, clinical nurses could update a care ssistant care guide should					
	with a copyright of 2 outlined the process and updating care p the standard MDS u quarterly or when the The policy indicated (CAA) would be use comprehensive care use the findings from starting point for de comprehensive plan responsible for add	Care Planning not dated but 2017 was provided. The policy is of completing assessments blan using the guidelines for upon admission, readmission, here is a significant change. If the Care Area Assessments ed to develop the e plan, saying: "the facility will im the CAA process as a veloping the resident's in of care. Note: the facility is ressing the needs and					
F 684 SS=G	included in the CAA provide information when changes occu periods, or how to r the EHR and the ha Quality of Care	dent weather [sic] or not it is process." The policy did not on how to maintain accuracy ur between assessment naintain continuity between andwritten care guides.	F 6	84			2/2/22
	applies to all treatm facility residents. Ba assessment of a re- that residents receivaccordance with pro-	care fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered					

Facility ID: 00419

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245153	B. WING			07/2022
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ADON	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 PREFI TAG		SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	ge 13	F 6	84		
	care plan, and the r	-				
	Based on observat	tion, interview, and document ailed to ensure staff monitored		F684 R108 was assessed and tre	eated for	
	edema and reporte edema to the physi and R114) reviewed	d indicators of increased cian for 2 of 3 residents (R108 d for edema. R108		edema and wound care by provider and orders and car updated the week of Januar	the medical re plan ry 5, 2022.	
	failed to monitor his physician of a six-p	harmed when the facility edema, failed to notify the ound weight gain in two days,		Orders have been updated edema checks and daily we reporting parameters includ	ights with ed. R114 has	
	physician's order, a	on stockings without a and R108 developed two open lower extremity with related		been discharged to home fr Residents with diagnoses o edema have the potential to by the alleged practice. Res	f CHF or be impacted idents with	
	Findings include:			these diagnoses were revie interdisciplinary team begin of January 10, 2022 and ord	ning the week	
	the facility on 12/28	identified he was admitted to /21 with diagnoses including,		revised and care plans upda indicated. Review of CHF p	ated if rotocol was	
		disease, sepsis due to ma, and congestive heart		completed with medical pro liaison, who explained this p initiated upon the medical p	protocol is rovider s	
		n Detail List Report dated he had no open areas on his		order after the first clinical v medical provider. Nursing w nursing interventions at adn	/ill implement	
	skin at the time of h and had, "2 + pitting	nis admission to the facility, g edema" (a build-up of excess		residents who have edema daily edema checks and da	that include ily weights.	
		the point an indentation 5 seconds after pressure is r extremities.		Unit managers will validate are completed and updates medical provider during rou chart reviews.	reported to	
	he had not had a M	nedical record (EMR) revealed linimum Data Set (MDS) eted at the time of survey.		The Director of Nursing or or provided education the wee 24, 2022 to licensed nurses	k of January on	
		ry included, an order for daily ays after admission beginning		management of CHF and e notification of medical provi in weight or edema. The Dir	der of changes	
		der for daily weights		Nursing or designee provide	ed education	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	-			APPROVE 0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED		
		245153	B. WING		01/	07/2022		
NAME OF	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, Z	ZIP CODE			
MADONI	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWE ROCHESTER, MN 55901	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE		
F 684	• • • • • • • • • • • • • • • • • • •	-	F 68					
	physician's orders i monitoring his eden R108's care plan, in potential for alterati 12/28/21. The appr increased edema a and report to NP/P/ Practitioner/Physici occurs." "Protect re and "weights as ord The care plan did r significant weight c R108's Care Guide revealed R108 was with no actual impa Care Guide reveale edema or location of compression stock R108's weights, ide pounds on 12/29/2 (a gain of 3.4 poun- pounds on 12/31/2 the previous day ar Further review of R	ncluded, "Resident with CHF, ion in vital signs," beginning roaches included, "Monitor for and significant weight changes A/MD [Nurse ian's Assistant/Physician] if esident from injury/trauma," dered," beginning on 12/28/21. not specify what constituted a hange. e for Unit B, where R108 ed by the facility on 1/5/22, s, "at risk" for skin impairment, airment. Further review of the ed no mention of R108's of his edema, or the use of ings. entified he weighed 210.3 1, 213.7 pounds on 12/20/21 ds in one day), and 216 1 (a gain of 2.3 pounds since nd 5.7 pounds in 48 hours). 108's weights revealed no re taken prior to 1/4/22 when		the week of January 24, nurses, trained medicati certified nursing assistant ensure orders for compri- or wraps are in place pri- these to residents. The Director of Nursing complete audits of daily four weeks, three times weeks, then weekly for f Results of audits will be facility Quality Council for Improvement for review recommendations.	on assistants, and ints on the need to ression stockings for to applying or designee will weights daily for weekly for four four weeks. submitted to the or Performance			
	5:23 a.m. included, left leg pain during stockings were rem had rolled partially	gress notes, dated 1/2/22, at "Resident c/o [complained of] the night. Ted [compression] noved from both legs as they down each leg and the elastic ich leg leaving grooves and						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		(X3) DATI	E SURVEY PLETED
		245153	B. WING		01/	07/2022
NAME OF I	PROVIDER OR SUPPLIER		S	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)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Continued From pa	ige 15	F 684			
	causing the fluid to Both legs and feet I Further review did r had an order for co physician was notifi R108's progress no included, "Nurse wa bed during night wh be applied to lower discovered skin bre blistering/weeping of and one major blist surrounding, draina which is mostly inta these areas. Reside from home he has	be trapped below the elastic. have +2 pitting edema." not reveal whether the resident intervention stockings, or if the ied of the pitting edema. betes dated 1/3/22, at 3:36 a.m. as assisting resident back to then resident requested lotion extremities. Nurse then eakdown and of right lower leg. One wound ther with other smaller blisters age scant and from blister act. Foam dressings applied to ent has compression stockings been wearing while at facility, current orders for compression				
	R108's Nurse Prac 1/3/22, included, "2 lower extremity that clear fluid now." Th blisters burst "unde R108's general ord	titioner progress notes dated blisters on the right lateral t have burst under draining he note did not specify what the er." ers dated 1/3/22, included, g changes to wo open areas on				
	R108's progress no "Received orders fo [bilateral lower extro open areas to RLE open blister area or cm [centimeters] x blister area next to	ote dated 1/5/22, included, or compression wraps to BLE emities] and foam dressings to [right lower extremity]. Larger n right shin measured today 5 [by] 2.5 cm, smaller open it measures 3 cm x 2 cm."				

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATI	E SURVEY IPLETED
		245153	B. WING	i		01/	07/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	 1/5/22, included the of R108's weights of R108's weights of 12/31/21. Further reextremity edema up weeping from the riblister anterior of has others that hav bilateral lower extremit although variable of certainly up - I susp LEs [lower extremit about 10 lb [pounds possible he will need trend continues daily dressing chan needed to the right edema soakage When interviewed of stated he had, "som the back of his right new within the past some discomfort. During interview an room on 1/5/22, at sitting in his wheelow were visibly swoller compression bandawere in the residem rest of a recliner in at the stockings and don't know where the They're garbage as can take them with 	e physician was not informed on 12/29/21, 12/30/21, or eview revealed, "Bilateral lower o to the knee level. He was ight lower extremity with 1 new on the right lower extremity. He re burst he does have emity edema and his weights, ver the past 48 hours are bect most of the weight is in his ties]. It is possible he is up s] post hospitalization It is ed IV diuresis if this weight . We will need to go to twice ages, or more frequently if lower extremity to control the ." on 1/4/22, at 2:07 p.m. R108 ne blisters or something" on t leg, which he stated were t two days and causing him ad observation with R108 in his 4:46 p.m. revealed R108 chair. His lower extremities n and loosely wrapped with a age. Compression stockings t's room, draped over the arm his room. The resident pointed d stated, "I don't wear those. I hey came from, but they hurt. a far as I'm concerned, and you	Fθ	584			

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STATEMENT	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245153	B. WING			01/	07/2022	
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
MADON	A TOWERS OF ROO	CHESTER INC			1 19TH AVENUE NORTHWEST CHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 684	 F 684 Continued From page 17 that she worked for a staffing agency, rather than the facility itself, so was not familiar with R108. NA-F stated that she would refer to her Care Guide for information on that resident. NA-F referred to the B Unit Care Guide and stated that R108 was, "at risk for skin problems but doesn't have any skin problems right now." NA-F stated the facility provided her with the Care Guide, which she carried with her and used as a reference when providing care, since she did not have access to resident care plans as an agency staff member. Review of the Care Guide revealed columns for resident room numbers and names, transfer status, devices such as dentures or glasses the resident used, toileting status, assistance needed for Activities of Daily Living (ADL's). whether the residents were "Skin/Fall Risk," and "Important Preferences." When interviewed on 1/6/22, at 11:13 a.m. NA-E stated he had worked with R108 in the past, but was not aware of any edema or if he wore compression stockings. NA-E stated that as a facility employee he could access both the care plan in the EMR and the Care Guide used by 		F6	84				
	licensed practical r not have any open 1/3/22, at that time	on 1/6/22, at 2:41 p.m. hurse (LPN)-D stated R108 did areas to his skin prior to ti was discovered he was ngs without an order and had						
	medical doctor (MI expectation that an	on 1/6/22, at 4:18 p.m. R108's D)-A stated, it was her ny resident admitted to the nosis of CHF would be placed						

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				PLE CONSTRUCTION		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
		245153	B. WING		01	/07/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MADONN	IA TOWERS OF ROC	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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	-	F 68	4		
	weights and skin as that daily weights w	I" which included both daily ssessments. The MD stated /ere the facility's primary mode so long as they were taken				
	before breakfast ea scale for accuracy.	The MD stated that the facility 108's almost 6-pound weight				
	gain in 48 hours be to her office, which	tween 12/29/21 and 12/31/21 she would have expected as rotocol." The MD stated that in				
	R108's case he had different hospital th	d been admitted from a an the facility was accustomed d she had been on vacation at				
	the time the resider the "CHF Protocol"	nt was admitted, so somehow did not get initiated. The MD ity should not have placed				
	physician's order an examined R108 on	ings on the resident without a nd that when she first 1/5/22, his edema was such				
	stockings because the point of weeping	have ordered compression he had, "significant edema, to g," and, "there was too much				
	damage or discomf would have been u	m safety without causing skin fort." The MD stated that R108 nable to don his own ings given the amount of				
	director of nursing (how R108 came to in his room, or who	on 1/7/22, at 8:19 a.m. the (DON) stated, he was not sure have compression stockings had applied them on 1/2/22 or tated, the facility was using				
	agency staff to cover so it was difficult to	er many shifts during this time, tell who had provided care for hts. The DON stated he				

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	H AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM	01/26/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245153	B. WING		01/	07/2022
NAME OF PROVIDER OR SUPPLIE	२		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADONNA TOWERS OF RO	CHESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 R108's care plan. the facility's policy well as the "CHF MD. At 10:11 a.m agency staff did h the EMR, but the as a shortcut so t limited amount of DON stated that h a spreadsheet in distributed them t When observed of family member (F R108 had used co in the past, but his stockings were to to hospitalization FM-B had been w compression ban had not brought ti over a chair in his R108's wound ca at 11:41 a.m. inclu- pitting edema of B from toes to mid so one open area an measurements w 1.0 cm x 1.0 cm. wound measured lateral right lower one large wound area within it. Tota pinpoint weeping 	bage 19 er and/or the stockings were on The DON was asked to provide of or Edema Management, as Protocol" referenced by R108's . the DON stated, "technically" ave access to the care plans in facility provided the Care Guide hey could provide care with a orientation to residents. The ne updated the Care Guides on his computer daily and o the nurse's stations. on 1/7/22, at 10:11 a.m. with M)-B, and LPN-D, FM-B stated ompression stockings at home is edema became so much the o tight, for about 2 months prior and nursing home admission. Trapping his legs with dages instead. FM-B stated she he stockings that were draped or oom, in for him. The progress note dated 1/7/22, uded, "Continues to have 2+ BLE (bilateral lower extremities) shin." "Right lower anterior had d two smaller areas." The ere right lower anterior shin 2.2 cm x 1.2 cm x 0.1 c.m. The leg, "does not appear to have but now has area with pin point al area 5.0 cm x 3.0 c.m. with areas throughout."	F 684			

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DAT	E SURVEY IPLETED
		245153	B. WING	i		01/	07/2022
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADONI	NA TOWERS OF ROC	HESTER INC			1001 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	the facility would ide resident at the time the "CHF Protocol" nurse would notify to administrator stated staff would not apple without a physician was asked to provid Edema Manageme The administrator do DON. The Administ preference that all so the EMR rather that Guide document the separately, and he team to, "make it hat When interviewed of DON stated the fac management or CH R114's Face Sheet admission date of 1 CHF. R114 did not completed at the time R114's Physician of and order to weigh the same scale ever be notified for weigh pounds in 48 hours weight. Dry weight of The physician was was over 280 pound R114's weights sind documented as: On 12/22/21, R114	entify CHF as a diagnosis for a of admission, and if orders for were not present, then the the physician. The d it was his expectation that ly compression stockings 's order. The administrator de copies of the facility's nt Policy and CHF Protocol. deferred these requests to the trator stated it would be his staff accessed the care plan in n try to keep a second Care at had to be updated would work with his leadership appen." on 1/7/22, at 12:41 p.m. the fility did not have an edema HF protocol. , undated, identified an 12/22/21, and a diagnosis of have an MDS assessment ne of the survey. rders dated 12/23/21, included daily, before breakfast, use ery day. The physician was to ht gain greater than 2.5 or 5 pounds over admission was noted to be 274 pounds. also to be notified if weight ds or under 268 pounds.	F	684			

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		AND HUMAN SERVICES			FORM): 01/26/2022 1 APPROVED). 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245153	B. WING _		01	/07/2022
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	over 280, defined a physician's orders) On 12/24/21, R114 On 12/25/21, R114 On 12/26/21, R114 explanation for this down from the prev On 12/27/21, R114 physician notification and a gain of greate hours) On 12/28/21, R114 Review of R114's E documentation that of weight variances 12/27/21, or 12/28/21 When interviewed of DON stated, the phy notified of R114's withe DON provided of physician had been 12/22/21, 12/29/21 physician had been 12/22/21, 12/29/21 physician had not b changes 12/23/21, Tree of Accident Ha CFR(s): 483.25(d)(1) \$483.25(d)(2)Each	 a notification point in the weighed 280.8. weighed 280.0. weighed 248.8 (no weighed 248.8 (no weighed 248.8 (no weighed 285.6 (warranting on for being over 280 pounds er than 2.5 pounds in 48 weighed 286.3. weighed 285.6. SMR, did not contain R114's physician was notified on 12/23/21, 12/26/21, 21. on 1/7/22, at 9:07 a.m. the hysician should have been <i>r</i>eight changes. At 1:26 p.m. documentation R114's notified of weight changes on and 1/3/22. However, the been notified of the weight 12/26/21, 12/27/21, or azards/Supervision/Devices 1)(2) 	F 68			2/2/22

Facility ID: 00419

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,	IG		IPLETED
		245153	B. WING		01/	07/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
MADON	NA TOWERS OF ROC	HESTER INC		Т		
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From pa	age 22	F 68	9		
	accidents.	NT is not met as evidenced				
		tions, interviews and record		F689		
	review, facility faile	d to clearly communicate and		R204 care plan reviewed		
		vention interventions for 2 of 2		January 7, 2022. R45 car		
		nd R45) who had recently fallen		and revised January 5, 20		
	in the facility.			interdisciplinary team con risk assessment and root		
	Findings include:			on previous falls for R204		
	·			week of January 24, 2022		
		Minimum Data Set (MDS)		care plan if indicated.		
		as completed upon return from		Residents who experienc		
		2/17/21. The MDS indicated		potential to be impacted b		
		ely impaired cognition and assistance of two persons with		practice. Residents who h since January 7, 2022 we		
		id not stand or walk at that		week of January 24,2022		
		osis list included a history of		interdisciplinary team with		
		nt fracture of his right ischium		analysis completed and c		
		c bone under buttock		updates implemented bas		
		a, secondary parkinsonism on's disease with tremors,		cause. The interdisciplina continue to review falls du		
		reduced movements), among		interdisciplinary meetings		
	many other co-mor			root cause and implemen reduction interventions. T	t effective falls	
		nealth record (EHR) care plan		was reviewed and remain	is current. The	
		n, start date 12/17,21, "resident		use of the Falls Checklist		
		T [related to] unspecified		be implemented at the tin		
		hium, Parkinson's dse [sic], al for this problem area dated		ensure falls investigation information that is useful		
		will remain free from injury."		root cause.	a dotor mining	
		isted included, "12/17/21 keep		The Director of Nursing o	r designee	
		t all times" and "12/17/21		provided education the w	eek of January	
		, "12/25/21 offer resident to lie		24, 2022 to licensed nurs		
		er meals", and an additional		medication assistants, an		
		dded 1/7/22, "W/C [wheelchair] h bed." A problem dated		nursing assistants on the with Huddle to assist in de		
		, "I have a self-deficit with the		root cause of the fall base		
		of daily living; bathing,		contributing factors. This		

Facility ID: 00419

		& MEDICAID SERVICES	(X2) MUL	TIPLE	E CONSTRUCTION		0938-039 SURVEY
ID PLAN OF CO		IDENTIFICATION NUMBER:	. ,	DING		COMPLETED	
		245153	B. WING			01/07/2022	
NAME OF PRO	/IDER OR SUPPLIER			ST			
	OWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	JLD BE COMPL	
F 689 Continued From page 23		F 6	89				
int as up as tra fol "1? ne de de as pe A 1/6 of ca no Th the so re: an ac do nu Pr Ar ca in the tha leated as ca an ca an ca an ca an ca ca an ca ca an ca ca an ca ca ca ca ca ca ca ca ca ca ca ca ca	bility, vision, bow erventions includ sist me with trans dated/changed o sist of 1 with FW nsfers." Howeve lowing two interv 2/17/21 I require eds addressed", vices can help m ficits. I use: EZ S sist with standing rsons]." Daper document, 5/22, indicated R2 one person and a re guide indicate t provide any ind e following state a guide: "Importa lely on these Car sident Care Plan d up to date infor cessed from POO cumentation site rsing assistants] ofile" in the uppe e event report dat ll-light was on, but his room sitting a e emergency root at time. No furthe	es, ambulation, transferring, wel and bladder." Listed led, "I require assist of 2 to sfers with EZ stand," on 1/7/21 to read, "I require W [front wheel walker] for r, the care plan maintained the entions listed separately, assist of 2 to get my toileting and "12/17/21 Using assistive be better take care of my Stand [mechanical device to g] with A x2 [assist of two "care guide" updated on 204 transferred with the assist a FWW, but did not walk. The d R204 was a fall risk, but did ication of safety interventions. ment was printed at the top of nt Notice: Please do not rely re Guides. Please refer to or Profile for more accurate rmation. The Profile can be C [point of care, a in the EHR primarily for by clicking on "Resident r right corner of POC."			included the need for the licensed to implement an immediate interve based on the information collected the completion of the falls checklis The Director of Nursing or designe complete audits of fall documentar care plan interventions three times for four weeks, twice weekly for four weeks, and then weekly for four weeks, and then weekly for four we Results of audit will be forwarded to facility Quality Council for Perform Improvement for review and recommendations.	ention I during it. ee will tion and s weekly ur eeks. to the	

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING			COMPLETED	
		245153				01	/07/2022
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	CHESTER INC			01 19TH AVENUE NORTHWEST DCHESTER, 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 689	Continued From pa	age 24	F 68	89			
F 689	on 12/17/21. The d greater than ten re R204 was assesses section of the form summary-identify r to the resident fall environmental risk documentation. Th appropriate" were therapy) and PT (p titled: Plan of Care documented: "indic continue current pl An event report da had an unwitnesse by a nursing assist but he was laying of The immediate inter	isk factors that may contribute risk, including medications and factors," contained no e referrals listed that, "may be checked as OT (occupational hysical therapy). In the section , the following was cate care plan action taken: an of care." ted 12/20/21 indicated R204 ed fall at 4:14 a.m.; was found ant responding to his call light on the floor next to the bed. ervention chosen was, "rest,"					
		rentions documented including aid in preventing this type of g again.					
	had an unwitnesse and he had said he No immediate inter been implemented continue to be mor	ted 12/25/21 indicated R204 d fall at 10:54 a.m. in his room, e was getting himself into bed. rventions were listed as having except to say he would hitored. He was noted to have cipating in therapy services at					
	an unwitnessed fal was found on his b intervention was ob indicated "post fall	ted 1/2/22 indicated R204 had I in his room at 12:25 a.m. He edroom floor. The immediate oservation, and a note monitoring in place along with d to care plan." No additional					

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		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:	. ,	G) ´co	COMPLETED	
		245153	B. WING		01/07/2022		
NAME OF F	PROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP O	CODE		
MADON	A 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 689	Continued From pa	age 25	F 68	9			
	interventions docu	mented.					
	1:14 p.m. included up] fall on 12/12, 1 12/12, resident fell on and was answe the nurse sitting or resting against his 12/20, at 4:15 am r right side, on the fl denied any pain. N On 12/25, resident injuries. None note laying on back upo am. Resident denie within normal limits per resident's base d/t [due to] history disorders (a person paranoia, odd or un Parkinsonism & de (proteins in brain a Most recent BIMS indicating moderat analysis): impaired awareness. Intervers sent to ED for eval conditions, fall mat after meals and ob supervised area with	ementia with Lewy bodies ffecting memory and thought). {cognitive assessment] is 9 e impairment. RCA (root cause l gait/balance and poor safety entions include: Resident being uation of underlying health at bed side, lie resident down serve frequently and place in hen out of bed."					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING	i		01/(07/2022
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	NA 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 689	bedside table was p R204 had a moist of backward and mou answer questions a 1/06/22, 10:42 a.m. room sitting up in w hall. During an interview nursing assistant (N how to care for the and experienced at learn was to follow them. NA-B said the available, but was r access the EHR ca the notice on the ca to be documenting time. NA-B said she or contracted "pool" On 1/6/22, 10:59 a. described the "care would describe how them in bed and "al said, "after a while" cares]." NA-A state assistance of two p the "care plan" india reported the followi falls as she knew th and make sure he is up because he has to sit up. And we has turns on his light to don't leave him."	positioned next to the bed. cough, kept his head extended th open. He was not able to at that time. . R204 was observed in his v/c, not able to be seen from v on 1/6/22, 10:50 a.m. a NA)-B stated staff would know residents if they were familiar t the facility, and the way to other staff and learn from ere was a paper care guide not able to describe how to are plan when asked despite are guide. NA-B was observed in the EHR POC system at the e sometimes trained the new		589			

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245153	B. WING _		01	/07/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
MADON	NA TOWERS OF ROC	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 689	practical nurse, (LF worked the evening that R204 had had LPN-A said there w guide for nursing a experienced staff w new. LPN-A stated not use his call ligh persons working or pillow under his rig him not to get up w place his call-light of turn on the call-light benefit from having reported this, but s and was unsure hor relation to fall preve pressure alarms wh help R204, and wa longer used, and a LPN-A did not upda confirmed her reco on the care plan or On 1/07/22, 8:46 a team would discuss the Interdisciplinary fall incidents to dec interventions, espe vary depending on unsure if night staff but night shift were monthly basis whea information about a said, as a clinical m to update the care residents on the sa	PN)-A stated she usually g and night shift, and confirmed several falls during the night. vere paper sheets that were a ssistants and the more vould help those who were R204 was quite impulsive, did it, and said to prevent falls, in the night shift would tuck a ht side which would remind vithout help, and they would under it so his weight would it. LPN-A thought R204 would g a fall mat on his floor and had aid she had never heard back we decisions were made in ention. She stated she knew ere noisy, but thought it would s unsure of why they were no lso stated, "I miss side rails." ate care plan interventions and mmendations were not listed care guide. .m. LPN-C stated their overall s care plan interventions, and y Team (IDT) would meet after	F 68	39		

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '	NG	· · ·	MPLETED
		245153	B. WING		01	/07/2022
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
MADON	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 689		age 28 e assist of one at all times, and	F 6	89		
	walking with therap should have his W breaks locked in ca however, LPN-C ca not indicate this wa nor did the care gu to update the care incorrect. LPN-C s be following the pa R204's care guide said clinical manage	by. Instead, LPN-C said R204 /C at his bedside with the ase he would attempt to get up; onfirmed the EHR care plan did as the appropriate intervention, ide. LPN-C said she was going plan immediately as it was tated nursing assistants should per care guide, and confirmed did not match the EHR. LPN-C gers were responsible to ide as well as the care plan in				
	On 1/07/22, 9:42 a (DON) stated inform related to falls wound resident, and the full Wednesday to discon- would rely on the ele- said a meeting was were to attend, but the nurses on the fi- directly with the clin or clinical manager Also, if the IDT man clinical managers on nurse working on t with the rest of the expectation for app added to the care pro- the care guide to a possible. DON stat care plan should b- guides had been d	.m. the director of nursing mation for safety interventions Id vary according to the ull IDT team met every cuss any issues, but the facility entire team to give input. DON is held each month and staff for the best continuity of care, floor should communicate nical managers, but that nurses rs could update the care plan. de recommendations the were expected to talk to the he unit who were then to share staff. DON also stated an propriate interventions to be plan as soon as possible, and lso be updated as soon as ted ideally the care guide and e matching. DON said the care esigned for contracted pool y reference, but he had an				

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245153	B. WING			01/	07/2022
NAME OF I	PROVIDER OR SUPPLIER		· [S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Continued From pa cares.	ge 29	F 6	89			
	with a copyright of 2 outlined the process and updating care p the standard MDS of quarterly or when the The policy indicated (CAA) would be use comprehensive care use the findings fro starting point for de comprehensive plan responsible for add strength of the reside included in the CAA provide information when changes occu- periods, or how to re the EHR and the has A facility policy titled not dated but with a provided. The police risk for falling will has through the residen resident experience assesses the reside for, safety and com- indicated, "Residen individualized residen	Care Planning, not dated but 2017, was provided. The policy is of completing assessments oblan using the guidelines for upon admission, readmission, here is a significant change. If the Care Area Assessments ed to develop the e plan, saying: "the facility will m the CAA process as a veloping the resident's in of care. Note: the facility is ressing the needs and dent weather [sic] or not it is A process." The policy did not on how to maintain accuracy ur between assessment maintain continuity between andwritten care guides. d Integrated Fall Management, a copyright of "20xx", was y indicated, "Residents with ave interventions implemented it centered care plan. When a es a fall, a licensed nurse ents condition, provides care fort." In addition, the policy ts at risk for falls have an ent centered care plan an interventions are based on					

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/0	07/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	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 PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Review of the facilit Management" polic Assessment is corr admission to the fa- falls have an indivic plan developed R45's Face Sheet in the facility on 11/23 12/01/21 with diagn COVID-19, Conges chronic respiratory concentration of ox diabetes mellitus, n unsteadiness on his R45's Fall Risk ass identified fall risk fa and functional impa functional status, hy impaired balance; r both of his upper ex anticoagulant, antih narcotic medication R45's care plan dat problem area for fa prevent falls was to R45's progress not a.m. included he has shortness of breath R45's progress not a.m. identified he h where he had been infection, weakness to assist R45 out of	by's undated, "Integrated Falls by revealed, " A Fall Risk inpleted within 48 hours of cility Residents at risk for dualized resident centered care " dentified, he was admitted to /21 and re-admitted on hoses which included stive Heart Failure (CHF), failure with hypoxia (lowered ygen in the blood), Type 2 huscle wasting and atrophy, is feet, and repeated falls. essment, dated 11/23/21, ictors included neuromuscular airment such as decline in ypotension, or syncope; range of motion impairments in ktremities; and the use of hypertensive, diuretic, and	F 6	89			

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/0	07/2022
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa extremities.	ige 31	F 6	89			
	risk assessment wi	rd did not include a new fall th his change of condition. d not been updated regarding assistance or fall					
	identified, R45's kn	e dated 12/2/21, at 5:12 a.m. ees were buckling, had an ransfer needs were to be					
	12:57 p.m. identifier for help, and found prone position." "Re on the side of the b Immediate interven encouraged to not s he agreed to do and	s report dated 12/2/21, at d, "Staff heard resident calling him laying on the floor in the esident stated he was sitting red and fell forward." tion was listed as: "he was sit at the side of the bed, which d demonstrated verbal d a work order put in for bed bariatric recliner.					
	approach added on	d a new fall prevention 12/2/21, "I have been sit on the edge of the bed."					
	cognitively intact ne 2 for bed mobility a	DS dated 12/7/21, identified eed for extensive assistance of nd transfers, did not ambulate, had experienced one fall with ion.					
		ded the fall intervention on rs and bariatric recliner.					
		e dated 12/15/21, at 8:22 a.m. t legs are bending, lifting,					

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/0	07/2022
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	NA TOWERS OF ROC	HESTER INC			01 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Therapy/nursing is spinal stenosis as the being observed. His R45's progress note identified the nurse at emergency depad dated 12/22/21, at the been returned to the R45's progress note included, "heard so hallway noticed the mergency and continuing that he had a spase Call light was not on Further review of the Emergency Medica summoned and the for treatment of the R45's care plan had falls added on 12/3 encouraged to slee [wheelchair]." During observation 1/4/22 at 9:29 a.m. in his room with his abdomen. R45 had left eyebrow, and a L-shaped scar exte above his nose, acr left eye just below h	he resident's control concerned about potential the cause for the movements s arms are also weak." e dated 12/21/21, at 2:22 p.m. practitioner wanted R45 seen artment. Another progress note 1:19 a.m. identified R45 had e facility with no new orders. e dated 12/29/21, at 3:51 a.m. meone yelling 'help' down the resident on floor facing down to the left upper portion of his oderate amount of blood on the g to bleed Resident stated m and his trunk flew forward. n but was within reach." his progress note revealed al Services (EMS) were e resident was sent to the ED e laceration. d a new approach to prevent 1/21, of, "I have been ep in bed and not my and interview with R45 on R45 was sitting in wheelchair overbed table pulled close to a reddish colored scar on his second upside down ending from between his eyes ross his forehead to above his hairline. The L-shaped scar	F 6	89	DEFICIENCY)		
	appeared to be from	m a laceration which had been the scars were from falls he					

If continuation sheet Page 33 of 48

TATEMEN	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	;		IPLETED
		245153	B. WING		01/	/07/2022
NAME OF	PROVIDER OR SUPPLIER		Ş	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)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 689	had in the facility. T fall, which resulted had been because forward while sitting the second had be sitting in the wheele face. R45 stated th sent to the hospital continued to experi the facility had not prevent further falls taken it upon himse table snugly to his in his wheelchair as prevent him from fa another episode of spasm. When interviewed stated she had bee since 6:00 a.m. NA agency and was no She had a care gui used that as a refe Guide" revealed co numbers and name such as dentures of toileting status, ass Daily Living (ADL's she worked for a st	The resident stated that the first in the scar on his eyebrow, he became fatigued and fell g on the edge of his bed, and en when he had a spasm while chair and fell forward onto his that after the second fall he was for sutures. R45 stated he ience spasms daily. R45 stated implemented any measures to a sa far as he knew, but he had elf to pull his wheeled overbed abdomen while he was sitting she believed that would alling should he experience fatigue or a "severe" muscle on 1/5/22, at 5:40 p.m. NA-F en assigned to care for R45 a-F worked for a staffing ot familiar with R45's needs. de provided by the facility and rence. Review of the "Care of glasses the resident used, sistance needed for Activities of). NA-F stated that because taffing agency, and not the ould not access individual	F 689			

If continuation sheet Page 34 of 48

STATE BURN OF DEFICIENCIES AND PLAN OF CORRECTION (X) IP ROVDERSUPPLIER IDENTIFICATION NUMBER: (X) INT_FLE CONSTRUCTION A BUILDING (X) IO PLATESUPPLIER (X)			AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC 4001 19TH A/ENUE NORTHWEST MADONNA TOWERS OF ROCHESTER INC PROVIDER SUPPLIER MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC PREVIDENCES, CITY, STATE, ZIP CODE MADONNA TOWERS TO THE AND TO STATE AND TO THE ADDRESS, CITY, STATE, ZIP CODE MADONNATOWERST F 689 Continued From page 34 F 689 F 585 Continued From page 34 F 689 F 689 Continued From page 34 F 689 F	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		LE CONSTRUCTION	(X3) DATI	E SURVEY
MADONNA TOWERS OF ROCHESTER INC 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 5801 PHEFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OBFICENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) Image: Continued From page 34 R45 without looking at him. The surveyor accompanied NA-F to R45's room, where R45 was sitting in his wheelchair with his overbed table palled snugly in front of his abdomen. NA-F stated R45 was alert and oriented so she did not have to check on him more frequently than every two hours but should respond quickly if the resident activated his call light. NA-F stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair. R45 stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair. R45 stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair. R45 stated that there was "nothing the receiner at some point, which may have been after his first fall, but did not instruct him to use it as a preventive measure against further falls and, "It wouldn't work anyway. I can't lift the footrest." R45 stated the footrest up, which felt "a lifte more secure" than his wheelchair, but he found that difficult because he liked his head elevated to make it aspir to breather. R45 stated sometimes he ended up sleeping in the recliner unless the footrest was up. R45 stated staff typically checked on him "revy couple of hours" unless he put his call light on, which would be fine "unless I have another spasm that causes me to fall." R45 stated to him ifrequently to			245153	B. WING	i		01/	07/2022
ROCHESTER INC ROCHESTER, NN 65901 (M)ID SUMMARY STATEMENT OF DEFICIENCIES INCACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID IPOVIDER'S INVO F CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) ID ID PROVIDER'S INVO F CORRECTION INCACH DORING STATUTE REGULATORY OR LSC IDENTIFYING INFORMATION) IPO F 689 Continued From page 34 R45 without looking at him. The surveyor accompanied NA-F to R45's from, where R45 was sitting in his wheelchair with his overbed table pulled snugly in front of his abdomen. NA-F stated R45 was alert and oriented so she did not have to check on him more frequently than every two hours but should respond quickly if the resident activated his call light. NA-F stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair. NA5 stated tha facility had brought in the recliner at some point, which may have been after his frost fall, but did not instruct him to use it as a preventive measure against further falls and, "It wouldn't work anyway, L can't lift the footnest." R45 stated to facility/ wanted him to sleep in a bis de and not the recliner or the wheelchair, but he found that difficult because the liked his head elevated to make it easier to breather. R45 stated sometimes he ended up alseping in the recliner without the footrest way. Use and the facility the more secure" than his wheelchair, but he was concerned another spasm could result in falling from the recliner unless have another spasm that causes me to fall." R45 stated it was his sexpectation that staff caring for him would be knowledgeable about his fa	NAME OF F	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
Preferst TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) COMMETER INTERPORTATION F 689 Continued From page 34 R45 without looking at him. The surveyor accompanied NA-F to R45's room, where R45 was sitting in his wheelchair with his overbed table pulled snugly in front of his abdomen. NA-F stated R45 was alert and oriented so she did not have to check on him more frequently than every two hours but should respond quickly if the resident activated his call light. NA-F stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair in his room. F 689 When interviewed on 1/5/22, at 5:45 p.m. R45 stated he had a recliner in his room, but was currently sitting in his wheelchair. R45 stated the facility had brought in the recliner at some point, which may have been after his first fall, but did not instruct him to use it as a preventive measure against further falls and, "It wouldn't work anyway. I can't lift the foortest". R45 stated to make it easier to breathe. R45 stated to make it easier to breathe. R45 stated sometimes he ended up sleeping in the recliner unless have another spasm that cause me to fall." R45 stated it must not was not current unless the put his call light on, which would be fine "unless have another spasm that causes me to fall." R45 stated it may have becked on him "every couple of hours" unless have another spasm that causes me to fall. R45 stated it has his expectation that staff caring for him would be knowledgeable about his fall history and checking on him frequently to	MADON	NA TOWERS OF ROC	HESTER INC					
R45 without looking at him. The surveyor accompanied NA-F to R45's room, where R45 was sitting in his wheelchair with his overbed table pulled snugly in front of his abdomen. NA-F stated R45 was alert and oriented so she did not have to check on him more frequently than every two hours but should respond quickly if the resident activated his call light. NA-F stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair in his room. When interviewed on 1/5/22, at 5:45 p.m. R45 stated he had a recliner in his room, but was currently sitting in his wheelchair. R45 stated the facility had brought in the recliner at some point, which may have been after his first fall, but did not instruct him to use it as a preventive measure against further falls and, "It wouldn't work anyway. I can't lift the footrest." R45 stated the facility wanted him to sleep in his bed and not the recliner or the wheelchair, but he found that difficult because he liked his head elevated to make it easier to breather. R45 stated sometimes he ended up sleeping in the recliner without the footrest up, which felt "a little more secure" than his wheelchair, but the was concerned another spasm could result in falling from the recliner unless the footrest was up. R45 stated staff typically checked on him "every couple of hours" unless he put his call light on, which would be fine "unless he put his call light on, which would be fine "unless he put his call light on, which would be fine "unless the footrest was he expectation that staff caring for him would be knowledgeable about his fall history and checking on him frequently to	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
When interviewed on 1/6/22, at 11:16 a.m. NA-E stated he regularly cared for R45. NA-E stated	F 689	R45 without looking accompanied NA-F was sitting in his wit table pulled snugly stated R45 was ale have to check on hi two hours but shoul resident activated h there was "nothing of in terms of R45's sitting in his wheeld When interviewed of stated he had a rec currently sitting in h facility had brought which may have be not instruct him to u against further falls I can't lift the footres wanted him to sleep recliner or the whee difficult because he make it easier to br he ended up sleepin footrest up, which fa his wheelchair, but spasm could result unless the footrest typically checked on unless he put his ca "unless I have anot fall." R45 stated it w caring for him would fall history and chece ensure his safety.	g at him. The surveyor to R45's room, where R45 heelchair with his overbed in front of his abdomen. NA-F rt and oriented so she did not im more frequently than every ld respond quickly if the his call light. NA-F stated that special" she had to be aware a safety or fall risk with him thair in his room. on 1/5/22, at 5:45 p.m. R45 liner in his room, but was is wheelchair. R45 stated the in the recliner at some point, en after his first fall, but did use it as a preventive measure and, "It wouldn't work anyway. st." R45 stated the facility p in his bed and not the elchair, but he found that to liked his head elevated to reathe. R45 stated sometimes ing in the recliner without the elt "a little more secure" than he was concerned another in falling from the recliner was up. R45 stated staff n him "every couple of hours" all light on, which would be fine her spasm that causes me to vas his expectation that staff d be knowledgeable about his cking on him frequently to	F	589			

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		ING	· · ·	MPLETED
		245153	B. WING		01	/07/2022
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 DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	age 35	F 6	89		
	did not consider hir because "he's total NA-E stated there staff had to take to	R45 had fallen in the past but m to be a current fall risk assist with almost everything." were no special precautions prevent falls for R45 and very two hours was sufficient.				
	director of nursing R45 a fall risk base facility. The DON s room, which was "r resulted in increase were also encourag and offering to lay I NA-F's lack of fami any precautions sh caring for R45, the pool [staffing agend Assistant], so I wou same depth of info own staff would hav recliner should be to he is taking a nap o it that way as far as Nutrition/Hydration CFR(s): 483.25(g)(Status Maintenance 1)-(3)	F 6	92		2/2/22
	(Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas	sessment, the facility must				
		tains acceptable parameters , such as usual body weight or				

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		& MEDICAID SERVICES	0.001		OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245153	B. WING _		01/0	07/2022
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
MADONI	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 692		pht range and electrolyte	F 69	2		
		resident's clinical condition his is not possible or resident e otherwise;				
	§483.25(g)(2) Is off maintain proper hyd	ered sufficient fluid intake to dration and health;				
t F E E F C C	there is a nutritiona provider orders a th	ered a therapeutic diet when I problem and the health care herapeutic diet. NT is not met as evidenced				
	and policy review th prescribed theraped residents (R3 and F	tion, interview, record review, ne facility failed to ensure the utic diet was followed for 2 of 2 R204) reviewed for therapeutic re potential for choking,		F 692 R3 Informed Consent proces with resident by Speech Lang Pathologist on January 6, 202 will receive puree foods and o non-puree foods as desired.	juage 22. Resident can request	
	Findings include:			provider was updated on resi to request non-puree foods a Nutrition care plan is updated	dent choice s desired.	
	admission date in A 11/4/21. Diagnoses (difficulty swallowin pain. R3's quarterly	ndated, indicated an ugust 2019 and readmission included, diabetes, dysphagia g), depression and chronic Minimum Data Set (MDS) ntified R3 was cognitively		staff have received training o therapeutic diets. R204: The Clear supplement was chang Plus and has been flow teste criteria to verify compliance w thick fluids.	Ensure ed to Ensure d per IDDSI	
	intact and did not has swallowing disorder	ave signs or symptoms of a r.		Residents who receive altere diets or thickened liquids hav potential to be impacted by th	e the le alleged	
	pureed diet and wa			practice. A comparison of die meal suite and orders entere electronic health record and o	d in the lata base	
	stated, "I am suppo but lately they have	on 1/4/22, at 10:30 a.m. R3 sed to be on a pureed diet, been sending me regular e was on a pureed diet due to		was updated if needed based and comparison. The policies texture and thickened liquids reviewed and remains curren	for altered was	

Facility ID: 00419

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			X3) DATE	0938-039 SURVEY PLETED
		245153	B. WING			04/0	7/2022
	PROVIDER OR SUPPLIER	243133			REET ADDRESS, CITY, STATE, ZIP CODE	01/(07/2022
	NA TOWERS OF ROC	CHESTER INC		40	01 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 692	Continued From pa	age 37	F 69	92			
	and determination The SLP made rec physician who agree on 11/10/21. During an observat R3's lunch meal, R that appeared to be pureed along with the cauliflower florets. chicken and rice an The dessert was a texture) that R3 ate and stated it went of regular consistency. The meal ticket on pureed diet circled. During an observation of regular texture full chips. No pureed it Tray ticket was observation regular texture full chips. No pureed it Tray ticket was observation stated she was una salad. R3 stated sh lettuce, chips, and consistency. During an observation R3's lunch meal was room at 11:25 a.m. time. Observation of regular texture full chips. No pureed it Tray ticket was observation stated she was una salad. R3 stated sh lettuce, chips, and consistency.	tion on 1/5/22 at 11:30 a.m. as observed delivered to her R3 was not in her room at the of the lunch meal revealed a taco salad with whole tortilla tems were noted on her tray. served and noted to have			culinary staff on how to properly thick fluids when commercially prepared thickened products are not available Training was also provided on follow the meal suite ticket when preparing plates for residents. The Director of Nursing provided training to the thera staff and to licensed nurses on follow diet texture orders and notifying the medical provider and completing the informed consent process for reside who choose not to comply with order The culinary director or designee will complete random meal audits. The frequency of these audits will be three times weekly for four weeks, twice w for four weeks, then weekly for four weeks. Results of audits will be forw to the facility Quality Council for Performance Improvement for review recommendations.	apy wing nts rs. I veekly varded	

	FORM	APPROVED 0938-0391					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		СОМ	PLETED
		245153	B. WING			01/	07/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	A TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 692	Continued From pa	ge 38	F 6	92			
	During an interview	on 1/6/22, at 3:30 p.m. with					
	the culinary service	s director (CSD), registered					
		director of nursing (DON); the quently would go into the					
	kitchen and "yell at	the kitchen staff that she					
		and not pureed." However, RD stated those interactions					
	-	ed in R3's chart and the CSD					
		ent diet order for R3 was a					
		t would be expected to be le RD stated she was not					
	aware that R3 did n	ot want a pureed diet and had					
		r to discuss any potential rent diet. The DON stated that					
		locumenting refusals for the					
	pureed diet and cor	mmunicating with the kitchen					
	staff, CSD or RD fo diet.	r a review, or changes, to her					
		MDS dated 12/23/21,					
		dmission assessment after 2/17/21, R204 had moderately					
		required the extensive					
	•	erson for eating. R204's					
		ed dementia, secondary lar to Parkinson's disease with					
	tremors, stiffness, s	slow and reduced movements,					
		and dysphagia (difficulty nd liquids) along with many					
	other co-morbidities	, ,					
	R204's care plan in	dicated a problem, start date					
	1/5/22, "I have ineff	ective breathing patterns					
		n, as evidenced by : Dx					
		nagia, coughing, pureed diet uids]. Additionally, the care					

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PRINTED: 01/26/2022

		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/	07/2022
NAME OF	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 DEFICIENCY	TEMENT OF DEFICIENCIES / 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 692	plan also contained have an alteration in to [sic] dx of dyspha events and need fo order and assistant "provide diet as ord honey-thickened liq recommended in ac therapy]. On 12/10/ was added, "provide Ensure clear (honey A paper document " 1/6/22 indicated that required a pureed of liquids. According to R204's date of 12/27/21, d Liquids: nectar cons On 1/05/22, 3:21 p. in his room, only the from the door. After positioned somewh pillows and a soft to had a moist cough, backward and mout answer questions a 1/06/22, 10:42 a.m. room sitting up in w hall; had half glass without a lid or stray but no straw sitting table. A boxed serv sitting on the table,	 a problem dated 12/10/21, "I in nutrition/hydration status r/t agia, hx [history] of aspiration r mechanically altered diet ce at meals." The goal stated: lered (pureed texture with juids 12/10/21) and ccordance with ST [speech 21 the following intervention e nutritional supplement: 8 oz y-thickened)." "care guide" updated on at R204 had dysphagia and diet with nectar thickened s physician orders with a start liet: dysphagia (pureed) sistency. m. R204 was observed in bed e foot of the bed was visible r entering, was observed to be at on his right side using buch call light in bed. R204 kept his head extended th open. He was not able to at that time. R204 was observed in his r/c, not able to be seen from of thickened orange juice w and a glass of water with lid, next to him on a bedside ing of Ensure Clear was also the contents could not be s no indication if it was 	F	\$92			

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/0	07/2022
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	NA TOWERS OF ROC				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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From pa	age 40	F 6	92			
	nursing assistant (N how to care for the and experienced at learn was to follow them. NA-B said th available, but was r access the electron On 1/6/22, 10:59 a. provided interventions said it was important right, put his head of swallowing and need At 1/06/22 11:04 a. enter R204's room wheel chair. NA-A to meal, but he pointe an overbed table. N Ensure and R204 ro observed in its original placed a straw into a drink, and then to During an interview registered nurse (R of Ensure Clear in the the container did not to its consistency. F thicker than water, [consistency]." RN- the people in the kii product was thicker re-entered the room taking it."	.m. NA-A, said the care guide ons for resident care. NA-A nt for R204 to be "positioned up because he has trouble					

		AND HUMAN SERVICES				FORM	: 01/26/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245153	B. WING	i		01/	07/2022
NAME OF	PROVIDER OR SUPPLIER			S	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	Ensure Clear was r Immediately after, t stated an expectation the product to a responsibility of the correct product to a responsibility of the provided in the dining the written direction resident's room. At 1/06/22, 11:15 a. retrieved the Ensure poured approximate cup and compared thickened juice and bedside table. RN-F appeared to be more other two beverage to be "nectar thick." During an interview said nursing assistat liquids, stating it was staff to thicken any they were the one be requires thickened how a person would had already been the room. RD stated a con-thickened liquid his dysphagia "act to Director who had be problem. We should poured into a glass On 1/06/22, 2:41 p. responsibility of the correct product for liquids, and they we who had the ability	not a pre-thickened product. the registered dietician (RD) on for whomever was taking sident to use a thickener ing area as needed, following its, before taking it to a .m. in R204's room, RN-B e Clear left in the room and ely two ml into a clear plastic the solution to R204's I thickened water sitting on his B confirmed the Ensure Clear re liquid in nature than the s, and stated it did not appear 1/06/22, 1:51 p.m. the RD ants or dietary could thicken is the responsibility of nursing liquid to match the orders if oringing it to a resident who liquids. RD was not able to say d know R204's Ensure Clear nickened if they found it in the concern in providing ds to R204 as it might make up." The Culinary Services een listening stated, "that's a d do something. It should be	F	692			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/26/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		E SURVEY PLETED
		245153	B. WING			01/0	07/2022
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	thickened liquids ar care plan or care gr come in the proper said a nurse might able to read and un instructions. DON of who had prepared the would be able to kn it was not visible the On 1/07/22, 9:57 a order for Ensure Pl R204. DON then sa could mix thickened not nursing staff, ar A facility policy titled but with a copyright receive thickened li which specifically si thickened liquids. It to ensure that the re the appropriate com while promoting add consistencies mato were described as: thin milkshake or en honey at room temp or pudding thick-con not run off a spoon. thickened liquids for commercially prepa- medication administ	e required by looking at the uide, but the liquid should state from the kitchen. DON thicken liquids if they were derstand the package onfirmed that only the person he Ensure Clear for R204 ow if it had been thickened as rough the container. .m. the DON stated a new us had been received for tid, the only persons who d liquids were dietary staff, and this was not a new policy. Thickened Liquids, not dated of 2012, indicated "residents quids per a physician's order tates the consistency of the is the responsibility of all staff esident receives all liquids in sistency to prevent aspiration equate hydration." The hing those used at the facility nectar thick-consistency of ggnog, honey-consistency of perature or a thick milkshake nsistency of pudding and does The responsibility of s described as "culinary ponsible for providing r meals and nourishments and tred products that are used for tration. In addition, the policy for thickened liquids should be	F 6	92			
F 880 SS=D	Infection Prevention	•	F 8	80			2/2/22

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/	07/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pro-	1)(2)(4)(e)(f) Control stablish and maintain an a and control program a safe, sanitary and ment and to help prevent the ransmission of communicable tions. In prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards; en standards, policies, and program, which must include, to: reillance designed to identify table diseases or ey can spread to other	F٤	380			

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		AND HUMAN SERVICES				FORM	01/26/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE	E SURVEY PLETED	
		245153	B. WING			01/07/202		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MADON	NA TOWERS OF ROC	HESTER INC			1001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	resident; including I (A) The type and du depending upon the involved, and (B) A requirement t least restrictive pos- circumstances. (v) The circumstand must prohibit emplo disease or infected contact with resider contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must han transport linens so infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observati review, it was deter ensure proper hand 16 residents observa- Findings include: Review of the faciliti dated June 2017, re-	but not limited to: uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility.	F	380	F880 R204 has been free of signs and symptoms of infection following the observations on January 4, 2022. Residents who receive assistance meal delivery, set up, or assistance meal delivery, set up, or assistance eating meals have the potential to the impacted by the alleged practice. T staff member involved in this obser was educated on hand hygiene, glo	with with be he vation		

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245153	B. WING			01/0	07/2022
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	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 880	Continued From pa	ge 45	F 8	80			
	Before and after dir and after assisting a hands with soap an resident's mucous r excretions " Review of R204's "I the "Face Sheet" ta record (EMR), reve recently admitted to diagnoses which in- dementia, need for and need for contin review of R204's EI Data Set (MDS) assi at the time of surve Observation of R20 AM and 12:12 pm. wheelchair at a tabl approached by the ST did not perform approaching the res an electronic tablet, near R204, then cro serve-out kitchen w of food. The ST had and was not wearin each bowl by placir on each side of the bowl, to carry them ST used R204's sp of the bowls, then p	rect resident contact Before a resident with meals - wash ad water After contact with a membranes and body fluids or Face Sheet," located under ab of his electronic medical aled he had been most to the facility on 12/17/21 with cluded dysphagia, Lewy body assistance with personal care, uous supervision. Further MR revealed no Minimum sessment had been completed y. 4 on 01/04/22 between 11:32 R204 was sitting in his le in the dining room and was Speech Therapist (ST). The hand hygiene before sident. The ST was carrying , which she placed on the table obsed the room to the there she obtained two bowls d not performed hand hygiene ng gloves. The ST grasped ng her thumb and index finger rim, with her thumb inside the across the room to R204. The oon to stir the contents of one blaced a spoonful of food into			use, and following infection control principles when carrying containers food and completed a hand hygien competency and post test the wee January 24, 2022. An ad-hoc Qual Council meeting was held on Janu 2022 to analyze root cause of failu complete hand hygiene and compl glove use. Signs were posted in di areas and near serving stations to staff of the need to complete hand hygiene. Availability of hand hygier products and gloves in the dining a was reviewed and products placed areas in dining room. Hand hygien was reviewed by the Director of Nursing/Infection Preventionist and remains current. The Director of Nursing or designe provided education the week of Ja 24, 2022 to the interdepartmental s hand hygiene and avoiding touchir or inside of food containers when delivering meals. The Project First Team Table Talk video on Hand Hy was presented for educational pur Resources from the CDC on Hand Hygiene were also presented. The Director of Nursing or designee co hand washing competency with interdepartmental staff and review Hand Hygiene guidelines with interdepartmental staff.	s of le k of ity ary 24, re to y with ning remind he area i in key e policy d he nuary staff on lg food line /giene poses. mpleted ed	
	of the bowls, then p his mouth. The resi picked up his cloth her bare hand to co was no longer coug without performing					n each d on inue	

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						. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION		E SURVEY		
		245153	B. WING _		01/	/07/2022		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE			
MADON	NA TOWERS OF ROO	CHESTER INC		4001 19TH AVENUE NORTHW ROCHESTER, MN 55901	EST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE		
F 880		mall cartons of beverages. The	F 88	reduce monitoring to the				
	obtained several small cartons of beverages. The ST placed all but one of the cartons in a reach-in refrigerator in the serve-out kitchen then returned to R204 with the remaining carton. R204 began to cough, and the ST picked up his cloth napkin to cover his mouth. After assisting the resident with a few bites from his bowl, the ST obtained two tissues from a dispenser on the table, handed			for four weeks, twice w weeks, then weekly un achieved. Results of a forwarded to the facility Performance Improver recommendations.	til compliance is udits will be y Quality Council for			
	them to R204 and nose. R204 blew h placed the used tis plate. The ST cont manner throughour	instructed him to blow his is nose as instructed then sues on the table next to his inued to assist R204 in this t the meal. The ST was						
	throughout the obs began to cough mo intensity. The ST re bare hands, then h tissues with which	o push up her glasses ervation. At 12:03 PM, R204 ore persistently and with more esponded by using first her is cloth napkin, then the soiled R204 had blown his nose to While other staff assisted R204						
	from the table, the sink at the edge of washed her hands returned to the tabl and tissues, which the surface of the t	ST went to the hand washing the dining room where she for three seconds. The ST le, used R204's soiled napkin were still on the table, to wipe table where R204 had been up her electronic tablet and						
	p.m. revealed, "Bas to wash my hands. seconds." When as	ne ST on 01/04/22 at 12:12 sically, when I touch food, I try I try to wash them for twenty sked if she had performed opriately while assisting R204, nd walked away.						
	who also served as	ne director of nursing (DON), s the facility's Infection 1/07/22 at 9:02 a.m. revealed						

		AND HUMAN SERVICES					FORM	01/26/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY PLETED
		245153	B. WING	;			01/0	07/2022
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 DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD	BE	(X5) COMPLETION DATE
F 880	the observation of t 01/04/22, "Does no way." An interview with th 10:45 a.m. revealed	ige 47 he ST during the meal on t meet my standards in any e administrator on 01/07/22 at d, "I am a nurse as well as an t you saw is not acceptable."	F	880				

		AND HUMAN SERVICES	F51530)31		FORM	02/03/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245153	B. WING			01/	06/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MADON	A TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 0	00			
	FIRE SAFETY						
	conducted by the M Public Safety, State 01/06/2022. At the Towers of Rochest compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe	e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 re and the 2012 edition of					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D.					
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						01/26/2022

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				FORM	02/03/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245153	B. WING			01/	06/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROO	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	 Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55107 By email to: FM.HC.Inspections THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A detailed deso taken or planned to 2. Address the m place to ensure the 3. Indicate how the future performance 3. Indicate how the future performance 3. Indicate how the future performance 5. The actual or pe the remedy. Madonna Towers of building with no bas The original building was determined to construction. In 199 and was determined to addition was addeed 	spections Division Suite 145 1-5145, OR s@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: cription of the corrective action o correct the deficiency. easures that will be put in e deficiency does not reoccur. the facility plans to monitor e to ensure solutions are responsible for the corrective oring of compliance. proposed date for completion of of Rochester is a 1-story sement. onstructed at 4 different times. g was constructed in 1967 and	κo	000			

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	: 02/03/2022 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245153	B. WING	÷		01/	/06/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	IA 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000 K 321 SS=D	(111) of constructio type allowed for exisurveyed as a V (1' surveyed as one bu The building is prot system. The facility full corridor smoke the corridors that is department notifica The facility has a ca census of 58 at the The requirement at NOT MET as evide Hazardous Areas - CFR(s): NFPA 101 Hazardous Areas a having 1-hour fire re fire rated doors) or system in accordar When the approved system option is us separated from oth partitions and doors Doors shall be self- and permitted to ha	 additions are of the type V n and meet the construction isting buildings, the facility was 11) building. This will be uilding under LSC 2012. ected by a full fire sprinkler has a fire alarm system with detection and spaces open to monitored for automatic fire tion. apacity of 64beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is inced by: Enclosure Enclosure Enclosure enclosure enclosure fire extinguishing the areas shall be er spaces by smoke resisting s in accordance with 8.4. closing or automatic-closing ave nonrated or field-applied 	K				2/2/22
	from the bottom of Describe the floor a	at do not exceed 48 inches the door. and zone locations of hat are deficient in REMARKS. Automatic Sprinkler					

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	-	AND HUMAN SERVICES			FORM	02/03/202 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
245153			B. WING _		01/	06/2022
NAME OF I	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Separation N// a. Boiler and Fuel-f b. Laundries (large c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if of Hazard - see K322 This REQUIREMEN by: Based on observa facility failed to mai (2012 edition), Life and NFPA 80 (2010 Other Opening Pro deficient finding co the residents within Findings include: On 01/06/2022 at 1 observation that du facility, a 20 minute room has three 1/2 door for a locking of located in (A) hallw An interview with th Director verified thi of discovery. Sprinkler System - CFR(s): NFPA 101	A Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe NT is not met as evidenced tion and staff interview, the ntain doors per NFPA 101 Safety Code section 8.3.3.1.1 O edition), Fire Doors and tectives, section 5.2.5.1. This uld have an isolated impact on the facility. 1:00 AM, it was revealed by ring walk-through of the e rated door for the clean linen " small holes located in the levice that was removed ay. the Facility Maintenance is deficient finding at the time Maintenance and Testing	K 32	 K321- Enclosure The doors that were in question been corrected or are being correctoring. As well as the laundry door had a few holes in it. The doors will be checked on weekly recurring basis for compliants. Keeping the documentation up in the fire book. Paul Mattson EVS is responsible designee 	cted for or that a ance. odated	2/2/22
	Director verified thi of discovery. Sprinkler System - CFR(s): NFPA 101 Sprinkler System -	s deficient finding at the time	К 35	53		2/2/2

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		AND HUMAN SERVICES				FORM	02/03/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		245153	B. WING	;		01/	06/2022
NAME OF I	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARI any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by: Based on observat facility failed to mai per NFPA 101 (201 section 9.7.5 and N Standard for the Inp Maintenance of Wa Systems, section 5 could have an isola within the facility. Findings include: On 01/06/2022 at 1 observation during that there was dust sprinkler heads loca to an air diffuser.	and maintained in accordance dard for the Inspection, aining of Water-based Fire a. Records of system design, ection and testing are cure location and readily system last checked aystem last checked aystem test supply source KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced tion and staff interview, the ntain the fire sprinkler system 2 edition), Life Safety Code, IFPA 25 (2011 edition), osection, Testing, and ater-Based Fire Protection .2.1.1.1. This deficient finding ted impact on the residents 0:00 AM, it was revealed by a walk-through of the facility found on two of the fire ated in the kitchen area close	K	353	There is attached documents for th sprinkler system. Both dry and the v system. So that should have not bea issue. As far as the dust found on th sprinkler heads. 1. This will be added to the wee cleaning checklist. 2. Keeping proper documentation this issue. 3. Checking weekly sign off shee As well as visual inspections. 4. Gwen Fredrick Culinary Direct and Paul Mattson EVS.	vet en an ne ekly on on eets.	
	On 01/06/2022 at 1 observation during that there was dust sprinkler heads loca to an air diffuser. An interview with Fa	a walk-through of the facility found on two of the fire			As well as visual inspections. 4. Gwen Fredrick Culinary Direct		

Facility ID: 00419

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		AND HUMAN SERVICES			FO	ED: 02/03/ RM APPRC <u>NO: 0938-(</u>	OVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			DATE SURVE COMPLETED	Υ
		245153	B. WING			01/06/202	2
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPLE DAT	ÉTION
K 353	Continued From pa	ge 5	КЗ	353			
	discovery. Fire Drills CFR(s): NFPA 101		К7	'12		2/2/22	2
	signal and simulatic conditions. Fire drill unexpected times u least quarterly on e- with procedures and established routine. between 9:00 PM a announcement may alarms. 19.7.1.4 through 19 This REQUIREMEN by: Based on a review and staff interview, and conduct fire dri edition), Life Safety deficient finding cou on the residents wit Findings include: On 01/06/2022 at 0 review of available drills were conducte and 3rd shift, and fo 3rd shift of the cale An interview with th Director verified this of discovery.	NT is not met as evidenced of available documentation the facility failed to maintain IIs per NFPA 101 (2012 Code section 19.7.1.6. This uld have a widespread impact thin the facility. 09:15 AM, it was revealed by a documentation that no fire ed for the 3rd quarter, 1st shift, or the 4th quarter-2nd shift and ndar year. e Facility Maintenance s deficienct finding at the time			There is an attached document for the fire drills. The 3rd Quarter 3rd shift was done. Please see the document. 1. To make sure that all fire drills ge done as they are required. 2. To make sure that the proper sta members are trained and can run the drills. 3. Keep proper paper work up to da and make sure that they are current. 4. Paul Mattson EVS	te	
K 918 SS=F		- Essential Electric Syste	К 9	918		2/2/22	

Facility ID: 00419

If continuation sheet Page 6 of 8

		AND HUMAN SERVICES				FORM	02/03/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245153	B. WING			01/	06/2022
NAME OF F	PROVIDER OR SUPPLIER	l .	<u> </u>	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 DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 918	Continued From pa	age 6	K 9	18			
	Maintenance and T The generator or of and associated equ service within 10 se criterion is not met process shall be pr capability for the life Maintenance and te transfer switches a with NFPA 110. Generator sets are under load 30 minu day intervals, and e months for 4 contin under load condition simulated cold star transfer of all EES competent person stored energy power accordance with NI circuit breakers are program for periodic components is estar manufacturer requi maintenance and te readily available. E circuits are marked separate from norm the possibility of da source is a design installations. 6.4.4, 6.5.4, 6.6.4 (111, 700.10 (NFPA This REQUIREMEI by: Based on a review	other alternate power source lipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this e safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised ttes 12 times a year in 20-40 exercised once every 36 nuous hours. Scheduled test ns include a complete t and automatic or manual loads, and are conducted by hel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder e inspected annually, and a ically exercising the ablished according to rements. Written records of esting are maintained and ES electrical panels and l, readily identifiable, and nal power circuits. Minimizing image of the emergency power consideration for new NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced			The generator did have issues wai the proper parts to arrive. But durin		

Facility ID: 00419

If continuation sheet Page 7 of 8

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	· ,	G 01 - MAIN BUILDING 01		PLETED	
		245153	B. WING		01/	06/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	DE		
MADON	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
K 918	failed to maintain, electric system per Health Care Facilit and NFPA 110 (20 and Standby Powe These deficient fin impact on the resid Findings include: On 01/06/2022 at review of the availa facility failed to ma under load monthly perform at 20 perc issues.	age 7 test, and inspect the essential r NFPA 99 (2012 edition), ties Code, sections 6.4.1.1.6.1 10), Standard for Emergency er Systems, section 8.3.1. dings could have a widespread dents within the facility. 11:30 AM, it was revealed by a able documentation that the intain and run the generator y. The generator would only cent capacity due to mechanical the Facility Maintenance his deficient finding at the time	K 918	 time. It was confirmed that all lift were covered. The generator has repaired and we will be doing a on it. 2. Trained staff will do the we monthly testing. The testing will load testing and no-load testing required. 3. To keep the records up to make sure that the proper testing down. 4. Paul Mattson EVS 	as been load test eekly and consist of as date and		

Facility ID: 00419

If continuation sheet Page 8 of 8



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 19, 2022

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

Re: State Nursing Home Licensing Orders Event ID: NH0D11

Dear Administrator:

The above facility was surveyed on January 4, 2022 through January 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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.

Madonna Towers Of Rochester Inc January 19, 2022 Page 2

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 immediately contact:

Karen Aldinger, Unit Supervisor St. Cloud A District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: karen.aldinger@state.mn.us Office: (651) 201-3794 Mobile: (320) 249-2805

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.

M. Pig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00419	B. WING		01/0	7/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	AVENUE N ER, MN 559	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 CORRECTI (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 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 hin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure and orders are issued. F electronic plan of co	TS: 1/7/22, a licensing survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your prrection you have reviewed				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 01/26/22

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/07/2022	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ADON	NA 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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	these orders and id be completed.	lentify the date when they will				
	federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested Time period for Cor					
	receipt of State lice the Minnesota Dep Informational Bullet https://www.health. n/infobulletins/ib14_ orders are delineate Department of Hea					
	is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	ate Statutes/Rules, please rected" in the box available for i indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

NH0D11

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/	07/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	IS NO REQUIREM CORRECTION FO	R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			2/2/22
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility f edema and reporte edema to the physi and R114) reviewed experienced actual failed to monitor his physician of a six-p applied compression physician's order, a wounds to his right pain. In addition, bui	ent is not met as evidenced ion, interview, and document ailed to ensure staff monitored d indicators of increased cian for 2 of 3 residents (R108 d for edema. R108 harmed when the facility s edema, failed to notify the ound weight gain in two days, on stockings without a and R108 developed two open lower extremity with related ased on observations, ord review, facility failed to te and implement fall		Corrected		

NH0D11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING		01/07/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	·	
	NA TOWERS OF ROO	CHESTER 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 ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 830	Continued From pa	age 3	2 830			
	•	ntions for 2 of 2 residents no had recently fallen in the				
	Findings include:					
	the facility on 12/28 mild chronic kidney	t identified he was admitted to 8/21 with diagnoses including, / disease, sepsis due to ma, and congestive heart				
	12/28/21, indicated skin at the time of and had, "2 + pittin fluid in the body to	n Detail List Report dated I he had no open areas on his his admission to the facility, g edema" (a build-up of exces the point an indentation 5 seconds after pressure is er extremities.	s			
	he had not had a M	nedical record (EMR) revealed /inimum Data Set (MDS) leted at the time of survey.	1			
	weights for three d 12/29/21, and an o beginning 1/3/22. F physician's orders	bry included, an order for daily ays after admission beginning rder for daily weights Further review of R108's revealed no orders for ma, or any treatments to na.				
	potential for alterat 12/28/21. The apprince and edema a and report to NP/P Practitioner/Physic occurs." "Protect re	ncluded, "Resident with CHF, ion in vital signs," beginning roaches included, "Monitor for and significant weight changes A/MD [Nurse ian's Assistant/Physician] if esident from injury/trauma," dered," beginning on 12/28/21				

NH0D11

	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY PLETED
		00419	B. WING		01/0)7/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NA TOWERS OF ROO	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 ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 4	2 830			
	The care plan did r significant weight c	not specify what constituted a hange.				
	resided and provid revealed R108 was with no actual impa Care Guide reveale	e for Unit B, where R108 ed by the facility on 1/5/22, s, "at risk" for skin impairment, airment. Further review of the ed no mention of R108's of his edema, or the use of ings.				
	pounds on 12/29/2 (a gain of 3.4 poun pounds on 12/31/2 the previous day a Further review of F	entified he weighed 210.3 1, 213.7 pounds on 12/20/21 ds in one day), and 216 1 (a gain of 2.3 pounds since nd 5.7 pounds in 48 hours). R108's weights revealed no re taken prior to 1/4/22 when 7 pounds.				
	5:23 a.m. included left leg pain during stockings were rem had rolled partially was constricting ea causing the fluid to Both legs and feet Further review did had an order for co	gress notes, dated 1/2/22, at , "Resident c/o [complained of] the night. Ted [compression] noved from both legs as they down each leg and the elastic ach leg leaving grooves and be trapped below the elastic. have +2 pitting edema." not reveal whether the residen ompression stockings, or if the fied of the pitting edema.				
	included, "Nurse w bed during night w be applied to lower discovered skin bro blistering/weeping	otes dated 1/3/22, at 3:36 a.m. as assisting resident back to hen resident requested lotion extremities. Nurse then eakdown and of right lower leg. One wound ter with other smaller blisters				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING		01/07/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ADONI	NA TOWERS OF ROO	CHESTER INC	HAVENUE NO STER, MN 559			
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET DATE
2 830	Continued From pa	age 5	2 830			
	these areas. Resid from home he has	act. Foam dressings applied to lent has compression stockings been wearing while at facility, current orders for compression at facility."	5			
	1/3/22, included, "2 lower extremity that	ctitioner progress notes dated 2 blisters on the right lateral at have burst under draining ne note did not specify what the er."				
		lers dated 1/3/22, included, g changes to wo open areas on emity.				
	"Received orders f [bilateral lower extr open areas to RLE open blister area o cm [centimeters] x	ote dated 1/5/22, included, or compression wraps to BLE remities] and foam dressings to [right lower extremity]. Larger n right shin measured today 5 [by] 2.5 cm, smaller open it measures 3 cm x 2 cm."				
	1/5/22, included the of R108's weights 12/31/21. Further r extremity edema u weeping from the r blister anterior	progress note for R108 dated e physician was not informed on 12/29/21, 12/30/21, or eview revealed, "Bilateral lowe p to the knee level. He was ight lower extremity with 1 new on the right lower extremity. He	,			
	bilateral lower extro although variable of certainly up - I sus LEs [lower extremi about 10 lb [pound	ve burst he does have emity edema and his weights, over the past 48 hours are pect most of the weight is in his ties]. It is possible he is up s] post hospitalization It is ed IV diuresis if this weight				
nesota D	trend continues	. We will need to go to twice nges, or more frequently if				

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00419	B. WING		01/07/2022	
					01/07/202	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ FH AVENUE N(
MADON	NA TOWERS OF ROO	CHESTER INC	STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE DA	
2 830	Continued From pa	age 6	2 830			
	needed to the right edema soakage	lower extremity to control the ."				
	stated he had, "sou the back of his righ	on 1/4/22, at 2:07 p.m. R108 me blisters or something" on It leg, which he stated were t two days and causing him				
	room on 1/5/22, at sitting in his wheel were visibly swolle compression band were in the resider rest of a recliner in at the stockings an don't know where t	nd observation with R108 in his 4:46 p.m. revealed R108 chair. His lower extremities n and loosely wrapped with a age. Compression stockings nt's room, draped over the arm his room. The resident pointed d stated, "I don't wear those. I hey came from, but they hurt. s far as I'm concerned, and you you."	t			
	nursing assistant (assigned to care for that she worked for the facility itself, so NA-F stated that si Guide for informati referred to the B U R108 was, "at risk have any skin prob the facility provided which she carried w reference when pro- have access to res	on 1/5/22, at 5:33 p.m. NA)-F stated, she was or R108 that shift. NA-F stated r a staffing agency, rather than o was not familiar with R108. he would refer to her Care on on that resident. NA-F nit Care Guide and stated that for skin problems but doesn't blems right now." NA-F stated d her with the Care Guide, with her and used as a oviding care, since she did not sident care plans as an agency				
	columns for reside transfer status, dev glasses the reside	iew of the Care Guide revealed nt room numbers and names, vices such as dentures or nt used, toileting status, I for Activities of Daily Living				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/07/2022	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			0112022
		4001 191				
MADONI	NA TOWERS OF ROC	HESTER INC	TER, MN 5590			
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 7	2 830			
	(ADL's). whether th Risk," and "Importa	ne residents were "Skin/Fall ant Preferences."				
	stated he had work was not aware of a compression stock facility employee he plan in the EMR an	on 1/6/22, at 11:13 a.m. NA-E ted with R108 in the past, but ny edema or if he wore ings. NA-E stated that as a e could access both the care of the Care Guide used by lose two documents did not e another.				
	licensed practical r not have any open 1/3/22, at that time	on 1/6/22, at 2:41 p.m. hurse (LPN)-D stated R108 did areas to his skin prior to it was discovered he was hgs without an order and had				
	medical doctor (ME expectation that an facility with a diagn on a "CHF Protoco weights and skin as that daily weights w of monitoring CHF before breakfast ea scale for accuracy. had not reported R gain in 48 hours be to her office, which	on 1/6/22, at 4:18 p.m. R108's D)-A stated, it was her by resident admitted to the osis of CHF would be placed I" which included both daily ssessments. The MD stated were the facility's primary mode so long as they were taken ach day and using the same The MD stated that the facility 108's almost 6-pound weight etween 12/29/21 and 12/31/21 she would have expected as rotocol." The MD stated that in				
	R108's case he had different hospital th to working with, and the time the resident the "CHF Protocol" stated that the facil	d been admitted from a lan the facility was accustomed d she had been on vacation at nt was admitted, so somehow d did not get initiated. The MD lity should not have placed ings on the resident without a				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR COMPLET	
		00419	- B. WING		01/07/2022	
	PROVIDER OR SUPPLIER		DDRESS, CITY, SI		1 0110112	ULL
		4001 191				
ADONN	IA TOWERS OF ROC	HESTER INC	STER, MN 559			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE CA	(X5) OMPLET DATE
2 830	Continued From pa	age 8	2 830			
	examined R108 on that she would not stockings because the point of weepin edema to apply the damage or discom- would have been u	nd that when she first 1/5/22, his edema was such have ordered compression he had, "significant edema, to g," and, "there was too much em safety without causing skin fort." The MD stated that R108 nable to don his own ings given the amount of				
	director of nursing how R108 came to in his room, or who 1/3/22. The DON s agency staff to cov so it was difficult to R108 on those nigh presumed family has stockings from hom have placed the sto a physician's order R108's care plan. The facility's policy f well as the "CHF P MD. At 10:11 a.m. agency staff did has the EMR, but the fa as a shortcut so the limited amount of o DON stated that he a spreadsheet in his	on 1/7/22, at 8:19 a.m. the (DON) stated, he was not sure have compression stockings had applied them on 1/2/22 o tated, the facility was using er many shifts during this time tell who had provided care for hts. The DON stated he ad brought the compression ne, but the staff should not ockings on R108 unless it was and/or the stockings were on The DON was asked to provide for Edema Management, as rotocol" referenced by R108's the DON stated, "technically" ve access to the care plans in acility provided the Care Guide ey could provide care with a orientation to residents. The e updated the Care Guides on is computer daily and the nurse's stations.	r ,			
	family member (FM R108 had used cor in the past, but his	1/7/22, at 10:11 a.m. with /)-B, and LPN-D, FM-B stated mpression stockings at home edema became so much the tight, for about 2 months prior				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING		01/07/2022	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, SI	IATE, ZIP CODE		
ADONN	IA TOWERS OF ROC	HESTER INC	HAVENUE NO			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 9	2 830			
	FM-B had been wra compression banda had not brought the over a chair in his r R108's wound care at 11:41 a.m. includ pitting edema of BL from toes to mid sh one open area and measurements wer 1.0 cm x 1.0 cm. Th wound measured 2 lateral right lower le one large wound bu area within it. Total pinpoint weeping an When interviewed of administrator stated the facility would id resident at the time the "CHF Protocol" nurse would notify the	a progress note dated $1/7/22$, ded, "Continues to have 2+ .E (bilateral lower extremities) in." "Right lower anterior had two smaller areas." The re right lower anterior 1.1 cm. > he Superior anterior shin 2.2 cm x 1.2 cm x 0.1 c.m. The eg, "does not appear to have ut now has area with pin point area 5.0 cm x 3.0 c.m. with reas throughout." on $1/7/22$, at 10:31 a.m. the d, it was his expectation that entify CHF as a diagnosis for a of admission, and if orders for were not present, then the				
	staff would not app without a physician was asked to provid Edema Manageme The administrator of DON. The Administ preference that all s the EMR rather tha Guide document th separately, and he	ly compression stockings 's order. The administrator de copies of the facility's ent Policy and CHF Protocol. deferred these requests to the trator stated it would be his staff accessed the care plan in n try to keep a second Care at had to be updated would work with his leadership				
		appen. on 1/7/22, at 12:41 p.m. the ility did not have an edema				

	HESTER INC 4001 19T	B. WING			
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ADONNA TOWERS OF ROC	HESTER INC 4001 19T			01/	07/2022
X4) ID SUMMARY STA	HESTER INC				
x()) IB	ROCHES	H AVENUE NC TER, MN 5590	-		
TAG REGULATORY OR L	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830 Continued From pa	ge 10	2 830			
management or CH	IF protocol.				
admission date of 1 CHF. R114 did not completed at the tir R114's Physician of and order to weigh the same scale ever be notified for weig pounds in 48 hours weight. Dry weight The physician was was over 280 poun R114's weights sind documented as: On 12/22/21, R114 On 12/23/21, R114 On 12/23/21, R114 On 12/25/21, R114 On 12/26/21, R114 On 12/26/21, R114 explanation for this down from the prev On 12/27/21, R114 physician notificatio and a gain of great hours) On 12/28/21, R114 Review of R114's E documentation that	rders dated 12/23/21, included daily, before breakfast, use ery day. The physician was to ht gain greater than 2.5 , or 5 pounds over admission was noted to be 274 pounds. also to be notified if weight ds or under 268 pounds. ce admission were weighed 280.8. weighed 282.8 (2.8 pounds s a notification point in the weighed 280.8. weighed 280.8. weighed 280.0. weighed 280.0. weighed 280.0. weighed 248.8 (no weight being 31.2 pounds ious days' weight) weighed 285.6 (warranting on for being over 280 pounds er than 2.5 pounds in 48 weighed 286.3.				
12/27/21, or 12/28/	21.				
When interviewed of esota Department of Health	on 1/7/22, at 9:07 a.m. the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING		01/07/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, SI	TATE, ZIP CODE		
IADONI	NA TOWERS OF ROC	CHESTER INC	HAVENUE NO			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF	CORRECTION	(X5)
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2 830	Continued From pa	age 11	2 830			
	notified of R114's w the DON provided physician had been 12/22/21, 12/29/21 physician had not k changes 12/23/21, 12/28/21. R204's admission k dated 12/23/21, wa hospitalization on 1 R204 had moderat required extensive bed mobility, and d time. R204's diagn recent falls, a receil (lower part of pelvio muscles), dementia (similar to Parkinso	hysician should have been veight changes. At 1:26 p.m. documentation R114's in notified of weight changes on and 1/3/22. However, the been notified of the weight 12/26/21, 12/27/21, or Minimum Data Set (MDS) as completed upon return from 12/17/21. The MDS indicated ely impaired cognition and assistance of two persons with lid not stand or walk at that osis list included a history of nt fracture of his right ischium c bone under buttock a, secondary parkinsonism on's disease with tremors, reduced movements), among				
	indicated a problem at risk for falling R/ fracture of right isc weakness. The goa 12/17/21, "resident The interventions li call light in reach a PT/OT as ordered" down for a nap after intervention was ac next to bed while in 12/17/21 indicated, following activities grooming, oral care	nealth record (EHR) care plan n, start date 12/17,21, "residen T [related to] unspecified hium, Parkinson's dse [sic], al for this problem area dated will remain free from injury." isted included, "12/17/21 keep t all times" and "12/17/21 t, "12/25/21 offer resident to lie er meals", and an additional dded 1/7/22, "W/C [wheelchair] n bed." A problem dated , "I have a self-deficit with the of daily living; bathing, es, ambulation, transferring, wel and bladder." Listed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/	07/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC				
			STER, MN 559	PROVIDER'S PLAN OF C		()(7)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	updated/changed c assist of 1 with FW transfers." Howeve following two interv "12/17/21 I require needs addressed", devices can help m deficits. I use: EZ S assist with standing persons]."	sfers with EZ stand," on 1/7/21 to read, "I require /W [front wheel walker] for er, the care plan maintained the rentions listed separately, assist of 2 to get my toileting and "12/17/21 Using assistive the better take care of my Stand [mechanical device to g] with A x2 [assist of two , "care guide" updated on				
	1/6/22, indicated R of one person and care guide indicate not provide any ind The following state the guide: "Importa solely on these Car resident Care Plan and up to date info accessed from PO documentation site nursing assistants]	204 transferred with the assist a FWW, but did not walk. The ed R204 was a fall risk, but did lication of safety interventions. ment was printed at the top of ant Notice: Please do not rely re Guides. Please refer to or Profile for more accurate rmation. The Profile can be				
	call-light was on, be in his room sitting a the emergency roo that time. No furthe	ted 12/12/21 indicated R204's ut staff found him on the floor against the bed. He was sent to m for respiratory symptoms at er assessment of the events all or interventions related to documented.				
	limitation observati on 12/17/21. The d greater than ten re	balance and functional ons was completed for R204 locument indicated a score presented a high risk for fall. ed to have a score of 17. The				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING		01/	07/2022
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NA TOWERS OF ROC	CHESTER 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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	to the resident fall i environmental risk documentation. Th appropriate" were of therapy) and PT (p titled: Plan of Care documented: "indic continue current plan An event report dat had an unwitnesse by a nursing assist but he was laying of The immediate intervi-	isk factors that may contribute risk, including medications and factors," contained no he referrals listed that, "may be checked as OT (occupational hysical therapy). In the section , the following was cate care plan action taken: an of care." ted 12/20/21 indicated R204 ed fall at 4:14 a.m.; was found ant responding to his call light on the floor next to the bed. ervention chosen was, "rest," rentions documented including aid in preventing this type of				
	had an unwitnesse and he had said he No immediate inter been implemented continue to be mor	ted 12/25/21 indicated R204 ed fall at 10:54 a.m. in his room e was getting himself into bed. rventions were listed as having except to say he would hitored. He was noted to have cipating in therapy services at				
	an unwitnessed fal was found on his b intervention was ob indicated "post fall	ted 1/2/22 indicated R204 had I in his room at 12:25 a.m. He bedroom floor. The immediate oservation, and a note monitoring in place along with d to care plan." No additional mented.				
	1:14 p.m. included	itten in R204's EHR on 1/3/22, the following: "IDT f/u [follow 2/20, 12/25 & 1/2/21 [sic]: On				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING.			
		00419	B. WING		01/	07/2022
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IADONN	A TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	on and was answer the nurse sitting on resting against his 12/20, at 4:15 am r right side, on the flo denied any pain. No On 12/25, resident injuries. None note laying on back upo am. Resident denie within normal limits per resident's base d/t [due to] history of disorders (a persor paranoia, odd or ur Parkinsonism & de (proteins in brain at Most recent BIMS 4 indicating moderate analysis): impaired awareness. Interve sent to ED for evalue conditions, fall mat after meals and ob supervised area wh On 1/05/22, 3:21 p in his room, only th from the door. Afte positioned somewh pillows and a soft to was at a standard H about six feet away bedside table was R204 had a moist of	mentia with Lewy bodies ffecting memory and thought). {cognitive assessment] is 9 e impairment. RCA (root cause gait/balance and poor safety entions include: Resident being uation of underlying health at bed side, lie resident down serve frequently and place in hen out of bed." .m. R204 was observed in bed e foot of the bed was visible r entering, was observed to be hat on his right side using ouch call light in bed. The bed height and wheelchair located /, facing away from him. A positioned next to the bed. cough, kept his head extended ith open. He was not able to				
	1/06/22, 10:42 a.m					1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00440	B. WING				
		00419			01/	07/2022	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST T H AVENUE NC				
ADONN	NA TOWERS OF ROO	CHESTER INC	TER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORF		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From page 15		2 830				
	room sitting up in v hall.	v/c, not able to be seen from					
	During an interview on 1/6/22, 10:50 a.m. a nursing assistant (NA)-B stated staff would know how to care for the residents if they were familiar and experienced at the facility, and the way to learn was to follow other staff and learn from them. NA-B said there was a paper care guide available, but was not able to describe how to access the EHR care plan when asked despite the notice on the care guide. NA-B was observed to be documenting in the EHR POC system at the time. NA-B said she sometimes trained the new or contracted "pool" staff.						
	described the "care would describe how them in bed and "a said, "after a while cares]." NA-A state assistance of two p the "care plan" indi reported the follow falls as she knew t and make sure he up because he has to sit up. And we have	.m. NA-A, a "pool" staff, e plan" as a piece of paper that w to transfer a resident, move ill that type of thing." NA-A also you learn them [resident ed R204 required the persons to transfer. NA-A said icated R204 was a fall risk and ing interventions to prevent hem, "well, we put him in bed, is positioned right, put his head s trouble swallowing and needs ave to watch him, like if he o go to the bathroom, stay,	1				
	practical nurse, (LF worked the evening that R204 had had LPN-A said there w guide for nursing a experienced staff w	v 1/07/22, 7:15 a.m. a licensed PN)-A stated she usually g and night shift, and confirmed several falls during the night. vere paper sheets that were a ssistants and the more vould help those who were R204 was quite impulsive, did					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/07/2022	
AME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ADONI	NA TOWERS OF ROO	CHESTER INC	HAVENUE NO			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
ŘÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	persons working ou pillow under his rig him not to get up w place his call-light turn on the call-light benefit from having reported this, but s and was unsure ho relation to fall preve pressure alarms w help R204, and wa longer used, and a	nt, and said to prevent falls, in the night shift would tuck a ht side which would remind vithout help, and they would under it so his weight would nt. LPN-A thought R204 would g a fall mat on his floor and had aid she had never heard back bw decisions were made in ention. She stated she knew ere noisy, but thought it would is unsure of why they were no lso stated, "I miss side rails."				
	confirmed her reco on the care plan or On 1/07/22, 8:46 a team would discus the Interdisciplinary	.m. LPN-C stated their overall s care plan interventions, and y Team (IDT) would meet after				
	vary depending on unsure if night staf but night shift were monthly basis whe information about a	cide on appropriate ecially for safety which would the resident. LPN-C was f were involved in this process, to attend a meeting on a re they would receive any care plan changes. LPN-C nanager, she was responsible				
	to update the care residents on the sa should not have a up unassisted now transferring with th walking with therap	plan for R204 and other ame unit. LPN-C said R204 fall mat because he might get that he was actively e assist of one at all times, and by. Instead, LPN-C said R204				
	breaks locked in ca however, LPN-C co not indicate this wa nor did the care gu	/C at his bedside with the ase he would attempt to get up; onfirmed the EHR care plan did as the appropriate intervention, ide. LPN-C said she was going plan immediately as it was				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00419	B. WING		01/07/2022		
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
MADONN	IA TOWERS OF ROC	HESTER INC	AVENUE NO				
(X4) ID PREFIX TAG	D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORREREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERE		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 17	2 830				
	incorrect. LPN-C st be following the pay R204's care guide of said clinical manag update the care gui the EHR. On 1/07/22, 9:42 a. (DON) stated inform related to falls would resident, and the fu Wednesday to disc would rely on the en- said a meeting was were to attend, but the nurses on the fl directly with the clin or clinical manager Also, if the IDT mad clinical managers w nurse working on th with the rest of the expectation for app added to the care p the care guide to al possible. DON state care plan should be guides had been de staff to use for easy expectation for thos the EHR care plan cares. A facility policy titled with a copyright of 2	ated nursing assistants should ber care guide, and confirmed did not match the EHR. LPN-C ers were responsible to ide as well as the care plan in m. the director of nursing nation for safety interventions d vary according to the III IDT team met every uss any issues, but the facility ntire team to give input. DON a held each month and staff for the best continuity of care, oor should communicate iscal managers, but that nurses s could update the care plan. de recommendations the vere expected to talk to the ne unit who were then to share staff. DON also stated an ropriate interventions to be blan as soon as possible, and so be updated as soon as ed ideally the care guide and e matching. DON said the care esigned for contracted pool y reference, but he had an se permanently hired to use for a more complete listing of					
anosota Dr	the standard MDS	blan using the guidelines for upon admission, readmission, here is a significant change.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/07/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC	HAVENUE NC			
(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 THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	(CAA) would be use comprehensive car use the findings fro starting point for de comprehensive pla responsible for add strength of the resid included in the CAA provide information when changes occuperiods, or how to r the EHR and the ha A facility policy titled not dated but with a provided. The polic risk for falling will h through the resider resident experience assesses the reside for, safety and com indicated, "Residen individualized resid developed. Care pl	d the Care Area Assessments ed to develop the re plan, saying: "the facility will im the CAA process as a eveloping the resident's in of care. Note: the facility is liressing the needs and dent weather [sic] or not it is A process." The policy did not on how to maintain accuracy ur between assessment maintain continuity between andwritten care guides. d Integrated Fall Management, a copyright of "20xx", was y indicated, "Residents with ave interventions implemented at centered care plan. When a es a fall, a licensed nurse ents condition, provides care fort." In addition, the policy its at risk for falls have an ent centered care plan an interventions are based on ill risk assessment."				
	Management" polic Assessment is com admission to the fa	ty's undated, "Integrated Falls by revealed, " A Fall Risk apleted within 48 hours of cility Residents at risk for dualized resident centered care				
	the facility on 11/23 12/01/21 with diagr COVID-19, Conges	dentified, he was admitted to /21 and re-admitted on noses which included stive Heart Failure (CHF), failure with hypoxia (lowered				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00419	B. WING		01/07/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MADONI	NA TOWERS OF ROO	HESTER INC	H 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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	age 19	2 830			
	diabetes mellitus, r	ygen in the blood), Type 2 nuscle wasting and atrophy, s feet, and repeated falls.				
	identified fall risk fa and functional impa functional status, h impaired balance; both of his upper e	essment, dated 11/23/21, actors included neuromuscular airment such as decline in ypotension, or syncope; range of motion impairments in xtremities; and the use of hypertensive, diuretic, and hs.				
	problem area for fa	ted 11/23/21, included a Il risk, the only approach to b keep the call light in place.				
	a.m. included he ha	es dated 11/25/21, at 2:45 ad been sent to the hospital for a and chest pressure.				
	p.m. identified he h where he had beer infection, weaknes to assist R45 out o	es dated 12/1/21, at 12:00 ad returned from the hospital of for fluid overload, COVID-19 s needing a mechanical lift and f wheel chair and into bed. R45 s and tingling in lower				
	risk assessment w	ord did not include a new fall ith his change of condition. d not been updated regarding assistance or fall				
	identified, R45's kn	e dated 12/2/21, at 5:12 a.m. ees were buckling, had an ransfer needs were to be				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/07/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•	
	NA TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 5590			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		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 T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 20	2 830			
	12:57 p.m. identifie for help, and found prone position." "Re on the side of the b Immediate interver encouraged to not he agreed to do an understanding," an with grab bars and	s report dated 12/2/21, at ed, "Staff heard resident calling him laying on the floor in the esident stated he was sitting bed and fell forward." ntion was listed as: "he was sit at the side of the bed, which d demonstrated verbal d a work order put in for bed bariatric recliner. d a new fall prevention				
	approach added or	a 12/2/21, "I have been sit on the edge of the bed."				
	cognitively intact ne 2 for bed mobility a	IDS dated 12/7/21, identified eed for extensive assistance o ind transfers, did not ambulate had experienced one fall with ion.				
		ded the fall intervention on rs and bariatric recliner.				
	included, "Residen moving outside of t Therapy/nursing is spinal stenosis as t	te dated 12/15/21, at 8:22 a.m. t legs are bending, lifting, the resident's control concerned about potential the cause for the movements s arms are also weak."				
	identified the nurse at emergency depa dated 12/22/21, at	e dated 12/21/21, at 2:22 p.m. e practitioner wanted R45 seen artment. Another progress note 1:19 a.m. identified R45 had he facility with no new orders.				
	included, "heard so	e dated 12/29/21, at 3:51 a.m. omeone yelling 'help' down the resident on floor facing down				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/07/2022	
					01/07/2022	
	VIDER OR SUPPLIER	4001 191	DDRESS, CITY, ST T H AVENUE NC			
IADONNA	TOWERS OF ROC	CHESTER INC	TER, 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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830 C	ontinued From pa	age 21	2 830			
fo fic th C Fi E su fo R fa ei [/	rehead with a mo bor and continuing at he had a spass all light was not o urther review of the mergency Medica ummoned and the r treatment of the 45's care plan ha ills added on 12/3 noouraged to slee theelchair]."	d a new approach to prevent 31/21, of, "I have been ep in bed and not my				
1/ in al L- al le al su fa fa fa co th pi ta ta	4/22 at 9:29 a.m. his room with his odomen. R45 had ft eyebrow, and a shaped scar exter oove his nose, ac ft eye just below opeared to be fro- utured. R45 state ad in the facility. T all, which resulted ad been because orward while sitting e second had be tting in the wheel for the hospital ontinued to exper e facility had not revent further falls ken it upon himso ble snugly to his	a and interview with R45 on R45 was sitting in wheelchair soverbed table pulled close to d a reddish colored scar on his a second upside down ending from between his eyes tross his forehead to above his his hairline. The L-shaped scar m a laceration which had been d the scars were from falls he The resident stated that the firs in the scar on his eyebrow, he became fatigued and fell g on the edge of his bed, and en when he had a spasm while chair and fell forward onto his nat after the second fall he was I for sutures. R45 stated he ience spasms daily. R45 stated implemented any measures to a sa far as he knew, but he had abdomen while he was sitting s he believed that would	t			

Minnesc	ota Department of He	ealth				IAPPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00419	B. WING		01/	07/2022
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC	TH AVENUE NO	-		
		ROCHES	STER, MN 559	01		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 22	2 830			
	another episode of fatigue or a "severe" muscle spasm.					
	stated she had bee since 6:00 a.m. NA agency and was no She had a care gui used that as a refer Guide" revealed co numbers and name such as dentures o toileting status, ass Daily Living (ADL's) she worked for a st facility itself, she co resident care plans Guide in her pocke risk for falls. When stated that it either on him every 15 mi confused or had to light" if the resident stated that she was R45 without looking accompanied NA-F was sitting in his wi table pulled snugly stated R45 was ale have to check on h two hours but shou resident activated h)			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/07/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	A TOWERS OF ROC	CHESTER INC	HAVENUE NO	-		
(X4) ID	SUMMARY ST	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 AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 830	Continued From pa	age 23	2 830			
	not instruct him to against further falls I can't lift the footre wanted him to slee recliner or the whe difficult because he make it easier to b he ended up sleep footrest up, which this wheelchair, but spasm could result unless the footrest typically checked o unless he put his c "unless I have ano fall." R45 stated it we	een after his first fall, but did use it as a preventive measure s and, "It wouldn't work anyway est." R45 stated the facility p in his bed and not the elchair, but he found that e liked his head elevated to reathe. R45 stated sometimes ing in the recliner without the felt "a little more secure" than he was concerned another t in falling from the recliner was up. R45 stated staff n him "every couple of hours" all light on, which would be fine ther spasm that causes me to was his expectation that staff Id be knowledgeable about his cking on him frequently to				
	stated he regularly that he was aware did not consider hin because "he's total NA-E stated there staff had to take to	on 1/6/22, at 11:16 a.m. NA-E cared for R45. NA-E stated R45 had fallen in the past but m to be a current fall risk assist with almost everything.' were no special precautions prevent falls for R45 and very two hours was sufficient.				
	director of nursing R45 a fall risk base facility. The DON s room, which was "n resulted in increase were also encourag and offering to lay	on 1/7/22, at 8:30 a.m. the (DON) stated, he considered ed on his history of falls in the tated that the location of R45's right in the middle of the hall" ed supervision, and that staff ging frequent position changes R45 down. When asked about iliarity with R45's fall history or				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		00419	B. WING	B. WING		01/07/2022	
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE	1 1		
ADONN	A TOWERS OF ROC	HESTER INC	TH AVENUE NO	-			
(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 THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 24	2 830				
	pool [staffing agend Assistant], so I wou same depth of infoi own staff would hav recliner should be u	DON stated, "Well she's a cy] CNA [Certified Nursing uld not expect her to have the rmation that someone on our ve." The DON stated R45's used, "In the reclined position or resting," and R45 was using s he knew.	if				
	The director of nurs audit orders for res ensure they are cle understandable. Do all nursing staff rec balance issues, ed appropriate interve ensure compliance	ON or designee could ensure eive education on fluid ema monitoring and ntion. Audits could be done to of proper daily weights, documentation of fluid intake	nd				
	make sure resident comprehensive can designee could pro on how to access t care plan, and the between the two do designee could do and care guides ar	nee could design a plan to t care guides match the re plan; additionally, DON or ovide on-going training to staff he electronic record for the importance of accuracy ocuments. The DON or audits to ensure care plans e updated on a regular basis, staff are following resident ions as listed.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one	•				
2 940	MN Rule 4658.052	5 Subp. 9 Rehab - Hydration	2 940			2/2/22	
	Subp. 9. Hydratior						

Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00419	B. WING		01/0	7/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	H AVENUE N TER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	Continued From pa	ge 25	2 940			
		ate water and other fluids to dration and health, unless				
	by: Based on observati and policy review th prescribed theraper residents (R3 and F diets; resulting in th aspiration and weig Findings include: R3's Face Sheet, u admission date in A 11/4/21. Diagnoses (difficulty swallowin pain. R3's quarterly dated 12/15/21, ide intact and did not h swallowing disorder	ndated, indicated an August 2019 and readmission included, diabetes, dysphagia g), depression and chronic Minimum Data Set (MDS) ntified R3 was cognitively ave signs or symptoms of a r.		corrected		
Minnocoto	When interviewed of stated, "I am support but lately they have food." R3 stated sh dysphagia difficultie speech language p and determination of The SLP made reco physician who agre on 11/10/21.	on 1/4/22, at 10:30 a.m. R3 used to be on a pureed diet, been sending me regular e was on a pureed diet due to es. R3 was evaluated by the athologist (SLP) on 11/09/21 was made for the pureed diet. ommendation to R3's ed and implemented the order				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING	B. WING		07/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MADONN	NA TOWERS OF ROC	HESTER INC	HAVENUE NO	-		
(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	FION SHOULD BE	(X5) COMPLET DATE
2 940	O antinue d Frances		2 940	DEFICIENC	CY)	
2 340	that appeared to be pureed along with t cauliflower florets. chicken and rice ar The dessert was a texture) that R3 ate and stated it went of regular consistency The meal ticket on pureed diet circled. During an observat R3's lunch meal wa room at 11:25 a.m. time. Observation of regular texture full chips. No pureed it	3 received chicken and rice e a ground texture and not three pieces of whole R3 stated "I tried to eat the nd it didn't go down very easy." blueberry bar (cake like e in this surveyor's presence down fine. Liquids were served y, as per the current diet order. R3's tray was noted with tion on 1/5/22 at 11:30 a.m. as observed delivered to her . R3 was not in her room at the of the lunch meal revealed a taco salad with whole tortilla ems were noted on her tray. served and noted to have				
	stated she was una salad. R3 stated sh	on 1/5/22, at 3:30 p.m., R3 able to eat her entire taco he was unable to eat the some of the meat due to the				
	had her dinner mea R3 stated "I had ma	ion on 1/5/22 at 4:50 p.m., R3 al tray which was not pureed. ashed potatoes and cream of ut I couldn't eat the Spanish				
	the culinary service dietician (RD), and CSD stated R3 free kitchen and "yell at wants regular food	on 1/6/22, at 3:30 p.m. with es director (CSD), registered director of nursing (DON); the quently would go into the the kitchen staff that she and not pureed." However, RD stated those interactions				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
00		00419	B. WING	B. WING		07/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IADONI	NA TOWERS OF ROC	CHESTER INC	TH AVENUE NO STER, MN 559	-		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 940	Continued From pa	age 27	2 940			
	pureed diet and that delivered to her. The aware that R3 did in not spoken with her changes to her cur nursing should be pureed diet and co staff, CSD or RD for diet. R204's admission completed as a reach hospitalization on the impaired cognition, assistance of one p diagnosis list include Parkinsonism (sim tremors, stiffness, poor coordination) swallowing foods a other co-morbiditie		/			
	1/5/22, "I have inef related to: aspiratio [diagnosis] of dysp with nectar thick lic plan also contained have an alteration to [sic] dx of dysph events and need fo order and assistan "provide diet as oro honey-thickened lic recommended in a therapy]. On 12/10	ndicated a problem, start date fective breathing patterns on, as evidenced by : Dx hagia, coughing, pureed diet quids]. Additionally, the care d a problem dated 12/10/21, "I in nutrition/hydration status r/t agia, hx [history] of aspiration or mechanically altered diet ce at meals." The goal stated: dered (pureed texture with quids 12/10/21) and accordance with ST [speech /21 the following intervention de nutritional supplement: 8 oz av-thickened)."				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		01/	07/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NA TOWERS OF ROC	CHESTER INC	TH AVENUE NO	-		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 940	Continued From pa	age 28	2 940			
	1/6/22 indicated that	"care guide" updated on at R204 had dysphagia and diet with nectar thickened				
		's physician orders with a start diet: dysphagia (pureed) isistency.				
	in his room, only th from the door. Afte positioned somewh pillows and a soft to had a moist cough	m. R204 was observed in bed be foot of the bed was visible or entering, was observed to be hat on his right side using ouch call light in bed. R204 , kept his head extended uth open. He was not able to at that time.				
	room sitting up in v hall; had half glass without a lid or stra but no straw sitting table. A boxed serv sitting on the table,	 R204 was observed in his w/c, not able to be seen from of thickened orange juice w and a glass of water with lid next to him on a bedside ving of Ensure Clear was also the contents could not be as no indication if it was straw was present. 	,			
	nursing assistant (I how to care for the and experienced a learn was to follow them. NA-B said th	v on 1/6/22, 10:50 a.m. a NA)-B stated staff would know residents if they were familiar t the facility, and the way to other staff and learn from here was a paper care guide not able to describe how to nic care plan.				
		.m. NA-A, said the care guide ons for resident care. NA-A				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING		01/07/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC	THAVENUE NO			
(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 940	Continued From pa	age 29	2 940			
		nt for R204 to be "positioned up because he has trouble eds to sit up".				
	enter R204's room wheel chair. NA-A the meal, but he pointed an overbed table. N Ensure and R204 robserved in its orig placed a straw into	m. NA-A was observed to where he was sitting in his told R204 it was time for his ad at the fluids sitting nearby or VA-A asked if he wanted his nodded. The Ensure Clear was inal boxed container. NA-A the container and gave R204 pok him to the dining area.				
	registered nurse (F of Ensure Clear in the container did no to its consistency. I thicker than water, [consistency]." RN- the people in the ki product was thicke	v on 1/06/22, 11:08 a.m. a RN)-B looked at the container R204's room and confirmed of have any information related RN-B said, "well, it's definitely but I guess I don't know B said she thought perhaps tchen would know if the ned. At that time NA-A n and said, "he's taking it, he's				
	Ensure Clear was in Immediately after, it stated an expectation the product to a responsible of the dini	.m. a dietary aid (DA)-A stated not a pre-thickened product. the registered dietician (RD) on for whomever was taking sident to use a thickener ng area as needed, following ns, before taking it to a				
	retrieved the Ensur poured approximat cup and compared	.m. in R204's room, RN-B re Clear left in the room and ely two ml into a clear plastic the solution to R204's d thickened water sitting on his				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00419	B. WING		01/	07/2022
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IADONN	IA TOWERS OF ROC	HESTER INC	THAVENUE NO STER, MN 5590			
(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	TION SHOULD BE	(X5) COMPLET DATE
2 940	Continued From pa	ge 30	2 940			
	appeared to be mo	B confirmed the Ensure Clear re liquid in nature than the s, and stated it did not appear				
	said nursing assista liquids, stating it was staff to thicken any they were the one b requires thickened how a person would had already been th room. RD stated a non-thickened liquid his dysphagia "act of Director who had be	ants or dietary could thicken as the responsibility of nursing liquid to match the orders if oringing it to a resident who liquids. RD was not able to say d know R204's Ensure Clear nickened if they found it in the concern in providing ds to R204 as it might make up." The Culinary Services een listening stated, "that's a d do something. It should be if you don't know."	y			
	responsibility of the correct product for liquids, and they we who had the ability DON stated nursing thickened liquids ar care plan or care gr come in the proper said a nurse might able to read and un instructions. DON c who had prepared to would be able to kn	m. the DON stated it was the culinary services to obtain the persons who require thickened are the ones who would know and training to prepare it. g assistants should know that re required by looking at the uide, but the liquid should state from the kitchen. DON thicken liquids if they were iderstand the package confirmed that only the person the Ensure Clear for R204 how if it had been thickened as rough the container.	ŀ			
	order for Ensure Pl R204. DON then sa	.m. the DON stated a new us had been received for aid, the only persons who d liquids were dietary staff, and	4			

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00419	B. WING		01/0	7/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE NO			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 940	Continued From pa	age 31	2 940			
	not nursing staff, and this was not a new policy.					
	but with a copyrigh receive thickened I which specifically s thickened liquids. It to ensure that the r the appropriate cor while promoting ad consistencies matc were described as: thin milkshake or e honey at room tem or pudding thick-co not run off a spoon thickening liquid wa services will be res thickened liquids for commercially prepa medication adminis indicated the need	d Thickened Liquids, not dated t of 2012, indicated "residents iquids per a physician's order tates the consistency of the t is the responsibility of all staff resident receives all liquids in hisistency to prevent aspiration equate hydration." The ching those used at the facility nectar thick-consistency of ggnog, honey-consistency of ggnog, honey-consistency of perature or a thick milkshake onsistency of pudding and does . The responsibility of as described as "culinary ponsible for providing or meals and nourishments and ared products that are used for stration. In addition, the policy for thickened liquids should be a resident care plan.				
		THOD OF CORRECTION: sing (DON) and/or registered				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00419	B. WING		01/07/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
ADONN	A TOWERS OF ROC	HESTER INC	HAVENUE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
2 940	Continued From pa	ge 32	2 940		
	altering the consiste understand and offe fluids as ordered.	e appropriate persons are ency of fluids, and that staff er the ordered and appropriate			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one			
21385	MN Rule 4658.0800 Staff assistance	O Subp. 3 Infection Control;	21385		2/2/22
	Personnel must be infection control pro the residents and n	istance with infection control. assigned to assist with the ogram, based on the needs of ursing home, to implement ocedures of the infection			
	by: Based on observati review, it was deter ensure proper hand	ent is not met as evidenced on, interview, and policy mined the facility failed to d hygiene while caring for 1 of yed for personal cares.		Corrected	
	Findings include:				
	dated June 2017, re Perform Hand Hygi Before and after dir and after assisting a hands with soap an	y's "Hand Hygiene" policy, evealed, " Times to ene are, but not limited to rect resident contact Before a resident with meals - wash d water After contact with a membranes and body fluids or	ı		
		Face Sheet," located under b of his electronic medical			

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00419	B. WING		01/0	07/2022
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ADONNA TOWERS OF ROO	CHESTER INC	HAVENUE NO			
	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE ⁻ DATE
21385 Continued From p	age 33	21385			
recently admitted t diagnoses which in dementia, need for and need for contin- review of R204's E Data Set (MDS) as at the time of surver Observation of R2 AM and 12:12 pm. wheelchair at a tak approached by the ST did not perform approaching the re an electronic table near R204, then ch serve-out kitchen v of food. The ST ha and was not weari each bowl by placi on each side of the bowl, to carry them ST used R204's sp of the bowls, then his mouth. The res picked up his cloth her bare hand to c was no longer cou without performing ante area of the se obtained several s ST placed all but of refrigerator in the se to R204 with the re cough, and the ST cover his mouth. A	ealed he had been most o the facility on 12/17/21 with neluded dysphagia, Lewy body r assistance with personal care nuous supervision. Further MR revealed no Minimum assessment had been completed by. 04 on 01/04/22 between 11:32 R204 was sitting in his ole in the dining room and was Speech Therapist (ST). The hand hygiene before esident. The ST was carrying t, which she placed on the table tossed the room to the where she obtained two bowls d not performed hand hygiene ng gloves. The ST grasped ng her thumb and index finger e rim, with her thumb inside the nacross the room to R204. The boon to stir the contents of one placed a spoonful of food into ident began coughing and she napkin which she used with over his mouth. When R204 ghing, she left the table and, hand hygiene, went into the erve-out kitchen where she mall cartons of beverages. The ne of the cartons in a reach-in serve-out kitchen then returned emaining carton. R204 began to picked up his cloth napkin to fter assisting the resident with s bowl, the ST obtained two				

linnesota Department of He TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00419	B. WING		- 01/07/2022	
AME OF PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ADONNA TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 5590			
PREFIX (EACH DEFICIENC)	TEMENT 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
21385 Continued From pa	ige 34	21385			
placed the used tist plate. The ST conti manner throughout touching her face to throughout the obse began to cough mo- intensity. The ST re- bare hands, then hi tissues with which I cover his mouth. W from the table, the sink at the edge of washed her hands returned to the tabl and tissues, which the surface of the ta- sitting, then picked left the dining room An interview with th p.m. revealed, "Bas to wash my hands. seconds." When as hand hygiene appro-	e ST on 01/04/22 at 12:12 sically, when I touch food, I try I try to wash them for twenty sked if she had performed opriately while assisting R204,				
who also served as Preventionist, on 0 the observation of t	te director of nursing (DON), the facility's Infection 1/07/22 at 9:02 a.m. revealed the ST during the meal on t meet my standards in any				
10:45 a.m. revealed	le administrator on 01/07/22 a d, "I am a nurse as well as an It you saw is not acceptable."	t			
SUGGESTED MET	HOD OF CORRECTION:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00419	B. WING		01/07/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
	NA TOWERS OF ROC	HESTER INC	TH AVENUE I STER, MN 55	NORTHWEST 1901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE COMPLET
21385	Continued From pa	ae 35	21385		
	The director of nurs retrain staff, includi importance of hand feeding a resident, environment while Audits could be dor	sing (DON) or designee could ng therapy staff, on the hygiene on, during and after and maintaining a clean assisting residents to eat. The to ensure that hand hygiene control practices are routinely			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one			
21565	MN Rule 4658.132 Medications Self Ac	5 Subp. 4 Administration of dmin	21565		2/2/22
	self-administer med resident assessme care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.			
	by: Based on observati	ent is not met as evidenced ion, interview, and document		Corrected	
	assessment and ec of medications for for self-administrati sample of 16 reside	ailed to complete an ducation for self-administration 1 of 1 resident (R3) reviewed on of medications from a total ents, resulting in the potential rs related to the inappropriate of medications.			
	Findings include:				
	12/15/21, identified supervisor for most	num Data Set (MDS) dated cognitively intact and required activities of daily living. R3's diabetes, rheumatoid	1		

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		01/	1/07/2022	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		<u> </u>	
	NA TOWERS OF ROO						
			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 DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21565	Continued From pa	Continued From page 36					
	arthritis, depression and chronic pain syndrome.						
	1/4/22, at 10:30 a.r medications in her medications were of gave them to herse eye drops, inhalers cream. R3 stated s sugar checks durin to six times a day, observed in a plast stated she informe completed the bloc administered her in stated, and showed mist treatment (NM of her dresser, with labeled) and stated "Whenever I feel th	ervation and interview on m. R3 had multiple prescription room. R3 verbalized the current medications that she elf. The medications included s, and a topical antifungal she performed her own blood ng the day, approximately four and the supplies were tic container on her dresser. R3 d the nurse when she bd sugar check, and the nurse nsulin based on that. R3 further d this surveyor, her nebulized IT) set up in the bottom drawer n four NMT ampules (not d she does her NMT's, he need to do them," and that edication cup and mouthpiece the was done.	3 r				
	review of the medie	v on 1/5/22, at 3:45 p.m. and cations in R3's room with R3 ations were reviewed with R3.					
	twice a day. R3 sta 2. Nasal spray one R3 stated, "I do my	spray each nostril twice a day /self."					
	daily. R3 stated, "I 4. Ciprodex ear dro	oray two sprays each nostril do myself." ops two drops right ear for it ear infection prescribed					
	I just haven't given 5. Two Ventolin (re	I am not using that any longer. it back to the nurse." spiratory medication) inhalers					
nesota D		ce a day. R3 stated "I use the t better." However she was					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING		01/	07/2022
IAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
ADONN	A TOWERS OF ROC	HESTER INC				
			ER, MN 5590			0.45
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)N SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	ige 37	21565			
	 Diclofenac (mild mild arthritic pain, u 7. Lidocaine gel thr moderate/severe an gel for pain if the D 8. Two tubes of Tria (antifungal cream) had a while ago," m 11/5/21 and resider 9. Artificial Tears or as needed prescrib "I no longer use." 10. Glucose tabs ei total, resident state used any as I have 11. DuoNebs (coml of Atrovent and Alb unlabeled in bottom "it's been a while si breathing machine, what medication the know what it is." R3 she used it when, " nightstand." R3 furt provided any educa utilize the DuoNeb's observe her when of checks. R3's EMR for the Ja under the, Orders t 11/5/21, which inclu- self-administer Albu respiratory medicat spray) after set-up. noted for R3 to com eye and ear drops of 	ee times a day as needed for rthritis. R3 stated she used the iclofenac cream did not work. amcinolone Acetonide 0.025% cream for, "a rash I nedication was prescribed at stated, "I no longer use." ne drop each eye three times and 7/6/21 and resident stated, ight tabs in a container of 10 d, "it's been a while since I others in my purse." bination respiratory medication uterol) ampules four, n dresser drawer. R3 stated, nce I've had to use my " and when asked if R3 knew ey were, she stated, "no I don't 8 also stated the nurse knew they see the machine on my ther stated the facility had not ation to her regarding how to s, give her eye drops or doing her own blood sugar anuary 2022 physician orders, ab revealed orders dated uded, "resident is ok to uterol, Advair, DuoNebs (all ions) and Flonase (nasal " No other specific orders were nplete her blood sugar checks, or creams.				
	RSS EIVIR UNDER TH	e Miscellaneous tab revealed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00419	B. WING		01/0	07/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
MADONNA TOWERS OF ROCHESTER INC 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901							
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE	
21565	Continued From pa	age 38	21565				
	a Self-Administration of Medications assessment, completed on 11/4/21, when R3 was readmitted after a hospitalization. The assessment from 11/4/21, covered her respiratory and nasal medications only, and did not include the eye drops, creams, or completing her own blood sugar checks.						
	sugar checks. During an interview on 1/6/22, at 10:40 a.m. Registered Nurse (RN)-B stated, the first step to determine if a resident can complete the medication pass they are requesting was to complete a Self-Administration skills observation form. RN-B stated she was aware that R3 kept creams, eye drops, and inhalers in her room, but had not personally gone over them with the resident to see what medications were current and/or expired. RN-B stated, she typically asked R3 if she had completed the medications for documentation purposes. RN-B stated she was unaware how often the medications were reviewed/looked at for current doses/not expired and stated she did not routinely observe the resident perform her blood sugar checks, complete her eye drops, or inhaler.						
	stated that she cor of Medications ass on the history of R3 re-admission proce speak to the respir and not the creams	v on 1/6/22, at 11:30 a.m. RN-A npleted the Self-Administration essment, dated 11/4/21, based 3 and as part of the ess. RN-A was only able to atory and nasal medications s, eye drops, or ear drops. t R3 was able to self-administer	I				
	the respiratory and up by the nurse or [TMA]." RN-A also the nurse or TMA to medication and the	t R3 was able to self-administer nasal medications, "after set trained medication aide stated, "after set up" meant prought the resident her en resident was allowed to do t for the medications to be left					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/07/2022	
		00419	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	CHESTER INC	TH AVENUE NO			
(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 C (EACH CORRECTIVE ACTIK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21565	Continued From pa	age 39	21565			
	in her room.					
	practical nurse (LP was able to self-ad nasal medications TMA, but not to ha room. The DON als until, 1/6/22, that R her room. The DOI did not have a syst appropriateness fo	sing (DON) and licensed N)-D, the DON confirmed R3 Iminister her respiratory and after set-up by the nurse or ve the medications left in the so stated he was not aware 3 had sixteen medications in N stated the facility currently tem in place for review of r a resident to continue with of medications or checking the r room.				
	R3's medical docto aware, and agreed her respiratory and also stated she wo her if there was an condition that woul continue to self-adu further stated, rega expect the facility w medications in R3's medications are cu duplicates. The MD may complete her R3 had conducted December 2021, in determine her cont stated she was awa completing her own not aware in the fa- originally dated 6/3 when the resident w	y on 1/6/22 at 4:00 p.m. with or (MD), she stated she was l, with R3 self-administrating I nasal medications. The MD uld expect the facility to notify y significant change in R3's d that affect R3's ability to minister medications. The MD arding medications, she would vould conduct a review of any s room to assure that urrent, not expired or D further stated the resident own blood sugar checks, and a fingerstick for her in n which the MD was able to tinued ability to do so. The MD are R3 had an order for n blood sugar checks but was cility EMR that the order, 0/20, had not been reinstated was re-admitted in December ed in her EMR system the				

STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00419	B. WING		01/	07/2022
IAME 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			
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	ge 40	21565			
		ility to not reinstate the order feel R3 was capable to inger sticks.				
	Review of the facility's policy titled, "Self-Administration of Medications," initiated on February 2019 revealed, "Residents will approach nurse at the time they are required, and the nurse will transfer the unopened medication to the resident to self-administer" and " Reevaluation of the ability to self-administer will be done according to the interdisciplinary team (IDT) Observation Guide"					
	The Director of Nur educate nursing sta assessments, phys for residents to be a medications. The D audits, including roo medications are no yet evaluated as co medications are no residents and their educated upon adm the assessment pro self-administration assure medications	HOD OF CORRECTION: sing or designee could aff on the process for ician orders and expectations able to safely self administer ON or designee could initiate om audits to assure t left in rooms of persons not mpetent to self-administer t doing so. Additionally, new support persons could be hission and as needed about ocess for safe medication of medications to are not available to residents deemed safe to do so.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21942	MN St. Statute 144 Resident and Fami	A.10 Subd. 8b Establish y Councils	21942			2/2/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00419	B. WING		01/07/202	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROO	HESTER INC	HAVENUE N TER, MN 55	NORTHWEST 1901		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21942	Continued From page 41 Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.		21942			
	by: Based on interview failed to make regu of a family counsel Resident Council in review of the Resid it was determined t concerns brought f for five residents (F who regularly atten total census of 54. potential that reside needs met or expe	ent is not met as evidenced is and record reviews, facility ilar attempts at the formation . In addition, based on hterview, policy review, and lent Council meeting minutes, he facility failed to follow up on orth by the Resident Council, R 3, R11, R15, R17, and R30) ded council meetings out of a The failure created the ents would not have care rience weight loss when the ond to concerns with nursing meal service.		Corrected		
	(SW) stated the fac counsel, and furthe didn't send anythin	m. the facility social worker cility did not have a family er stated, "to be honest, we g out this year. We did the year further information was erview.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00440	B. WING		04/		
		00419			01/	07/2022	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST TH AVENUE NC				
MADONI	NA TOWERS OF ROO	CHESTER INC	STER, MN 559				
(X4) ID	_	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	DATE	
21942	Continued From pa	age 42	21942				
	March 10, 2020 wa contained the gree are you interested Council and would Family council?" Thi information about to and a survey about On 1/7/22, 12:53 p stated he felt face between departme and thus has a me and a monthly mee unable to address been established of made in the last ye expectation that eff	at title, but with the date of as provided. The document ting:" Dear Family and Friends in being a part of Family you like to learn more about his document provided the purpose of family council t goals and interests. the facility Administrator to face communication ents in the facility was important eting for departments to talk, eting for staff; however, he was why a family counsel had not or why no attempt had been ear. Administrator stated and forts would be made and said, with the SW." No further ceived.	t				
	policy revealed, "th upon the concerns facility demonstrate	ity's undated Resident Council le facility listens to and acts of the residents The es follow-through on written voiced by the Resident	5				
	1/6/22, at 1:11 p.m attendance (R3, R that they regularly the facility and had months," about del and lack of staffing that the facility relie staffing agencies; I seem to know the	v with the Resident Council on ., all five residents in 11, R15, R17, and R30) stated attended Resident Council in been complaining, "for layed call light response times g. The residents complained ed heavily on staff from nursing but the agency staff did not resident's specific care needs. urther complained that the					

NH0D11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00419	B. WING		01/	07/2022
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
	A TOWERS OF ROC	HESTER INC	THAVENUE NO			
(X4) ID	SUMMARY STA			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 T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21942	Continued From page 43		21942			
	preferences and requests or would tell residents they were out of requested food items. The residents reported these concerns were noted in the Resident Council minutes each month, but they did not receive information as to how the facility planned to address the concerns and their concerns had not been resolved. Review of the Resident Council Meeting minutes for 7/6/21, 8/3/21, 9/7/21, 10/5/21, 11/2/21, 12/7/21, and 1/4/22, provided by the facility, revealed the Resident Council voiced concerns with food service at each meeting except the meeting on 10/5/21; and concerns with staffing levels all months except 8/3/21. Further review of the Resident Council Meeting minutes revealed no feedback to the residents as to how the facility planned to resolve the concerns, or resident satisfaction with the outcomes.					
	administrator stated when the Resident concern, the Social the attention of the leadership team wo plan to address the keep the residents towards resolution. was aware of the residents the SW would have feedback to the residents communication pro- we need to do a be When interviewed of	on 1/7/22, at 11:18 a.m. the	3			
	SW stated, she away the Resident Counce plans to resolve the	are of the ongoing concerns of cil but had not documented the ose concerns or communicated ents. When informed that the	•			

Minneso	ta Department of He	ealth			-	_
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00419	B. WING		01/0	7/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONN	IA TOWERS OF ROC	HESTER INC	H AVENUE N TER, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21942	Continued From pa	ige 44	21942			
		ance felt the facility was not cerns, the SW stated, "Well tever."				
	Facility Administrate could ensure a plan expectations of follo resident council me been advanced. An council meetings an effectiveness of the Facility Administrate could ensure that a minimum of no less family counsel. Per completed, such as conferences, to det any road blocks to counsel be explored	THOD OF CORRECTION: or or social service designee in that meets the residents' ow-up during and after seting where grievances have monthly audit during resident ind/or in between could ensure e plan. or or social service designee ttempts have been made at a s than a yearly basis to form a iodic surveys could be a during resident care termine family interest, and the formation of such a d with the leadership team. R CORRECTION: Twenty one				
Minnesota De	epartment of Health					·